UNIVERSAL HEALTH COVERAGE IN NIGERIA: THE NHIA ACT AND SDG 3*

Abstract
Universal Health Coverage sits at the heart of Sustainable Development Goal 3, which requires states to secure access to quality healthcare without financial hardship. Nigeria's National Health Insurance Authority Act 2022 replaced the weak framework of the former National Health Insurance Scheme with mandatory participation, a dedicated fund for vulnerable persons and wider regulatory powers. Four years into implementation, enrolment has reached roughly 22 million people, out-of-pocket payments still account for more than 70 per cent of current health expenditure, and federal health allocations remain near four per cent of the budget. This article appraises the Act against Target 3.8 and finds the legal architecture sounder than anything Nigeria has had before, yet defective in three respects. The compulsion in section 14 is unenforceable in both directions, since no penalty attaches to a resident who fails to enrol and no clear remedy lies for a vulnerable person refused the free cover that section 13(7) requires states to provide. The Vulnerable Group Fund has no independent revenue and leans on a statutory fund created by other legislation. Enforcement content sits in operational guidelines rather than in the statute. Rwanda's tiered subsidy and Ghana's arrears crisis supply direct evidence for the second and third of these, and the article sets out what amendment and subsidiary regulation would each need to contain.

Keywords: Universal Health Coverage, National Health Insurance Authority Act 2022, SDG 3, Healthcare Financing, Health Equity and Justiciability, Comparative Health Law.

1. Introduction

Universal Health Coverage (UHC) rests on a simple proposition. No person should have to choose between health and financial survival. Everyone, whatever their income or location, should be able to obtain healthcare without being pushed into poverty by the cost of it. The idea draws on a tradition in human rights thought that treats health as a condition of dignity and a foundation for other rights.[1] The idea acquired institutional force in 2015, when the United Nations (UN) adopted the Sustainable Development Goals (SDGs). Goal 3 calls for healthy lives and wellbeing for all. Target 3.8 places UHC at the centre of that goal by requiring financial risk protection, access to essential services, and affordable medicines and vaccines for everyone.[2] For Nigeria, as for every other member state, this was a political undertaking to reorganise the health system around the premise that healthcare is an entitlement rather than a privilege. Delivering on that undertaking is particularly difficult in lower-income countries, where constrained public financing and persistent weaknesses in health systems impede progress towards universal health coverage.[3] Across sub-Saharan Africa, heavy disease burdens and reliance on external financing that shifts with donor priorities compound the difficulty.

Nigeria shows the problem in sharp relief. The country has a population above 240 million and a health system under chronic strain, so its progress towards UHC matters well beyond its own borders.[4] Out-of-pocket payments account for more than 70 per cent of current health expenditure, among the highest proportions anywhere.[5] A household that meets a serious illness borrows, sells what it owns, or goes without treatment. The consequences appear in persistently poor maternal and child health outcomes and in wide inequalities of access between income groups, between rural and urban populations, and between regions.[6]

The National Health Insurance Scheme (NHIS), established by legislation in 1999 and operationalised in 2005, was intended to expand access to healthcare and provide financial protection through health insurance.[7] It reached a small fraction of the population, almost all of them in the formal sector. Weak oversight, governance failures and recurrent

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[1] WHO, *The World Health Report 2010: Health Systems Financing, the Path to Universal Coverage* (WHO 2010) ix-xii.

[2] UNGA, *Transforming our World: the 2030 Agenda for Sustainable Development*, UN Doc A/RES/70/1 (25 September 2015) Goal 3, Target 3.8.

[3] WHO and International Bank for Reconstruction and Development/The World Bank, *Tracking Universal Health Coverage: 2023 Global Monitoring Report* (WHO 2023).

[4] UN Department of Economic and Social Affairs, Population Division, *World Population Prospects 2024* (UN 2024), medium variant projection for Nigeria, 2026.

[5] Federal Ministry of Health and Social Welfare, *State of Health of the Nation Report 2025* (FMHSW 2026); Nigeria Health Watch, 'Nigeria's State Health Insurance Schemes Are Expanding, Enrolment Must Now Lead to Care' (*Nigeria Health Watch*, 6 August 2026) https://nigeriahealthwatch.com/articles/thought-leadership/nigerias-state-health-insurance-schemes-are-expanding-enrolment-must-now-lead-to-care/ accessed 3 September 2026.

[6] National Population Commission (Nigeria) and ICF, *Nigeria Demographic and Health Survey 2024* (NPC and ICF 2025) accessed 3 September 2026.

[7] National Health Insurance Scheme Act, Cap N42, LFN 2004, s 1; C A Onoka and others, 'Promoting Universal Financial Protection: Constraints and Enabling Factors in Scaling-Up Coverage with Social Health Insurance in Nigeria' (2013) 11 *Health Research Policy and Systems* 20.

allegations of financial impropriety further undermined the Scheme and contributed to a crisis of institutional confidence.[8] The National Health Insurance Authority (NHIA) Act 2022 was the government's answer. The Act repealed the 1999 framework and introduced compulsory participation, a Vulnerable Group Fund and a regulator with broader statutory powers.[9] The reform came against a background of longstanding structural weaknesses in Nigeria's health system and its health-financing architecture. Whether the Act can deliver universal health coverage depends partly on conditions beyond the statute's control and partly on matters that the statute itself addresses imperfectly.[10]

This article evaluates the Act against the requirements of SDG 3. It sets out what UHC demands, traces the evolution of health financing in Nigeria, examines the structure of the Act, tests its capacity to move the indicators by which Target 3.8 is measured, and asks whether the entitlements it creates can be enforced by the people they are meant to benefit. Comparative material from Rwanda and Ghana tests two of the defects identified. The argument is that the Act supplies a stronger legal foundation than any previous Nigerian instrument on the subject, yet leaves three defects that limit its effect however much money is appropriated. They concern the enforceability of the scheme in both directions, the revenue base of the Vulnerable Group Fund, and the displacement of the power to sanction into subsidiary instruments.

2. UHC and SDG 3

The Concept and Its Dimensions

The idea behind UHC is not new. It can be traced to the middle of the twentieth century, when the post-war international order began to treat health as an element of social protection. The Constitution of the World Health Organisation (WHO) declared in 1948 that the highest attainable standard of health is a fundamental right of every human being.[11] That declaration was aspirational. UHC converts the aspiration into a framework of obligations that can be measured. The WHO describes UHC as a condition in which all people have access to the full range of quality health services they need, from health promotion and prevention through to treatment, rehabilitation and palliative care, without suffering financial hardship.[12] The literature usually breaks coverage into three dimensions.[13] Population coverage asks who in the population is included. Service coverage asks which services the arrangement pays for.[14] Financial protection asks how much of the cost still falls on the household at the point of use. Movement is required on all three fronts. A system that includes everyone but funds only a narrow package is not universal, and neither is one that offers a broad package while leaving patients exposed to ruinous bills. Quality of care is now treated as a fourth dimension, since enrolment counts for nothing where facilities are inadequate, staff are poorly trained or medicines are unavailable.[15] In Nigeria the distance between registration and effective access is unusually wide, which makes quality a decisive rather than an incidental measure.

The Right to Health Foundation

The case for UHC does not rest only on health system efficiency. It has a footing in international human rights law. The right to health is guaranteed in article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR),[16] article 16 of the African Charter on Human and Peoples' Rights (African Charter),[17] and article 14 of the African Charter on the Rights and Welfare of the Child (ACRWC).[18] The Committee on Economic, Social and Cultural Rights (CESCR) has interpreted the right as one requiring that health facilities, goods and services be

[8] C A Onoka, K Hanson and J Hanefeld, 'Towards Universal Coverage: A Policy Analysis of the Development of the National Health Insurance Scheme in Nigeria' (2015) 30(9) *Health Policy and Planning* 1105.
[9] National Health Insurance Authority Act 2022 (Act No 17 of 2022), Federal Republic of Nigeria Official Gazette No 95, Vol 109 (24 May 2022) (NHIA Act).
[10] I Abubakar and others, 'The Lancet Nigeria Commission: Investing in Health and the Future of the Nation' (2022) 399 *The Lancet* 1155, 1155-60.
[11] Constitution of the World Health Organisation (adopted 22 July 1946, entered into force 7 April 1948) 14 UNTS 185, preamble.
[12]World Health Organization, 'Universal Health Coverage (UHC)' (Fact Sheet, 5 December 2025) https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc) accessed 3 September 2026.
[13] T Boerma and others, 'Monitoring Progress towards Universal Health Coverage at Country and Global Levels' (2014) 11(9) *PLoS Medicine* e1001731.
[14] ibid.
[15] M E Kruk and others, 'High-Quality Health Systems in the Sustainable Development Goals Era: Time for a Revolution' (2018) 6(11) *The Lancet Global Health* e1196.
[16] International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966, entered into force 3 January 1976) 993 UNTS 3, art 12.
[17] African Charter on Human and Peoples' Rights (adopted 27 June 1981, entered into force 21 October 1986) 1520 UNTS 217, art 16.
[18] African Charter on the Rights and Welfare of the Child (adopted 11 July 1990, entered into force 29 November 1999) OAU Doc CAB/LEG/24.9/49, art 14.

available, accessible, acceptable and of adequate quality, without discrimination.[19] General Comment No 14 treats economic accessibility as integral to enjoyment of the right. Health services must be affordable, and payment arrangements must be equitable, so that poorer households are not disproportionately burdened.[20] Where out-of-pocket charges consume the income of the poorest households, what is at stake goes beyond policy design and reaches obligations Nigeria accepted at the international and regional levels. Whether those obligations can be invoked by an individual before a Nigerian court is a separate question, taken up in section 6.

How Progress is Measured

Of the thirteen targets set out under Goal 3, Target 3.8 bears most directly on health systems, since it requires UHC together with financial risk protection, access to quality essential services, and access to safe, effective and affordable medicines and vaccines.[21] Two indicators track progress. Indicator 3.8.1 is the UHC Service Coverage Index, which aggregates coverage of essential services across reproductive, maternal, newborn and child health, infectious disease, non-communicable disease and service capacity.[22] Indicator 3.8.2 measures the proportion of the population with large household expenditure on health as a share of total household spending or income.[23] By tying domestic health policy to an international commitment, the framework gives civil society, researchers and treaty bodies an opening to press for improvement, and it casts the NHIA Act as a response to an international obligation rather than a purely domestic initiative.

3. Health Financing in Nigeria Before 2022

From Public Provision to Direct Payment

The history of health financing in Nigeria is largely a history of costs falling on individuals. After independence in 1960, hospitals, clinics and primary health centres were funded from general government revenue, and the oil boom of the 1970s allowed that model to expand.[24] The collapse of oil revenue in the 1980s reversed the position. Structural adjustment cut public spending sharply, and existing facilities decayed, drug supplies failed and health workers left. No alternative financing mechanism existed, so patients paid directly at the point of use. Those who could not pay went without or turned to unregulated providers.[25] Donor financing has played an important part in supporting programmes in areas such as maternal and child health, immunisation and infectious-disease control, and it remains a significant component of Nigeria's health-financing landscape.[26] A health system financed principally through household payments and donor priorities is not organised around a right. It operates as a market, and in that market the poorest are served last.

The Scheme and Why It Failed

The NHIS was Nigeria's first substantial attempt at social health insurance.[27] It pooled contributions from employers, employees and government, and paid accredited providers. Its stated aims were to widen access, shield families from financial hardship and hold providers to a standard of delivery.[28] The design did not match the economy it was meant to serve. Coverage stayed concentrated among federal public servants and other formal-sector employees, while the overwhelmingly informal workforce remained outside any effective insurance arrangement.[29] By the end of the 2010s, fewer than 5 per cent of Nigerians held health insurance of any kind.[30] Governance problems widened the gap. Allegations of corruption, thin oversight and irregular payment of providers damaged confidence, and employers frequently failed to register eligible workers because the Scheme had no effective means of compelling them.[31]

The Route to Reform

Pressure for change came from several directions. Researchers and civil society organisations argued that the defects were structural and could not be corrected within the existing framework.[32] Nigeria's adoption of the SDGs supplied

[19] CESCR, *General Comment No 14: The Right to the Highest Attainable Standard of Health*, UN Doc E/C.12/2000/4 (2000) para 12.
[20] ibid para 12(b).
[21] UNGA (n 2) Goal 3, Target 3.8.
[22] WHO and World Bank (n 3) 28-34.
[23] WHO and World Bank (n 3) 25-26.
[24] Onoka, Hanson and Hanefeld (n 8) 1107-1108.
[25] B S C Uzochukwu and others, 'Health Care Financing in Nigeria: Implications for Achieving Universal Health Coverage' (2015) 18(4) *Nigerian Journal of Clinical Practice* 437, 438-440.
[26] Abubakar and others (n 10) 1155-60.
[27] National Health Insurance Scheme Act (n 7).
[28] ibid s 5.
[29] Onoka and others (n 7).
[30] Abubakar and others (n 10) 1188.
[31] WHO, *Nigeria Health System Review* (WHO Regional Office for Africa 2021) 61-70.
[32] Onoka, Hanson and Hanefeld (n 8) 1112.

an external reference point, and the COVID-19 pandemic sharpened the argument for pooled financing.[33] The National Health Insurance Authority Bill passed the Senate on 1 December 2021 and the House of Representatives on 3 March 2022. Presidential assent followed on 19 May 2022, and the Act was published in the Official Gazette five days later. Section 58 repealed the NHIS Act.[34]

4. Structure and Innovations of the Act

The Authority and Its Governance

Section 1 establishes the National Health Insurance Authority. Section 1(2) confers corporate personality, perpetual succession and an official seal, together with the capacity to sue and be sued in its own name, to hold and dispose of property, and to contract.[35] Those attributes, with its expanded statutory powers, give the NHIA an enforcement mandate and a regulatory reach that the former Scheme lacked. Section 2 sets out the objects of the Authority, which are to promote, regulate and integrate health insurance schemes, to harness private sector participation in service provision, and to do such other things as will assist in achieving UHC for all Nigerians. Section 3 sets out the functions of the Authority across twenty-eight paragraphs. They include enforcement of a basic minimum package across federal, state and private schemes, accreditation and re-accreditation of Health Maintenance Organisations (HMOs), Mutual Health Associations, Third-Party Administrators and health facilities, and maintenance of an information technology infrastructure able to integrate scheme data nationally.[36]

Section 4 establishes a Governing Council drawn from several ministries and sectors, with representatives from the six geopolitical zones on a rotating basis and a civil society organisation whose objectives relate to health. Section 5 gives the Council power to regulate and supervise schemes and to receive and investigate complaints of impropriety against HMOs and other institutions. The Council may also discipline erring organisations by suspension, licence revocation or fines.[37] Section 13(1) empowers every state and the Federal Capital Territory to establish a health insurance or contributory scheme covering its residents, subject to the scope of the basic minimum package under the National Health Act 2014. Section 13(7) requires states to cover vulnerable persons through the Basic Health Care Provision Fund and other sources without charging them premiums.[38] That subsection carries more weight than its placement suggests, and section 6 of this article returns to it.

Compulsory Participation

The pivotal provision is section 14(1), which requires every person resident in Nigeria to obtain health insurance. Section 14(2) identifies the categories affected by the mandate, including employers and employees in the public and private sectors with five staff and above, informal sector employees, and all other residents.[39] Compulsion matters because voluntary insurance produces adverse selection, with healthier individuals declining to join and costs rising sharply for those who remain. Two features of the drafting limit the reach of the obligation. The first is the definition of 'employer' in section 59, which captures only an employer with five or more employees. Micro-enterprises, a very large share of Nigerian economic activity, fall outside the employer duty entirely. Their workers remain within section 14(2)(c) as residents, but no one else bears a duty to register them. The second concerns enforcement. Section 48 creates offences, and every one of them is directed at institutional actors. The listed conduct includes failure to pay contributions into the appropriate account, deduction of an employee's contribution followed by failure to remit it, failure to remit payment to healthcare providers within the period set in the operational guidelines, failure to settle claims, manipulation of the enrollee register, refusal to provide care to a registered enrollee, and issuing a dud cheque. Nothing in section 48 addresses a resident who simply does not enrol. Section 48(2) then prescribes penalties for the dud cheque offence alone, and section 48(3) refers the remaining offences to prosecution under the general law governing financial transactions.[40] On the better reading, section 48(3) is a residual referral rather than a self-contained penalty provision, since it prescribes no punishment and identifies no offence-creating statute. The Act therefore declares participation mandatory without attaching any consequence to individual non-participation, and attaches a determinate penalty to only one of the seven offences it creates. Section 14(4) adds a further complication. A person who takes out private health insurance is not eligible for free coverage as a vulnerable person under section

[33] T M Ipinnimo and others, 'The Nigeria National Health Insurance Authority Act and its Implications towards Achieving Universal Health Coverage' (2022) 29(4) *Nigerian Postgraduate Medical Journal* 281; B S Aregbeshola and M O Folayan, 'Nigeria's Financing of Health Care during the COVID-19 Pandemic: Challenges and Recommendations' (2022) 14(1) *World Medical and Health Policy* 195.
[34] NHIA Act (n 9) s 58.
[35] NHIA Act (n 9) s 1.
[36] ibid ss 2-3.
[37] ibid ss 4-5.
[38] NHIA Act (n 9) s 13; the Basic Health Care Provision Fund to which s 13(7) refers is established by the National Health Act 2014, s 11.
[39] NHIA Act (n 9) s 14.
[40] ibid s 48.

13(7). The provision is intended to prevent double subsidy. Its effect is to require a household near the poverty threshold to choose in advance between a private plan and future eligibility for public support.

The Vulnerable Group Fund and Other Reforms

Section 25(1) establishes the Vulnerable Group Fund, and section 25(2) lists the sources from which it is to be derived. Those sources are the Basic Health Care Provision Fund, a health insurance levy, a Special Intervention Fund allocated by government and appropriated to the Vulnerable Group Fund, income from investments made by the Council, and grants, donations and gifts.[41] Section 26 states the object of the Fund, which is to subsidise the cost of health services for vulnerable persons and to pay premiums for indigents. Section 27 requires the Council to determine and submit criteria for disbursement to the Minister for approval, and to prescribe how indigence is to be determined. Section 59 defines the vulnerable group as children under five, pregnant women, the aged, the physically and mentally challenged, and the indigent as may be defined from time to time. The definition is generous in scope. The financing is not. Of the five sources named in section 25(2), only the health insurance levy would constitute new revenue dedicated to the Fund, and the Act sets neither its rate nor its base. The Basic Health Care Provision Fund is not a new source at all. It was created by section 11 of the National Health Act 2014 and is financed by an annual grant of not less than one per cent of the Consolidated Revenue Fund, together with donor grants and other contributions.[42] The Special Intervention Fund depends on an appropriation that the National Assembly is under no statutory duty to make. What the Act creates, in substance, is a fund with a defined purpose and an undefined income.

Other reforms are more straightforward. Section 33 governs the accreditation of health maintenance organisations, mutual health associations and third party administrators, and it permits withdrawal of a licence for breach of the operational guidelines. Section 34(4) assigns mutual health associations continuous community mobilisation and sensitisation, and the negotiation and purchase of services for their members. Section 24(4)(c) requires the Authority to provide for the administration of an Ombudsman to handle enrollee complaints, and section 47 routes disputes first to mediation and conciliation before the Authority and then to arbitration. Section 37 obliges the Authority to ensure that beneficiaries receive quality services as provided in the operational guidelines.[43]The recurrence of that last phrase deserves attention. Sanction under section 49, quality assurance under section 37, accreditation standards under section 33 and the timeframe for provider payment under section 48(1)(c) all take their content from the operational guidelines rather than from the statute. Parliament legislated the architecture and delegated the substance. The guidelines were issued in October 2023, some seventeen months after assent.[44]

The Act and Target 3.8

The Act aligns with Target 3.8 on three points. Compulsory enrolment under section 14 addresses population coverage by creating a legal obligation the former Scheme lacked. The Vulnerable Group Fund and the contributory premium structure address financial risk protection. Accreditation and quality assurance under sections 33 and 37 address the quality dimension that Indicator 3.8.1 now incorporates.

The indicators, however, measure outcomes rather than instruments. An unenforced obligation does not raise the Service Coverage Index, and a fund without revenue does not reduce the incidence of catastrophic expenditure. The next section tests the Act against each dimension using the evidence available four years after commencement.

5. Measuring the Act against SDG 3

Population Coverage

The record on enrolment is the strongest part of the story. The Authority reported coverage of 22.03 million in July 2026 and described this as a 35 per cent year-on-year increase, attributing the growth to closer collaboration with state social health insurance agencies, ministries and employers.[45] The figure represents substantial growth from the 19.2 million enrolments reported in December 2024,[46] although the published reports do not identify the precise July 2025 baseline used to calculate the stated year-on-year increase. Every state and the Federal Capital Territory now operates a social health insurance agency, the formal launch of Akwa Ibom State's ARISECare scheme in September

[41] ibid s 25.
[42] National Health Act 2014 (n 38) s 11.
[43] NHIA Act (n 9) ss 24(4)(c), 33, 34(4), 37, 47.
[44] 'NHIA Act 2022, FG Unveils Long-Awaited Operational Guidelines' *BusinessDay* (Lagos, 10 October 2023) https://businessday.ng/news/article/nhia-act-2022-fg-unveils-long-awaited-operational-guidelines/ accessed 3 September 2026.
[45] J Ajia, 'Health Insurance Enrolment Jumps 35% to 22 Million' *Punch* (13 July 2026) https://punchng.com/health-insurance-enrolment-jumps-35-to-22-million/ accessed 2 September 2026.
[46] '19.2 Million Nigerians Use Health Insurance - Official' *Premium Times* (16 December 2024) https://www.premiumtimesng.com/health/health-news/761654-19-2-million-nigerians-use-health-insurance-official.html accessed 3 September 2026.

2024 having completed the nationwide rollout.[47] The Federal Government has set a target of enrolling at least 44 million Nigerians by 2030.[48] Set against a projected 2026 population of approximately 242.4 million,[49] 22 million enrollees represent fewer than one Nigerian in ten. Even full achievement of the 2030 target would leave more than four-fifths of the population outside the system. The trajectory is upward and the base is very low.

In the formal sector the obligation is administratively credible, since civil servants and employees of larger organisations can be reached through payroll. Experience under the former Scheme nonetheless shows that a legal duty does not by itself produce compliance, and the point applies with greater force where the duty carries no penalty. The informal sector presents the harder problem. Informal employment accounted for 92.2 per cent of total employment in 2023 and remained at a similarly high level in 2024, reaching 93.0 per cent in the second quarter of that year.[50] Enrolment mechanisms must therefore reach people who have no regular wage, often no fixed address, and no employer to register them. Section 31(1)(b) contemplates contributions from individuals, groups and families at rates fixed by state scheme councils, and section 34(4) gives mutual health associations a mobilisation role. Whether either works depends on administrative reach, community confidence and the perceived value of the benefit package. Rural residents face an additional barrier, since insurance coverage does not itself guarantee effective access to care where accredited facilities are distant or unavailable.[51]

Financial Protection

This is where Nigeria's health system has failed most severely and where progress has been slowest. Out-of-pocket payments account for around 71 per cent of health expenditure.[52] Such heavy reliance on direct household payment exposes patients to financial hardship and can deter access to needed care. The Act shifts financing towards pooled contributions, and for those enrolled a premium replaces unpredictable payment at the point of service. Protection nonetheless reaches only those enrolled who can also reach an accredited provider, which returns the analysis to the coverage figures above. The Vulnerable Group Fund carries the burden of protecting those who cannot contribute, and its dependence on the Basic Health Care Provision Fund turns the drafting defect identified in section 4.3 into an operational one. Because the Basic Health Care Provision Fund is calculated as a share of the Consolidated Revenue Fund, subsidised coverage expands only as quickly as federal revenue does. The health of federal finances therefore governs the pace at which the poorest are covered, and those finances are not generous to health. The 2026 budget proposed ₦2.48 trillion for health out of ₦58.47 trillion in total spending, about 4.2 per cent, and successive budgets since 2023 have kept the share below six per cent.[53]

Under the 2001 Abuja Declaration, African states committed to allocate at least 15 per cent of their annual budgets to the health sector.[54] Nigeria's federal health allocations have remained well below that benchmark, including throughout the period since 2023.[55] Applied to the proposed ₦58.47 trillion federal budget, the 15 per cent benchmark would have required approximately ₦8.77 trillion for health, about ₦6.29 trillion above the proposed allocation.[56] The source fund is itself under strain. An assessment and audit disclosed major programmatic, operational and fiduciary weaknesses in the implementation of the Basic Health Care Provision Fund, following which all thirty-six states and the Federal Capital Territory signed up to remediation plans with the Federal Ministry of Health.[57] Official data report approximately 2.65 million vulnerable people supported through the Fund and 8,309 primary healthcare

[47] National Health Insurance Authority, 'State Health Insurance Agency' https://www.nhia.gov.ng/sshias/ accessed 5 September 2026; Akwa Ibom State Health Insurance Agency, 'About Us' https://akshia.ak.gov.ng/about-us/ accessed 5 September 2026.

[48] Federal Ministry of Health and Social Welfare, 'How Four Days Dialogue Elevates Sustainable Health Financing Gains for Nigeria's Universal Health Coverage' (2025) https://health.gov.ng/how-four-days-dialogue-elevates-sustainable-health-financing-gains-for-nigerias-universal-health-coverage/ accessed 3 September 2026.

[49] United Nations Department of Economic and Social Affairs, Population Division, *World Population Prospects 2024* (United Nations 2024), projecting Nigeria's mid-2026 population at approximately 242.4 million.

[50] National Bureau of Statistics, *Nigeria Labour Force Survey Annual Report 2023* (NBS 2024) 41-43; National Bureau of Statistics, *Nigeria Labour Force Survey Q2 2024* (NBS 2024) 9.

[51] WHO, *Nigeria Health System Review* (n 31) 88-92.

[52] Federal Ministry of Health and Social Welfare, 'FG Says Tinubu's Administration Establishes Strong Policy, Legislative Framework for Healthcare Financing' (2026) https://health.gov.ng/fg-says-tinubus-administration-establishes-strong-policy-legislative-framework-for-healthcare-financing/ accessed 3 September 2026.

[53] 'Tinubu Raises Health Allocation but Misses Abuja Declaration Target' *Premium Times* (Abuja, 4 January 2026) https://www.premiumtimesng.com/health/health-interviews/847409-2026-proposed-budget-tinubu-raises-health-allocation-but-misses-abuja-declaration-target.html accessed 2 September 2026.

[54] Organisation of African Unity, *Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases*, OAU Doc OAU/SPS/ABUJA/3 (2001) para 26.

[55] (n 53).

[56] (n 53). The figures are the author's calculations based on the proposed ₦58.47 trillion federal budget and the ₦2.48 trillion proposed health allocation.

[57] National Health Insurance Authority, 'NHIA Hosts State Social Health Insurance Agencies on the Basic Health Care Provision Fund' (6 May 2024) https://www.nhia.gov.ng/nhia-host-state-social-health-insurance-agencies-on-basic-healthcare-provision-fund/ accessed 2 September 2026.

facilities directly funded across the thirty-six states and the Federal Capital Territory.[58] Measured against the 83 million poor Nigerians whom the Federal Government identified at the Act's commencement as unable to afford health-insurance premiums, the shortfall remains substantial.[59] Section 25(2) identifies a health insurance levy as a source of the Vulnerable Group Fund, but the Act specifies neither its rate nor its base. The Special Intervention Fund is likewise dependent on government allocation, with budgetary records showing no stable or independently defined stream of funding.[60] The uncertainty matters because section 13(7) is framed in mandatory terms. States and the Federal Capital Territory shall provide coverage for vulnerable persons through the Basic Health Care Provision Fund and other sources, without requiring premiums.[61] The difficulty is not the absence of a statutory entitlement but the predictability and adequacy of the financing available to give practical effect to it.

Service Availability and Quality

Coverage without accessible, good-quality services is coverage in name only. Indicator 3.8.1 captures this by incorporating service capacity and access into the UHC service coverage index. The Act sets standards for providers and insurers, but the expansion of infrastructure, the training and retention of health workers, and the availability of medicines depend on the broader health system as much as on the insurance framework.[62] The workforce deficit is acute. In June 2026 the number of doctors practising in Nigeria was reported at roughly 55,000, notwithstanding more than 130,000 doctors having been registered by the Medical and Dental Council of Nigeria.[63] Against a projected 2026 population of approximately 242.4 million, that amounts to roughly one practising doctor for every 4,400 people. Outward migration has taken a heavy toll, with at least 16,000 Nigerian doctors reported to have emigrated in the preceding five years.[64] Regional disparity sharpens the effect, since rural populations face greater geographical barriers to reaching health services than their urban counterparts.[65] The Authority has begun to address quality more directly, reporting that 7,592 healthcare facilities had been assessed under the SafeCare quality framework by July 2026.[66]

6. Enforcing the Entitlement

The Act creates statutory duties alongside institutions, which raises the enforcement question of who may invoke those duties, against whom, and by what legal route. The question is at its sharpest in relation to section 13(7), which requires states and the Federal Capital Territory to provide coverage for vulnerable persons without premiums. Whether that provision creates an individually enforceable entitlement, and what remedy exists when the duty is not performed, needs separate examination.[67]

The Right to Health in Nigerian Law

Nigeria's constitutional framework presents an initial obstacle. Section 17(3)(d) directs the state to ensure adequate medical and health facilities for all persons, but it falls within Chapter II, and section 6(6)(c) generally bars judicial review of compliance with the Fundamental Objectives and Directive Principles.[68] A claim seeking to enforce section 17(3)(d) directly therefore encounters the constitutional prohibition in section 6(6)(c). The treaty position is uneven. Nigeria has ratified the ICESCR but has not domesticated it, and section 12(1) of the Constitution denies a treaty the force of law until enacted by the National Assembly. Article 12 of the Covenant and General Comment No 14 therefore bind Nigeria internationally without being directly enforceable in a Nigerian court. The African Charter stands differently. Domesticated through the African Charter on Human and Peoples' Rights (Ratification and Enforcement) Act, it was confirmed by the Supreme Court in *Abacha v Fawehinmi* as part of Nigerian law,

[58] Basic Health Care Provision Fund, 'Frequently Asked Questions' https://bhcpf.gov.ng/bebuilder-2815/ accessed 3 September 2026 (reporting Q2 2025 figures of 2,649,221 poor and vulnerable persons covered through BHCPF under the NHIA Gateway and 8,309 primary healthcare centres).

[59] The State House, Abuja, 'In Bid to Achieve Universal Coverage, President Buhari Signs National Health Authority Bill into Law' (19 May 2022) https://statehouse.gov.ng/in-bid-to-achieve-universal-coverage-president-buhari-signs-national-health-authority-bill-into-law/ accessed 3 September 2026.

[60] NHIA Act (n 9) s 25(2); Centre for Social Justice, 'Analysing the 2023 Health Budget Proposal' (2022), noting the absence of the Special Intervention Fund for the Vulnerable Group Fund from the 2023 health budget proposal.

[61] NHIA Act (n 9) s 13(7).

[62]WHO, 'Service Coverage Index and Components (SDG 3.8.1)' https://www.who.int/data/gho/data/themes/topics/service-coverage accessed 3 September 2026; B O Josiah, 'Critical Review of Healthcare Financing and a Survey of System Quality Perception among Healthcare Users in Nigeria (2010-2023)' (2025) 5(5) *PLOS Global Public Health* e0004615.

[63]'Japa: Only 55,000 Doctors Left for 220m Nigerians' *Vanguard* (18 June 2026) https://www.vanguardngr.com/2026/06/japa-only-55000-doctors-left-for-220m-nigerians/ accessed 3 September 2026.

[64] ibid.

[65] WHO, *Nigeria Health System Review* (n 31) 88-92.

[66] 'NHIA Enrolment Hits 22m as Health Insurance Coverage Expands' *BusinessDay* (Lagos, 10 July 2026).

[67] NHIA Act (n 9) s 13(7).

[68] Constitution of the Federal Republic of Nigeria 1999 (as amended) ss 6(6) (c), 17(3)(d).

enforceable by Nigerian courts though subordinate to the Constitution.[69] Article 16 of the African Charter, which guarantees the right to the best attainable state of physical and mental health, is accordingly part of Nigerian domestic law. That conclusion has proved less useful in practice. The ECOWAS Community Court has entertained socio-economic rights claims against Nigeria, and in *SERAP v Federal Republic of Nigeria* it found Nigeria in breach of obligations arising from environmental degradation in the Niger Delta. Health-related harms formed part of the claim, but the operative finding rested on articles 1 and 24 of the African Charter rather than on article 16 as an independent basis of liability.[70] The case shows that regional human-rights adjudication is available. It stops short of establishing article 16 as a developed domestic route to orders for the provision of specific health services.

Section 13(7) as a Statutory Duty

Section 13(7) provides that States and the Federal Capital Territory shall provide coverage for vulnerable persons under the state scheme through the Basic Health Care Provision Fund and other sources, and that they shall not require payment of premiums for that coverage. The language is mandatory, the duty-bearer is identified, and the beneficiary class is defined in section 59.[71] The significance of that framing is that a claim under section 13(7) need not be presented as an attempt to enforce section 17(3) (d) of the Constitution directly. A person denied the coverage contemplated by section 13(7) could instead argue that a public body has failed to discharge a statutory duty. *Mandamus* is in principle available in Nigerian public law to compel performance of such duties.[72] There is accordingly a credible argument that individuals within the statutory class could seek public-law relief for non-performance of section 13(7), with the domesticated African Charter serving as interpretive support rather than as the sole cause of action. Whether Nigerian courts would accept that argument in the specific context of the NHIA Act remains untested.

Two obstacles stand in the way. The first concerns the identification of indigent beneficiaries. Section 59 includes indigent persons within the vulnerable group, while section 27(2) assigns to the Council the responsibility for determining the criteria by which such persons are identified.[73] Where those criteria are insufficiently specified or accessible, an applicant relying on indigence may struggle to establish membership of the protected class. The difficulty lies in ascertaining this category of beneficiary rather than in the existence of the statutory duty itself. The second obstacle concerns federalism. Section 13(7) expressly addresses the states and the Federal Capital Territory, yet state health-insurance schemes are created under state legislation. The constitutional basis on which federal law imposes this obligation directly upon state institutions therefore requires closer examination, and it cannot simply be assumed from the general classification of health as a concurrent legislative matter.[74] For an individual claimant, the issue could furnish a respondent state agency with an additional line of argument about the source and scope of the duty invoked.

The Grievance Machinery and Who It Reaches

The Act contains two internal routes for complaint, and neither is obviously open to the person section 13(7) protects. Section 47(1) requires disputes between parties under the Act to be referred first to the Authority for mediation and conciliation and provides that where conciliation fails the parties may resort to arbitration. Section 47(2) identifies those parties as including HMOs, healthcare providers, contributors, and the Authority or its agents.[75] Vulnerable beneficiaries are not expressly named, though the use of 'include' suggests the listed categories may not be exhaustive. A vulnerable person whose contribution is paid from public funds, or who has been refused enrolment altogether, is not obviously a 'contributor' in the ordinary sense. Section 31(2), which permits contributions to be made on behalf of vulnerable persons, may support the argument that such beneficiaries fall within the statutory dispute-resolution framework. The Act leaves the point unresolved.[76] The Ombudsman route presents a related difficulty. Section 24(4)(c) requires the Authority to establish an Ombudsman to handle complaints from enrollees.[77] A person refused enrolment is not obviously an 'enrollee'. On the face of the Act it is therefore unclear whether the Ombudsman

[69] *Abacha v Fawehinmi* (2000) 6 NWLR (Pt 660) 228 (SC); African Charter on Human and Peoples' Rights (Ratification and Enforcement) Act, Cap A9, Laws of the Federation of Nigeria 2004; see also *Ibidapo v Lufthansa Airlines* (1997) 4 NWLR (Pt 498) 124 (SC).

[70] *Registered Trustees of the Socio-Economic Rights and Accountability Project (SERAP) v Federal Republic of Nigeria*, General List No ECW/CCJ/APP/08/09, Judgment No ECW/CCJ/JUD/18/12 (ECOWAS Community Court of Justice, 14 December 2012); J Oduwole and A Akintayo, 'The rights to life, health and development: The Ebola virus and Nigeria' (2017) 17 *African Human Rights Law Journal* 194.

[71] NHIA Act (n 9) ss 13(7), 59.

[72] *Layanju v Araoye* (1961) All NLR 313 (SC); see also *African Continental Bank Plc v Nwaigwe* (2011) 1 NWLR (Pt 1226) 302 (SC).

[73] NHIA Act (n 9) ss 27(2), 59.

[74] Constitution of the Federal Republic of Nigeria 1999 (n 68) s 4 and Second Schedule, Parts I and II.

[75] NHIA Act (n 9) s 47(1)-(2).

[76] NHIA Act (n 9) ss 31(2), 47(2).

[77] NHIA Act (n 9) s 24(4)(c).

mechanism extends to complaints of wrongful exclusion from coverage, as opposed to grievances by existing enrollees about the administration or delivery of that coverage.

Section 47(4) adds a procedural hurdle. No action may be instituted against the Authority, its agents or employees without one month's prior written notice.[78] For a claimant seeking relief directly against the Authority, that requirement adds another step to an already uncertain enforcement route. The distinction between enrolment and post-enrolment protection appears elsewhere in the Act. Section 48(1)(f) makes it an offence to deny care to a duly registered enrollee,[79] attaching an enforcement consequence to failures occurring after registration. It does not address the prior situation of a vulnerable person alleging wrongful refusal of enrolment. The contrast with the National Health Act 2014 is instructive. Section 20 prohibits a health care provider, health worker or health establishment from refusing a person emergency medical treatment for any reason and makes contravention an offence punishable on conviction by a fine of ₦100,000, imprisonment for a term not exceeding six months, or both.[80] Parliament had already attached criminal liability to the denial of statutory health protection eight years before the NHIA Act. The 2022 Act likewise creates offences relating to health-insurance operations, including failure to provide care to a registered enrollee, but it does not criminalise wrongful refusal to enrol a vulnerable person under section 13(7).[81] Sanctions are not absent from the Act. What is missing is any express penalty for wrongful exclusion from the vulnerable-person coverage that section 13(7) mandates. Read alongside the analysis in section 4.2, the pattern is consistent. The Act uses mandatory language to pursue both universal participation and vulnerable-person coverage, yet its enforcement framework does not mirror either obligation with equal clarity. Residents who fail to obtain insurance face no express statutory penalty, while vulnerable persons alleging wrongful refusal of enrolment must rely on grievance or public law routes whose application to that situation remains unresolved.

Federalism and Institutional Capacity

Implementation of the decentralised insurance framework depends substantially on the thirty-six state social health insurance structures and that of the Federal Capital Territory. Progress has been uneven. Delta, Lagos, Kano and Kaduna have recorded comparatively substantial development and uptake of state health-insurance arrangements, while performance across the federation remains variable.[82] Section 24(6) contemplates transitional arrangements under which a state without an established scheme may engage a third-party administrator for the period specified by the Authority.[83] The resulting decentralisation permits significant variation in implementation, administrative capacity and enrolment across states. Such variation, reflecting differences in resources, institutional development and priorities, poses a practical challenge for a federal statute aimed at universal coverage. Regulatory accountability is a related concern. Section 44(2) requires the Authority to maintain proper accounts and records, audited by auditors appointed from the list and guidelines supplied by the Auditor-General of the Federation. Section 45 obliges the Council, within six months of each year's end, to submit its annual report and audited accounts to the Minister, and to present and publish the audited accounts, the auditor's report and a report on the Authority's activities.[84] These are express duties of financial reporting and publication, yet sections 44 and 45 prescribe no specific remedy by which a member of the public could enforce compliance with the publication requirement.

7. Comparative Lessons

Rwanda and Ghana are used here to test two of the defects identified above rather than to supply general encouragement.

Rwanda and the Revenue Base

Rwanda's *Mutuelle de Santé* developed an income-sensitive contribution structure tied to the *Ubudehe* socio-economic classification, under which poorer households received subsidised coverage.[85] Its financing combines household contributions with identified sources of subsidy and cross-subsidy, drawing on public funds and on support from other institutions and development partners.[86] The lesson for Nigeria is not that fiscal dependence can be

[78] NHIA Act (n 9) s 47(4).
[79] NHIA Act (n 9) s 48(1)(f).
[80] National Health Act 2014 (n 38) s 20(1)-(2).
[81] NHIA Act (n 9) ss 13(7), 48(1)(f).
[82] S Una, *An Overview of the National Health Insurance Authority Act: Implementation and Structural Challenges* (Research Paper, National Assembly Library Trust Fund 2025) 18-22; Federal Ministry of Health and Social Welfare, 'Opening Remarks by the Honourable Minister of State for Health and Social Welfare, Dr Iziaq Adekunle Salako, Delivered at the National Council on Health (NCH), 2025' (2025).
[83] NHIA Act (n 9) s 24(6).
[84] NHIA Act (n 9) ss 44(2)-(3), 45.
[85] A Makaka and others, 'Universal Health Coverage in Rwanda: A Report of Innovations to Increase Enrolment in Community-Based Health Insurance' (2012) 380 *The Lancet* S7.
[86] M Nyandekwe and others, 'Universal Health Insurance in Rwanda: Major Challenges and Solutions for Financial Sustainability, Case Study of Rwanda Community-Based Health Insurance Part I' (2020) 37 *Pan African Medical Journal* 55; A Woldemichael

eliminated. It is that differentiated contributions work only where the sources of support for households unable to meet the full cost are themselves identified.

Section 25(2) of the Nigerian Act names several sources for the Vulnerable Group Fund but leaves important parts of the revenue architecture, including the rate and base of the health-insurance levy, unspecified. The contrast with Rwanda is one of financing design rather than of absolute fiscal certainty. Rwandan outcome data show why the design matters. Empirical analysis of its community-based insurance records significant reductions in out-of-pocket spending and in catastrophic health expenditure, although the reduction was larger among richer households than poorer ones.[87] Predictable and diversified financing is what makes subsidised coverage effective, and the uncertainty in section 25(2) is therefore a practical risk to the scale and continuity of vulnerable-person coverage rather than a drafting untidiness. Rwanda cannot be transplanted wholesale, given the differences in population, governmental structure and health-system organisation. The narrower point still holds. Subsidised coverage is more credible when both the sources of subsidy and the mechanisms of cross-subsidy are named in the legislation.

Ghana and the Cost of Guideline-Based Enforcement

Ghana offers a closer comparison. Its National Health Insurance Scheme was established by legislation in 2003 and implemented thereafter, against a background of heavy out-of-pocket financing and the difficulty of extending insurance to a large informal-sector population.[88] Coverage expanded substantially in the early years, and the financing and eligibility framework exempted specified categories of beneficiary from premium payment, later adding free maternal coverage.[89] The caution concerns financial sustainability and provider payment. As expenditure rose, the scheme came under persistent financial pressure and fell behind in reimbursing provider claims.[90] Arrears erode the practical value of insurance. Evidence from Ghana links delayed reimbursement to financial difficulty for providers, disruption in the supply of medicines and other inputs, and additional charges imposed on insured patients.[91] Insurance entitlements lose their content when the purchasing institution cannot reimburse providers reliably. Ghana later enacted the National Health Insurance Act 2012 (Act 852), which replaced the earlier statutory framework and consolidated the governance and financing arrangements of the scheme.[92] That experience bears directly on the drafting choice identified in section 4.3. Section 48(1)(c) of the Nigerian Act makes failure to remit payment to providers an offence, but the period within which payment must be made is fixed by operational guidelines rather than by the Act itself. Ghana does not establish that such an arrangement will necessarily produce arrears in Nigeria. It does show what follows when an insurance purchaser cannot pay providers on time.

What Nigeria Can Take

Both cases point the same way. Coverage expands only where the financing behind it is identified in law and where the statutory obligations can be enforced against those who must perform them. Community engagement supplies a further lesson. Section 34(4) gives Mutual Health Associations a potentially significant role, requiring them to mobilise communities, negotiate with providers, purchase services, remit member contributions and assist in quality assurance.[93] The statutory framework then leaves the important questions open. Section 33(2) places accreditation in the Authority's operational guidelines, sections 33 and 34 establish no dedicated financing mechanism for the functions assigned, and section 34(4) imposes no reporting duty equivalent to the one placed on HMOs by section 34(1)(g).[94] How these community-based functions are to be financed, supervised and reported is left to a regulatory framework that has yet to be developed.

8. Recommendations

Three legislative amendments follow from the principal defects identified above.

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and others, 'The Impact of Community Based Health Insurance Schemes on Out-of-Pocket Healthcare Spending: Evidence from Rwanda' (IMF Working Paper WP/19/38, 2019) 6-8.

[87] Woldemichael and others (n 86) 18-24; C Lu and others, 'Towards Universal Health Coverage: An Evaluation of Rwanda Mutuelles in Its First Eight Years' (2012) 7(6) *PLoS ONE* e39282.

[88] I A Agyepong and S Adjei, 'Public Social Policy Development and Implementation: A Case Study of the Ghana National Health Insurance Scheme' (2008) 23(2) *Health Policy and Planning* 150-152.

[89] A Arhin, 'Promising Start, but Bleak Future? Progress of Ghana's National Health Insurance Scheme Towards Universal Health Coverage' (2013) 3(12) *Developing Country Studies* 120, 120-122.

[90] H Wang, N Otoo and L Dsane-Selby, *Ghana National Health Insurance Scheme: Improving Financial Sustainability Based on Expenditure Review* (World Bank 2017).

[91] P A Dalinjong and A S Laar, 'The National Health Insurance Scheme: Perceptions and Experiences of Health Care Providers and Clients in Two Districts of Ghana' (2012) 2(1) *Health Economics Review* 2-13; P Akweongo and others, 'How Does It Affect Service Delivery under the National Health Insurance Scheme in Ghana? Health Providers and Insurance Managers Perspective on Submission and Reimbursement of Claims' (2021) 16(3) *PLoS ONE* e0247397.

[92] National Health Insurance Act 2012 (Act 852) (Ghana).

[93] NHIA Act (n 9) s 34(4).

[94] ibid ss 33(2), 34(1)(g), 34(4).

Make the obligation enforceable in both directions. Section 14 should be supported by an express and proportionate enforcement mechanism for persons able to contribute, subject to an appropriate transition period and to protection for persons entitled to subsidised coverage under section 13(7). Administrative implementation has already moved partly in this direction, a 2025 presidential directive having linked proof of NHIA coverage to federal procurement and to the issuance or renewal of licences and permits.[95] A legislative amendment would provide a clearer and more durable basis for such measures. In the other direction, section 47(2) should expressly include beneficiaries and applicants for coverage under the Vulnerable Group Fund within the statutory dispute-resolution framework, and section 24(4)(c) should make clear that the Ombudsman may receive complaints concerning refused enrolment as well as complaints by existing enrollees. The Council should also exercise its power under section 27(2) to specify sufficiently clear and accessible criteria for identifying indigent persons, since uncertainty over those criteria may impede enforcement of section 13(7).

Define the health insurance levy. Section 25(2)(b) identifies a health-insurance levy as a source of the Vulnerable Group Fund without specifying its rate or base. Legislation should define those essential elements and identify an appropriate collection mechanism, converting the levy from an incompletely specified statutory source into a predictable component of the Fund's revenue base. The reform should be accompanied by transparent accounting and independent audit of the Fund, with annual publication of receipts and expenditure disaggregated by funding source and by principal category of expenditure.

Return the enforcement content to the statute. The Act leaves important elements of enforcement to operational guidelines. Sections 48(1)(c) and (d) make delayed provider payments and claims settlement offences by reference to periods specified in those guidelines, while section 49 permits the Authority to sanction regulated actors in accordance with the guidelines.[96] Legislation could instead prescribe a maximum period for provider payment, leaving detailed claims procedures to subsidiary regulation. It could also state more precisely the penalties or other consequences attaching to breach of the core payment obligations. Ghana's experience does not show that guideline-based deadlines necessarily fail, but it demonstrates the practical harm that persistent provider-payment arrears can cause to an insurance system.

Several further measures can be pursued within the existing administrative framework. Operational guidelines developed under section 3(y) could strengthen requirements for publication of data on coverage, utilisation, financial protection and quality, disaggregated where practicable by income, sex, age and location, so that inequalities in progress towards UHC can be identified and monitored.[97] Contribution arrangements for informal-sector participants could be tailored to irregular income patterns, using cooperatives, market associations and digital-payment channels. Periodic review of the benefit package against the service-coverage objectives in Target 3.8 could help align insured services with population health needs. None of these measures would resolve the broader financing constraint, but each could improve effectiveness, transparency and equity within available resources.

9. Conclusion

Nigeria's National Health Insurance Authority Act 2022 is a stronger statutory framework than the scheme it replaced. It establishes a regulator with legal personality and substantial regulatory powers, makes participation in health insurance mandatory, brings state schemes into the national architecture, and creates a dedicated Vulnerable Group Fund for subsidised coverage. Implementation has advanced as well, with coverage reported at 22.03 million by July 2026 and quality assessment of healthcare facilities under way at substantial scale.

The defects that remain are significant, and in important respects they are legal in character. A compulsory scheme whose primary legislation specifies no express sanction for an individual resident's non-participation depends heavily on administrative implementation. A fund intended to subsidise those unable to pay remains vulnerable where important elements of its revenue architecture, including the rate and base of the health-insurance levy, are left unspecified. An enforcement regime is weakened where matters such as provider-payment periods are settled by operational guidelines rather than fixed in the statute. Beneath all three lies a gap between the obligations the Act expresses and the financing and remedial mechanisms available to give them effect. The Act does create legal obligations. What remains substantial is the distance between those obligations and an entitlement a person can actually enforce.

Out-of-pocket payments at around 71 per cent of health expenditure and a proposed federal health allocation of about 4.2 per cent of the 2026 budget set the conditions in which that distance falls to be assessed. Legislation alone will not shift either figure. What the Act can supply is the legal machinery through which they are addressed, and by 2030 its contribution to Target 3.8 will be measured by whether coverage has brought people to services they can use, whether households are meeting less of the bill at the point of care, and whether the gap between rich and poor and between rural and urban has narrowed. On the evidence available four years in, none of those questions can yet be answered in the affirmative.

[95]National Health Insurance Authority, 'Presidential Directive on Mandatory Health Insurance Implementation Across MDAs' (12 September 2025).
[96] NHIA Act (n 9) ss 48(1)(c)-(d), 48(3), 49.
[97] WHO and World Bank (n 3).