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Successes and Failures of Social Health Insurance Schemes in Africa – Nigeria versus Ghana and Rwanda: A Comparative Analysis

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I. INTRODUCTION AND PRELIMINARY BACKGROUND

In this paper, we argue that the social health insurance (SHI) system of financing health care provides the most effective means of attaining universal health coverage (UHC), the goal of every health system. We canvass two reasons why SHI lends itself to emerging health systems in Africa. First, the underlying philosophic basis of SHI – solidarity – is consistent with African cosmology. Second, the financing system provides a veritable route for countries to address the critical challenge of adequately funding health systems. These factors underpin the enactment of Nigeria’s National Health Insurance Scheme (NHIS) Act, a legal framework which institutionalized SHI in the country. Following the Act’s passage, however, Nigeria did not experience the same level of success as other African countries, such as Ghana and Rwanda, both of which had introduced SHI as a system to finance health care around the same time. This dichotomy – success stories in Rwanda and Ghana versus underperformance in Nigeria – raises questions which need to be fleshed out if Nigeria is to reap the dividends of SHI system. This paper will explore these questions, with the goal of distilling the...
experiences in Rwanda and Ghana, and using the same to improve health care financing in Nigeria.

A. Background

In 2000, the World Health Organization (WHO) published an authoritative report which ranked Nigeria’s health system 187 out of 191 countries surveyed — better than only four countries, which, at the time, were all engaged in armed conflict. This means that among stable nations, Nigeria’s health system ranked worst. Quite naturally, Nigeria’s response was swift and vociferous, with stunned disbelief and unremitting finger pointing across the country. The political leadership was aware of the dismal state of the health system, but was unaware of the exact nature and extent of the health system’s rot. Paradoxically, although it has been eighteen years since the publication of the WHO Report, the health landscape in Nigeria has not seen any significant improvement, especially when juxtaposed with key health indicators in other countries. The state of health in Nigeria compared to what is obtainable in other countries, particularly those in Africa, is an important concern because Nigeria is the most populous and boasts the

2. WHO, supra note 1.
3. Nigeria’s Low Ranking in Global Healthcare Index, Guardian (Jun. 6, 2017), https://guardian.ng/opinion/nigerias-low-ranking-in-global-healthcare-index/ (stating that the results showing Nigeria came 140th in the WHO’s healthcare rankings only reinforced what Nigerians knew about the state of health care services in the country).
4. Id.
largest economy in the region. Yet, the health status of its population does not reflect these advantages. In fact, in most major dimensions of human wellbeing, the country grossly underperforms relative to other countries.

For instance, the aggregated life expectancy at birth in Nigeria stands at 54.5 years — better than only six countries in Africa (Lesotho, Ivory Coast, Chad, Central African Republic, Angola and Sierra Leone).

Maternal health in the country is even more appalling. Although the maternal mortality ratio (MMR) – the number of maternal deaths per 100,000 live births – declined to 216 globally in 2015, the number veered in the opposite direction to 814 in Nigeria, which was superior to only three countries in Africa. This is hardly surprising given the country’s low level of access to skilled birth attendants (SBAs), a key indicator of maternal health. Consequently, even though seventy-three percent of births globally were assisted by a midwife, nurse or physician in 2013, the rate was only thirty-five percent in Nigeria between 2006 and 2014. This particular challenge – the dire shortage of SBAs in the country – is a significant booster of the national MMR. Relatedly, the country is also underperforming with respect to child mortality. The current global under-five mortality rate is 42.5 deaths per 1,000 live births, but in Nigeria, the rate (including neonatal


7. GUARDIAN, supra note 3.

8. TOYIB OLANYAN, RESEARCHGATE, THE HEALTH STATUS IN NIGERIA AND THE NIGERIAN HEALTH SYSTEM 1-2 (November 2012) (stating that there are significant disparities between rural and urban areas in health outcomes as well as limited access to clean water and sanitation); Nigeria. HAPPY PLANET INDEX (Nov. 11, 2017, 8:08 AM), http://happyplanetindex.org/countries/nigeria.

9. World health statistics 2016: Monitoring Health for the SDGs, Sustainable Development Goals 8 (2016) [hereinafter Monitoring Health] (providing a figure which shows the life expectancy at birth for countries around the world organized by region and ranked from highest to lowest age).

10. Monitoring Health, supra note 9, at 44.

11. Id. at 45.

12. Id. at 47 (The proportion of births attended by skilled health personnel in Nigeria is higher than only five other African countries).

13. Id. at 46.

14. Id. at 47.

15. Peter Nkwo et al., Poor Availability of Skilled Birth Attendants in Nigeria: A Case Study of Enugu State Primary Health Care System, 5 ANNALS MED. HEALTH SCI. RES., 20, 20 (2015) (stating that availability of SBAs is pivotal to achieving the fifth Millennium Development Goal (MDG), which is to improve maternal health).

16. Monitoring Health, supra note 9, at 48-49 (providing data showing that Nigeria had an under-five mortality rate of 108.8 per 1000 live births in 2015 compared to the global mortality rate of 42.5 per 1000 live births).

17. Id. at 48.
deaths) is abysmally high, at 109 deaths.\textsuperscript{18} The national record is equally disconcerting in other key areas of health such as rates of tuberculosis, malaria and hepatitis B vaccination.\textsuperscript{19}

Although multiple factors account for the poor performance of the health system in Nigeria, access issues relating to health care costs is the most critical.\textsuperscript{20} Though Nigeria is endowed with greater human and material resources than others in the region, its over-dependence on oil, deeply embedded institutional and structural ineptitudes, and decades of brazen economic profligacy, leakages and mismanagement have combined to foist untold hardship on the citizenry.\textsuperscript{21} Poverty yields a menacing stranglehold on the country, with more than half of the population (53.5 percent) surviving on less than $1.90 per day and, therefore, unable to access health care services.\textsuperscript{22} This situation demands a radically different approach. Even before the publication of the WHO Report in 2000, the political leadership of the country had begun to lay the foundation for a risk-sharing arrangement to replace the extant financing mechanism in the country (user fees), which were blamed for access to health care barriers throughout the country.\textsuperscript{23}

The idea of health insurance first surfaced in 1962, but was quickly shelved due to an inability to generate widespread support, which was not totally surprising given the readily available free or subsidized services at public hospitals at that time.\textsuperscript{24} The economic shock brought about by the

\begin{itemize}
  \item \textsuperscript{18} Id. at 49.
  \item \textsuperscript{19} Id. at 52–57 (providing data showing that the global TB incidence per 100,000 population was 133 compared to 322 in Nigeria (2014), the global incidence of malaria per 1000 population at risk was 91 (2015) compared to 343 in Nigeria (2013), and only 66% of infants in Nigeria receive three doses of the hepatitis B vaccination (2014)).
  \item \textsuperscript{21} Mapping Africa’s natural resources: An overview of the continent’s main natural resources, AL JAZEERA, Feb. 20, 2018, https://www.aljazeera.com/indepth/interactive/2016/10/mapping-africa-natural-resources-161020075811145.html; see generally Nigeria’s Corruption Challenge, TRANSPARENCY INT’L (2015) https://www.transparency.org/news/feature/nigerias_corruption_challenge, (last visited Nov. 12, 2018, 8:39 AM) ("Corruption hits hardest at the poor in Nigeria who make up more than 40 per cent of the 179 million people. Global Financial Integrity estimates more than US$157 billion in the past decade has left the country illicitly. Corruption is everywhere: even the health and medical services, considered the least corrupt government institution, are considered very corrupt by 41 percent of Nigerians.")
  \item \textsuperscript{22} SELIM JAHAN, UNITED NATIONS DEVELOPMENT PROGRAMME, HUMAN DEVELOPMENT REPORT 2016: HUMAN DEVELOPMENT FOR EVERYONE 219 (2016); see also Nigeria, supra note 5.
  \item \textsuperscript{23} K.O. Osungbade et al., Social Health Insurance in Nigeria: Policy Implications in a Rural Community, 57 NIGERIAN MED. PRACTITIONER 90, 90 (2010).
  \item \textsuperscript{24} Isaac AO Odeyemi & John Nixon, Assessing Equity in Health Care Through the National Health Insurance Schemes of Nigeria and Ghana: A Review-Based Comparative Analysis, 12 J. FOR EQUITY IN HEALTH 1, 2 (2013).
\end{itemize}
global oil glut of the 1980s and subsequent imposition of user fees sent policymakers back to the drawing board, desperate for a change in health care financing in the country. Consequently, in 1984, the National Council on Health, the highest policy-making body on health, resurrected the idea of health insurance in the country. Following extensive consultations with various stakeholders from different sectors of the economy, the National Health Insurance Scheme (Scheme) Decree 35 of 1999 established a SHI system of health care financing in Nigeria. The Scheme is predicated on a public-private sector partnership — a shared responsibility between the people and the government for financing the health system — with the ultimate purpose of achieving UHC.

WHO defines UHC as “access to key promotive, preventive, curative and rehabilitative health interventions for all at an affordable cost” meaning, equitable access to health services without being subjected to financial hardship. These are the two critical benchmarks that countries committed to UHC, such as Nigeria, must strive to attain. Nonetheless, despite the urgency of the country’s situation, the Scheme was not implemented until June 2005 due to challenges associated with logistics and widespread skepticism regarding the Scheme’s operation.

Implementation regulations are contained in the NHIS Operational Guidelines (Guidelines), which were adopted in 2005 and revised in 2012, to improve the efficiency and viability of the Scheme’s various programs. The current Guidelines merge existing programs into three broad categories: (1) the formal sector social health insurance program, (2) the informal sector social health insurance program, and (3) the vulnerable group social health insurance program. However, despite being implemented for the last

25. Id.
27. The National Health Insurance Scheme Decree 35 of 1999 is now referred to as Act, rather than Decree. See National Health Insurance Scheme Act (Act No. 35/1999), § 1 (Nigeria).
28. Id. at § 5.
30. Chima A. Onoka et al., Towards Universal Coverage: A Policy Analysis of the Development of the National Health Insurance Scheme in Nigeria, 30 HEALTH POL’Y AND PLANNING 1105, 1109-10 (2014) (explaining that initial attempts to commence the program were constrained by changes in the policy environment and stakeholder positions because of several contentious issues).
31. NATIONAL HEALTH INSURANCE SCHEME OPERATIONAL GUIDELINES (OCT. 2012).
32. Id.
thirteen years, the NHIS’ impact remains monstrously epileptic and covers merely three percent of the population.33 The low coverage rate in Nigeria sharply contrasts with the performances in other countries that operate SHI systems across Africa, notably Rwanda and Ghana.34 Rwanda and Ghana are appropriate comparators because, aside from sharing regional affinity, both nations implemented SHI Schemes within the same relative time period as Nigeria; yet, Rwanda and Ghana are markedly separated by different levels of attainment.35 Ghana implemented its own NHIS in 2004, just a year before Nigeria, following the enactment of its National Health Insurance Act in 2003.36 Remarkably, the coverage rate in Ghana rose to thirty-three percent of the population in 2010, and forty percent at the end of 2015.37 Rising concern about efficiency, transparency, and corruption triggered the enactment of a new statute in 2012, the National Health Insurance Act (Act 852), to replace the 2003 Act.38 Act 852 quite clearly mandates that regulations, notices, directions, or any other act lawfully enacted under the previous statute shall remain in effect until revoked.39 The new statute merges all existing District Mutual Health Insurance Schemes (DMHIS) to form a nationwide NHIS, to which every Ghanaian must belong.40

Rwanda’s health insurance system that covers those outside the formal sector is anchored on a community-based health insurance (CBHI) program known as “Mutuelle de Santé.”41 Although the country utilizes two other

36. Anthony Kusi et al., Refusal to Enroll in Ghana’s National Health Insurance Scheme: Is Affordability the Problem?, 14 INT’L J. FOR EQUITY IN HEALTH L. 2 (2015) (explaining that Ghana began the implementation of a National Health Insurance Scheme (NHIS) in 2004 as a way to ensure equitable access to basic healthcare for all residents).
40. National Health Insurance Act (Act No. 650/2003), § 31 (Ghana); see also Id. § 27 (1); see also Anthony Kusi et al., supra note 36, at 3.
2019 Successes and Failures of Social Health Insurance Schemes

health insurance programs, this article focuses on the CBHI Scheme. This focus is based on the fact that the Rwandan CBHI Scheme provides coverage to the vast majority of the population. The program resulted from a pilot project, which began in 1999 and was adopted as a national policy in 2004. In 2011, Rwanda witnessed a comprehensive insurance reform which transformed the Mutuelle de Santé to an income-based premium payment system. Tiered progressive premium payments, coupled with a 2008 legal requirement that residents of the country affiliate with a health insurance scheme, are perhaps the major driving forces behind the scaling up of Rwanda’s health insurance. Ultimately, these aspects make Rwanda the best success story in Africa, with coverage rates exceeding ninety percent of the population in 2010-11 although declining to seventy-five percent in 2015.

Institutionalizing a prepayment system of health care financing is a response to the severe financial hardship that is often commonplace in a user fees system. The idea is to provide protection against health-related financial catastrophe or impoverishment – defined as paying over forty percent of household income directly on health care after satisfying basic needs. The growing problem of health-related financial catastrophes affects 150 million people globally, and forces 100 million into poverty. The NHIS in Nigeria, like similar programs in other countries, aims to address this problem by positioning the country on a path to UHC by establishing various health programs through which residents may access health services. But these efforts have come with some serious hurdles.

42. World Health Report 2010, supra note 29, at 7 (discussing Rwanda’s two health insurance programs as (1) the Rwandaise insurance malady, which is a SHI providing coverage to government and private-sector employees; and (2) the Military Medical Insurance scheme, in which all military personnel are enrolled).
43. Makaka et al., supra note 41.
44. Chunling Lu et al., Towards Universal Health Coverage: An Evaluation of Rwanda Mutuelles in its First Eight Years, 7 PLOS ONE 1, 2 (2012) (explaining how the success of the pilot motivated the local governments and communities to quickly adopt and expand the program nationwide).
45. Id.
48. Id.
51. Id. at 9.
52. National Health Insurance Scheme Guidelines, supra note 31, at 3.
This article analyzes these hurdles or the various factors that frustrate efforts to attain UHC in Nigeria. This task is grounded in intercountry discourse – a comparative endeavor that seeks to transplant knowledge gained from the experiences in Ghana and Rwanda to Nigeria. It is not coincidental that a twenty-two-member delegation from Sierra Leone embarked on a two-day visit to the NHIS of Ghana to understudy its operations, as did a six-member delegation from Mali, which spent five days in the country. Similarly, many sub-Saharan and South Asian countries have sent delegates to study the Rwandan health insurance system.

Underlying these visits to Rwanda and Ghana is the intention to use the lessons learned to improve the health insurance schemes of other countries. This suggests that this paper, although primarily focused on Nigeria, could be beneficial to other countries in Africa and to countries elsewhere that are invested in relying on a SHI system of health care financing to achieve UHC. While laudatory of Rwanda’s and Ghana’s successes, this article equally recognizes the external and internal challenges that impede optimal performance in the two countries. For example, Ghana’s NHIS struggles against inadequate logistics and infrastructure, as well as inadequate human resources. However, this article does not dwell on these challenges, because they are typical of most emerging health systems. Instead, the article focuses on those key challenges from which the experiences of better performing SHI systems, like those of Rwanda and Ghana, could be harnessed and used to improve their underperforming counterparts, specifically in Nigeria.

This article consists of three sections. Following the Introduction, Part II explores the obstacles to scaling up SHI in Nigeria. This section projects five factors as the most critical: poor sensitization and mobilization campaigns, unavailability of health services to enrollees, corruption and its impact on enrollment, non-compulsory enrollment, and poverty as a barrier to enrollment. The goal is to explore the challenges that are stifling progress in Nigeria, as well as strategies that have worked in other countries, specifically Rwanda and Ghana, and to make a case for transplanting those strategies to Nigeria. The Conclusion, Part III, highlights the complexity of health policy.

55. Makaka et al., supra note 41.
56. Id.
implementation in third world countries and urges a retooling or recalibration of Nigeria’s NHIS by tackling the issues that were identified as responsible for its underperformance.

II. CHALLENGES TO NIGERIA’S NATIONAL HEALTH INSURANCE SCHEME AND LESSONS FROM RWANDA AND GHANA

A. Inadequate Sensitization and Mobilization Campaign

Creating public awareness, specifically by dedicating adequate resources to sensitization and mobilization campaigns, has been identified as essential to the realization of the goal of government-initiated programs, particularly those requiring financial contribution from the people, like SHI schemes. This is especially critical in a country like Nigeria, where there is a high degree of distrust of the government due to decades of irresponsible leadership and financial recklessness on the part of public officials entrusted with management of public resources. Cognizant of this divide, a reasonable measure in Nigeria would have been an intensive effort to gain public support before unveiling the NHIS in the country; that is, saturating the airwaves with vital information about the Scheme’s operation and its impact on access to health services. Yet, quite inexplicably, no such heavy lifting was done. The unintended, but visible, consequences of this grave omission are the apathy, misconception, and continued distancing of the vast majority of the population from participating in the Scheme. Knowledge deficits do not attract participation in any program, particularly government-sponsored programs, which explains the dismal level of enrollment and the current underperformance of the NHIS. The story is quite different in comparable countries.

In Ghana, dedicating resources to public sensitization programs regarding SHI and its operation is yielding tremendous benefits for Ghana’s residents. In 2008 household survey, more than seventy percent of respondents affirmed that participation in the NHIS afforded them access to health services at a cheaper cost. Knowledge levels are high, at 78.8 percent of

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58. Nnamuchi, supra note 26, at 159.
59. Id. at 160.
60. Id.
61. Id. at 151.
62. Id.
63. Id. at 160, 163.
65. Id. at 48.
the population, with nearly sixty-eight percent of households identifying radio as their main source of information, while television programming and information from neighbors, friends, and local associations/community-based organizations account for 8.2, eleven, and 2.2 percent, respectively, of the sources of information for the remainder of the population. The likelihood of sustaining this momentum is great given policymakers’ renewed efforts to continue providing more information and education to providers, clients, and the general public through intensive media campaigns, which would cover the operations of the Scheme and the activities of the National Health Insurance Authority (NHIA).

In Rwanda, aside from initial mobilization efforts, which were credited with creating a surge in the number of enrollees, declining enrollment recently triggered a fresh round of mobilization campaigns – including a month-long national campaign under the leadership of the country’s Prime Minister, Anastase Murekezi, and fresh rounds of sensitization campaigns aimed at creating better appreciation of health insurance among the people. Reports indicate that “people are comfortable with Mutuelle de Santé because of the thorough sensitization about its advantages.” Local leaders and 45,000 community health-care workers recently received incentives to increase individual enrollment in the CBHI program. In 2015, the government disclosed that a plan was underway to take awareness campaigns to the communities, and to bring registration services closer to the people.

B. Denial of Services to Enrollees and its Impact on the Scheme

A crucial factor driving enrollment in health insurance is the belief or knowledge that services will be available when illness strikes. After all, the sole reason for gaining coverage is to ensure that lack of funds does not impede accessing health care services when the need arises. Yet, quite often, this hope does not materialize for enrollees under Nigeria’s NHIS.

66. Id. at 55.
67. Id. at 41.
68. See e.g., Health Insurance Profile: Ghana, supra note 37 (reporting Ghana’s health insurance profile, including how it is financed and the package benefits).
70. Asaba, supra note 69.
71. Makaka et al., supra note 41.
72. Asaba, supra note 69.
73. Id. at 5, 6.
74. Id. at 6.
75. See e.g. Agency Report, NHIS Expels 23,000 Fake Enrollees in Three Months –
Health establishments routinely deny beneficiaries services due to non-receipt of payment from Health Maintenance Organizations (HMOs), despite having been paid three months in advance by the NHIS. The result is atrocious. For instance, one report indicates that Nigeria loses seventy newborn babies and 100 women every day, notwithstanding coverage under the NHIS. In addition, HMOs have been found to be submitting names of thousands of fake enrollees for which payment was made by the Scheme – a key reason these organizations have been described as “blood sucking monsters” and “the problem of the NHIS” This causes continued access difficulties, which negates the reason for NHIS’ establishment, and causes concomitant loss of confidence in the Scheme’s operation.

In Ghana, the situation is markedly different. For instance, while the rate of births attended by SBAs in Nigeria stagnates at thirty-five percent, the figure in Ghana has risen to seventy-one percent, up from just fifty percent in 2006. This increase indicates that SHI in Ghana has significantly boosted pregnant women’s access to health care services and positively impacted maternal survival rates in the country. The MMR in Ghana stands at 319 deaths per one hundred thousand live births, compared to 814 in Nigeria. These differences account for the disparate perspectives in the two countries regarding the impact of health insurance in the respective countries. Dissatisfaction is rife in Nigeria, whereas the reverse is true in Ghana, with approximately ninety-two percent of enrollees reporting that they are satisfied or very satisfied with the Scheme’s performance.

Similar confidence is seen in Rwanda, as can be gleaned from this assertion by a health insurance provider in that country, to wit, the vast majority of the “people are comfortable with Mutuelle de Santé” on account

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76. Id.


78. Agency Report, supra note 75; see also Okafor, supra note 77.

79. Agency Report, supra note 75.

80. WHO, supra note 9, at 108.

81. WHO, supra note 9, at 106; see also Nat’l Dev. Planning Comm’n, supra note 64, at 34.

82. Nat’l Dev. Planning Comm’n, supra note 64, at 34.

83. WHO, supra note 9, at 106, 108.

84. Nat’l Dev. Planning Comm’n, supra note 64, at 52.
of the widespread knowledge about its benefits. An enrollee recently affirmed, “without Mutuelle de Santé, hospital bills would be unmanageable.” This degree of confidence is remarkable because the ability to afford or manage health care costs is one of the reasons for the steep decline in the rate of infant and maternal mortality in Rwanda, assuring its place among the few African countries to attain the relevant benchmarks of the Millennium Development Goals.

C. Corruption and its Impact on the Psyche of Potential Enrollees

In the third quarter of 2017, the Health Minister suspended Executive Secretary of Nigeria’s NHIS, the Chief Executive Officer of the Scheme, Usman Yusuf, over allegations of fraud. His alleged transgressions included unauthorized acquisition of a luxury vehicle at a grossly inflated price, awarding contracts without adherence to pre-existing procedures at figures that were multiple times over prevailing market rates, as well as granting himself immunity from prosecution on the basis of his closeness to the Nigerian President. The suspension came barely a year after he assumed office, and his proclamation that his “mandate at the [NHIS],” namely, “to design and implement strategies and instruments that will make [the Scheme] a good steward of the nation’s commonwealth . . . will have no place for vices and distractions like corruption, inefficiency, impunity and political patronage.” This was quite a startling, paradoxical development.

Regardless of the authenticity of these allegations or the paradoxical nature of the events at the leadership or management level of Nigeria’s NHIS, a disturbing reality is that the situation does not augur well for the Scheme, especially considering that the two prior executive secretaries

85. Asaba, supra note 69.
86. Id.
87. Id.
89. Abdulganiy, supra note 88.
presently face corruption charges. Specifically, one is being investigated by the Economic and Financial Crimes Commission (EFCC) for money laundering in the amount of nearly $2.2 million, while the other is charged with fraud, embezzlement, and misconduct in office. They are also being prosecuted by the Independent Corrupt Practices and Other Related Offences Commission (ICPC) for fraud connected with funds belonging to the Scheme. In a report entitled “Corruption Practices and Abuse of Office in NHIS,” published in the last quarter of 2015, the ICPC found the two aforementioned officials culpable of “abuse of office: flagrant abuse of financial rules and the regulations; executive rascality: embezzlement of public funds and monumental diversion of government funds.” A news article report was even more virulent, accusing the two of being “neck-deep in the systematic creation and manifestation of ghost enrollees in the scheme at a staggering cost” to the health sector and the country. This abuse is quite disturbing because it dampens public enthusiasm in the public-private partnership that the Scheme represents, a factor that one of the authors of this article identifies in a related publication as a reason for extant low-enrollment, particularly in the informal sector:

It is no secret that government projects usually come to naught due, in most cases, to misappropriation of budgeted funds by public officials. Corruption is endemic in Nigeria and, as more fully argued elsewhere, is at the core of many of the challenges stifling the development of the country. Health care is no exception. Seen this way, it becomes easy to understand why people are reluctant to buy into an insurance scheme operated by a government that has done little to earn public trust. There is no guarantee that contributions squeaked out by the people would not wind up in some private bank accounts but will in fact be used to provide health care to the contributors as the need arises.

The point is that even if other challenges bedeviling the Scheme are expunged, it would be difficult, if not impossible, to engineer large-scale enrollment in the absence of a commitment to eradicate corruption in the

94. Ibeh, supra note 93.
95. THE ICON, supra note 93.
97. Id.
98. Id.
operation of the NHIS. While the current Executive Secretary denies his suspension in the media, the Health Minister appointed a replacement, in acting capacity. Although the wisdom of the Health Minister’s actions is not in dispute, the instability generated by constant changes at the highest echelon of the NHIS administration does not bode well for the Scheme. Aside from funds lost and its impact on performance and provision of services, instability implies unsustainability, which hardly incentivizes uptake of coverage, thereby contributing to further erosion of confidence in the Scheme.

In this context, there is a need to consider the situation in other countries. Admittedly, the NHIS in Ghana is not corruption-free, and neither is the insurance program in Rwanda. Nevertheless, the pervasiveness and impact are not as pronounced compared to the scenario in Nigeria. There have been reports in Ghana of informal payments, such as charging for services provided during unofficial hours, and demanding payment for out-of-stock drugs and/or drugs not listed in the government’s Essential Drug List, which affects up to forty percent of the insured population. Similarly, Rwanda has also battled corruption, but its key challenges are of a different genre, ranging from infusing efficiency to financial management, addressing the affordability of premiums for the poorest citizens, and scaling up the range of services available while reducing out-of-pocket costs.

D. Non-Compulsory Enrollment

A peculiar feature of Nigeria’s NHIS is its non-compulsory enrollment, except for formal sector employees. Formal sector employees refer to civil servants and those employed in medium/large companies whereas those engaged in small-scale businesses, such as petty traders, farmers, and artisans, operate in the informal sector. Those in the informal sector are at liberty to enroll or not enroll. Non-compulsory enrollment of the informal sector’s population is one of the major factors responsible for the low

102. Nnamuchi, supra note 26, at 156.
103. Id.
104. Asaba, supra note 69.
107. Offiong, supra note 33.
108. Id.
coverage rate in the country. As to the benefit of compulsory enrollment, health policy expert, Felix Abrahams Obi, opines that “everyone will be insured,” resulting in a “risk pool large enough to provide a robust benefit package”; whereas voluntary participation encourages adverse selection – in the sense of incentivizing enrollment when people are ill and in need of coverage. The result would be large numbers of sick enrollees and abnormally high rates of expenditure, which, if left unchecked, could bankrupt the program.

Recently, one of the states in Nigeria, Oyo, adopted a statute which makes health insurance compulsory for all of its residents. When fully operational, the state health insurance program will provide free coverage to pregnant women, vulnerable groups, and children under five years old. A significant feature of the program is its premium prices, estimated to be approximately $2 per month or $21 annually, depending on the payment preference of the enrollee. The point is that health sector successes do not need to be driven by the central government; at times, as in this case, NHIS could learn from the example of a component of the federating unit. Needless to add that enrollment is compulsory in Ghana and, in Rwanda, Law No 62/2007 makes affiliation with a health insurance scheme mandatory for all residents.

E. Poverty as an Enrollment Barrier

The extent to which poverty poses a challenge to enrollment under an SHI system depends on the cost of contributions that households are required to make to the health insurance program. The contribution is considered

109. Id.
110. Id.
113. Waheed, supra note 112.
114. Id. (explaining that the premiums depending on preferred payment method will either be 650 Naira ($1.79 US Currency) or 7,800 Naira ($21.46 US Currency)).
115. National Health Insurance Scheme Act No. 852, §27 (1) (2012) (Ghana); accord National Health Insurance Scheme Act (2003) § 31 (Ghana) (reinforcing that enrollment in a health insurance scheme is mandatory).
117. Kusi et al., supra note 36, at 4 (describing how affordability of insurance is influenced by over-all household income).
affordable if purchasing health insurance leaves sufficient income to meet other socially defined minimum essential requirements of life.\textsuperscript{13} This means that sometimes health insurance would be affordable to socioeconomically disadvantaged households insofar as the amount expended does not deprive the household of funds needed to purchase other things that are essential to sustaining life.\textsuperscript{13} Governments should be mindful of this when fixing the price of contributions payable to the health insurance pool. Equally noteworthy is projecting poverty as an impediment to participating in a SHI scheme is the fact that raw poverty measures do not correlate to enrollment, as other factors might turn the tide the opposite direction. The poverty rate in Rwanda is higher than in Nigeria, at 60.4 and 53.5 percent respectively,\textsuperscript{25} yet, Rwanda provides better access to health care through effective and efficient SHI management,\textsuperscript{14} meaning that the reason for Nigeria’s low performance is not necessarily poverty-driven. As key issues pinpointed in this discourse demonstrate, the reasons for Nigeria’s low performance are much deeper and multifaceted,\textsuperscript{13} and these same reasons explain why Ghana’s coverage rate is lower than Rwanda’s, even though the poverty rate in the former is much lower, at 25.2 percent.\textsuperscript{13} Often, the decisive factor in rates of participation in SHI schemes is whether the government provides premium subsidies or exempts some of the participants in the informal sector, particularly the poor, from making contributions.

In Ghana, poverty is a major challenge to enrollment.\textsuperscript{22} Disaggregated data on the country’s NHIS subscription among socioeconomic groups portrays the lowest enrollment among the poor.\textsuperscript{15} Out of every ten people in the

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118. Id. (defining health insurance as affordable if after purchase a household still retains enough income to meet minimum necessities required for living).
119. Id. (explaining the ‘budget-based approach to affordability’ where insurance affordability is based on the over-all household income).
120. SELIM JAHAN, supra note 22, at 219 (reporting the population percentage living below income poverty line at purchasing power parity (PPP) of $1.90 a day).
121. Id. (reporting a 29.8% health contribution to deprivation in dimension to overall poverty in Nigeria, and 18.4% contribution in Rwanda).
122. Kusi et al., supra note 36, at 4.
123. SELIM JAHAN, supra note 22, at 218-19 (reporting percentage living below income poverty converted to PPPs at 25.2% in Ghana, and 60.4% in Rwanda); see also Chemouni supra note 35, at 88 (reporting coverage rates at 81.6% under CBHI, and 87% including other insurance in Rwanda, and 38% coverage in Ghana); see Id. (reporting multi-faceted monetary and nonmonetary variables in Ghana).
124. GHANA STAT. SERV., GHANA HEALTH SERV., GHANA DEMOGRAPHIC \& HEALTH SURV. 2008 48-49 (2009) (illustrating the large percentile difference in enrollment between both men and women from the lowest wealth quintile and highest wealth quintile).
125. Id. (reporting percentage distribution of individuals enrolled in the National/District Health Insurance scheme at 29.3% of women in the lowest wealth quintile compared to 47% of women in the highest wealth quintile, and 16.6% of men in the lowest wealth quintile compared to men at 37.7% in the highest wealth quintile); see also ARIN DUTTA \& CHARLES HONGORO, HEALTH POLICY PROJECT, SCALING UP NATIONAL
lowest socioeconomic group, only about three are registered with the Scheme.\textsuperscript{126} A recent study reports that about sixty-four percent of the uninsured and forty-seven percent of the partially insured households attribute non-enrollment with the NHIS to costs they cannot afford.\textsuperscript{127} The link between affordability and enrollment is illustrated by a finding that fully insured households have the lowest annual NHIS contribution (Gh C38.01 or US $25.33), with partially-insured households having the highest contribution (Gh C53.69 or US $35.79), followed by the uninsured (Gh C47.73 or US $31.81).\textsuperscript{128} Part of the response to this problem has been to exempt certain categories of people from premium payment, including: children; persons in need of ante-natal, delivery, and post-natal health care services; persons with mental disorders; indigents; pensioners; contributors to the Social Security and National Insurance Trust; senior citizens (aged above 70 years); and such other persons as may be prescribed by the Minister.\textsuperscript{129}

Nigeria has a specific program that caters to the health insurance needs of indigents, known as the “Vulnerable Group Social Health Insurance Program.”\textsuperscript{130} It provides free coverage to individuals who are physically challenged, prison inmates, children less than five years old, refugees, victims of human trafficking, internally displaced persons and immigrants, and pregnant women and orphans.\textsuperscript{131} Mentally challenged persons are also included.\textsuperscript{132} Moreover, Nigeria’s National Health Act requires the Minister of Health to prescribe conditions under which some “categories of persons may be eligible for exemption from payment for health care services at public

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\item[126.] Nat'l Dev. Planning Comm'n, supra note 64, at 25.
\item[127.] Kusi et al., supra note 36, at 7.
\item[128.] Id. at 8.
\item[129.] National Health Insurance Scheme Act No. 852 § 29 (a-i) (2012) (Ghana).
\item[132.] See NATIONAL HEALTH INSURANCE SCHEME OPERATIONAL GUIDELINES, supra note 31, § 1.3.2.1. (defining Physically Challenged Persons Social Health Insurance [Program] (PCPSHIP) as “a [program] designed to provide Healthcare Services to Physically/Mentally Challenged Persons who due to their physical status cannot engage in any meaningful economic activity”).
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Those whom the exemption contemplates are "vulnerable groups such as women, children, older persons, and persons with disabilities." While these stipulations parallel regimes in other countries, a distinguishing feature in Nigeria is the wide dissonance from the reality on the ground, in that free coverage is, in practice, not provided to the specified demographics. No such dissonance exists in Ghana and Rwanda. In fact, in Ghana, the NHIA subsidizes more than eighty-two percent of total expenditure of the DMHIS and provides eighty to ninety percent of their revenue, coupled with freedom from co-payments, co-insurance, or any other form of deductibles. In contrast, Nigeria’s NHIS requires ancillary payments such as co-payment, payment of ten percent of total cost of drugs dispensed per prescription, and co-insurance payments related to treatments and investigations covered under the partial exclusion list.

There are four major factors fueling enrollment in Rwanda’s Mutuelle de Santé, despite the high poverty rate in that country (60.4 percent). These factors include: (1) heavy subsidies, (2) affordable contributions, (3) drastic reduction in out-of-pocket health spending from twenty-eight to twelve percent of total health expenditure, and (4) the institutionalization of a wealth categorization program as a key component of the funding mechanism. This program, known as Ubudehe, was initially developed as a basic community target scheme. After the 1994 genocide, Ubudehe was modified to expand enrollment to incorporate the national social protection

134. Id. at § 3(2)(d).
135. See Onoka et al., supra note 30, at 1105, 1106 (emphasizing Nigeria’s difficulty in expanding insurance coverage in a significant way or post federal employees).
136. See Gajate-Garrido & Owusua, supra note 57, at 4 (illustrating how Ghana subsidizes a large portion of the National Health Insurance Act); Nyandekwe, supra note 46, at 3 (reporting that Community Based Health Insurance coverage in Rwanda has increased from 7% in 2010, to 90.75% in 2011/2012, with overall health insurance coverage at 96.15%).
138. Id. (stating co-payments, co-insurance, or deductibles are required to be paid).
139. Nat’l Health Ins. Scheme, supra note 31, at 38 Section One (stating “[t] is 10% of the total cost of drugs dispensed per prescription in accordance with the NHIS Drug Price List” which is not applicable to vulnerable groups and tertiary institutions programmes).
140. See SELIM JAHAN, supra note 22, at 219 (reporting that the percentage of the population living below the income poverty line at purchasing power parity (PPP) of $1.90 a day is 60.4% in Rwanda).
141. See WORLD HEALTH REPORT supra note 29, at 7 (explaining 50 percent of the funding is provided by the government, with the other half coming from premiums).
142. Asaba, supra note 69.
143. Makaka, et al., supra note 41, at 7 (reporting further that a reduction in out-of-pocket spending from 28 to 12 percent of total health expenditure).
144. Makaka, et al., supra note 41, at 7.
programs serving the most vulnerable citizens. Ubudehe not only provides a progressively tiered contribution system and completely subsidizes the premiums for households in the two lowest socioeconomic quintiles, covering twenty-three percent of the population. It also enables members of each village to collectively assess the income, household assets, and employment status of each person as a basis for setting the premium amount. Additionally, Ibimina, a program adopted throughout Rwanda, is a household cooperative savings mechanism initiated by a rural district, resulting in up to forty percent of premiums being fully prepaid three months in advance of the next fiscal year in several districts. Ibimina allows members to contribute a specified amount to a fund according to a defined schedule. From the funds contributed, members can borrow money and also share in interest that loans drawn from the fund generate.

III. CONCLUSION: RECALIBRATING NIGERIA'S SOCIAL HEALTH INSURANCE SYSTEM

Despite explicit proclamation of UHC as a national objective in the three countries studied, with all three adopting fairly appropriate legal and policy regimes aimed at using SHI to expand access to health coverage, monstrous gaps still remain among these countries in attaining their desired objectives. At just three percent coverage rate, the NHIS in Nigeria grossly underperforms vis-a-vis Rwanda and Ghana, which are currently at seventy-five and forty percent respectively. This disparity highlights the crux of this study: how to expand health insurance coverage in Nigeria by borrowing from the strategies and experiences of Rwanda and Ghana. Aside from the factors explored previously as core challenges confronting the NHIS in Nigeria, attention should be drawn to the health expenditure or public

145. Id.
146. Republic of Rwanda, supra note 69.
147. Makaka et al., supra note 41, at 7.
148. Id.
150. Id.
151. See generally Offiong, supra note 33 (discussing Nigerians’ low NHIS enrollment rate).
152. Id. (discussing Nigerians’ low NHIS enrollment rate).
spending on health in each country. The permutation is simple: high public expenditure on health services coupled with low out-of-pocket spending signals progress, and the reverse holds equally true.

Although there are many standards for assessing whether the amount expended on health care delivery is consistent with international standards regarding advancements toward UHC, this article considers only two standards, for brevity and pragmatic reasons. The first is total spending on health as a percentage of general government expenditure; in other words, the budgetary allocation to health (the Abuja Declaration requires African governments to allocate at least fifteen percent of their annual budgets to health). In this context, a necessary concern should be whether Ghana outperforms Nigeria. The latest data shows a surprising result. While budgetary allocation to health in Ghana stands at eleven percent, the figures for Nigeria and Rwanda are eighteen and twenty-four percent respectively, signifying compliance in the latter nations with the Abuja Declaration. The second standard examines total expenditure on health by comparing government expenditure on health with private expenditure. In 2012, the ratio of government expenditure on health versus private expenditure was 33.2 versus 66.8 percent in Nigeria, meaning higher private spending than government spending on health. The reverse is typically the case in high-performing health systems. In Ghana, government spending at the relevant period was 68.3 percent while private expenditure was 31.7 percent – quite similar to Rwanda, at 58.8 versus 41.2 percent respectively. Better health outcomes in Ghana and Rwanda and robust movement toward UHC through heightened health insurance enrollment highlight the advantages inherent in keeping private expenditure on health care low.

Regarding budgetary allocation on health, the analysis is not straightforward. One needs to inquire as to the reason the health insurance system in Ghana outperforms that of Nigeria, even though its budget on health is seven percent less than that of Nigeria. Among the challenges explored in Part II of this article, to which Nigeria’s NHIS is exposed, none is more damaging to the health sector in that country than corruption and

156. Id. at 130.
158. WHO, supra note 155, at 128, 130.
159. Id. at 130, 132.
misappropriation of funds meant for provision of health services.\textsuperscript{160} A 2008 publication succinctly captures this point, stating that, although blaming every malaise in the country on corruption seems “somewhat exaggerated and scarcely sustainable,” according appropriate recognition to the deleterious impact of corruption in public life is “the key to understanding the genealogy and intractable nature of current challenges facing the country, particularly within the health sector."\textsuperscript{161}

In September 2017, the Panel that the Federal Ministry of Health tasked with investigating the activities of the suspended Executive Secretary of the NHIS, Usman Yusuf, submitted its report to the Presidency.\textsuperscript{162} It indicted Yusuf for large-scale fraud and embezzlement of funds, and recommended his referral to the EFCC.\textsuperscript{163} Recall that Part II of this article documented that the two previous executive secretaries, who were top administrators of the Scheme, face similar charges before the EFCC and ICPC.\textsuperscript{164} Regardless of the outcome, one thing remains clear: the maxim “where there is smoke, there is fire” is apposite in this context. Even if the Executive Secretary, described in said report as having “portrayed a holier-than-thou attitude but in the background, milked the agency dry,”\textsuperscript{165} is eventually cleared of direct involvement in the scandal, enormous damage has already been inflicted upon the Scheme and its future.\textsuperscript{166} The perception that the leadership of the apex health insurance institution in the country is populated by ‘crooks’ would hardly incentivize enrollment, even if all the other challenges enumerated in this article are addressed. Therefore, without appearing to diminish the seriousness of other problems confronting NHIS in Nigeria, the question of corruption must be accorded priority in any future reform process.\textsuperscript{167}

Additionally, the funding base of Nigeria’s NHIS must be strengthened to accelerate the pace toward UHC. Worthy of consideration is Ghana’s National Health Insurance (NHI) Levy, which is a value-added tax imposed at the rate of 2.5 percent upon goods and services provided in Ghana, whether produced locally or imported.\textsuperscript{168} The levy generates about sixty percent of

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\item \textsuperscript{161} \textit{Id.}
\item \textsuperscript{163} \textit{Id.}
\item \textsuperscript{164} Ibeh, \textit{supra} note 93 (detailing Olumefi Thomas’ money laundering accusations); \textit{see also} THE ICON, \textit{supra} note 93 (discussing allegations against Femi Akingbade).
\item \textsuperscript{165} Janah, \textit{supra} note 162.
\item \textsuperscript{166} \textit{Id.}
\item \textsuperscript{167} Nnamuchi, \textit{supra} note 160, at 12.
\item \textsuperscript{168} Ghana National Health Insurance Act (Act. No. 852/2012), § 47(1) (Ghana).
\end{thebibliography}
the total revenue funding Ghana’s Scheme, making it the major source of funding for the country’s NHIS. This funding system offers a fine example for emerging SHI Schemes in Africa, such as Nigeria’s NHIS.

The last key lesson deserving of Nigerian policymakers’ attention is the role of compulsory insurance in attaining UHC. Except for formal sector workers in the country, enrollment in Nigeria’s NHIS is voluntary, in contrast to enrollment in Rwanda and Ghana. This contrast in voluntary versus involuntary enrollment partially explains the wide disparity in attainment levels among the three nations. Mandatory insurance is consistent with the current global trend, as forcefully canvased in a 2009 article. WHO similarly affirmed that not only does “compulsory prepayment [provide] the most efficient and equitable path towards universal coverage... countries that have come closest to achieving universal health coverage,” are those where “prepayment is the norm, organized through general taxation and/or compulsory contributions to health insurance.” WHO was quite unequivocal, asserting that “in the long run, participation will need to be compulsory if 100 [percent] of the population is to be covered.” The inevitable consequence of not heeding this admonition by the global apex health institution, as well as the other recommendations and suggestions of this article, will be either retrogression or continued stagnation of Nigeria’s NHIS – an outcome that nobody wants and, therefore, should be avoided at all costs.

169. Kusi et al., supra note 36, at 3.
172. World Health Org., supra note 29, at 87 (emphasis added).
173. Id. at 89.