HEALTHCARE FINANCING UNDER NIGERIA‟S NATIONAL HEALTH INSURANCE ACT (NHIA): IMPLICATIONS FOR PERSONS LIVING WITH NON-COMMUNICABLE DISEASES IN NIGERIA.

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Abstract

Nigeria‘s rising burden of chronic non-communicable diseases (NCDs) presents a fundamental challenge to the healthcare financing system under the National Health Insurance Act (NHIA). While the NHIA aspires to advance universal health coverage, its financing design remains largely oriented towards episodic and curative care, offering limited protection for persons living with chronic NCDs who require continuous, preventive and long-term treatment. This article demonstrates that the existing healthcare financing framework under the NHIA is structurally inadequate to secure health security and financial protection for persons living with chronic NCDs, thereby reinforcing health-related impoverishment and inequity. Drawing on the capabilities approach, the article reconceptualizes healthcare financing not merely as access to services, but as a legal and institutional mechanism for enabling full functioning and sustained well-being. Using the universal health coverage pillars of equity, access and coverage as an evaluative yardstick, the article interrogates the NHIA‘s benefit package, cost-sharing arrangements and regulatory design to expose critical gaps in chronic disease financing. It argues that the current framework insufficiently addresses the social and economic determinants of NCDs, including preventive interventions linked to unhealthy diets, and fails to mitigate the vicious cycle between chronic illness and poverty. The article contributes to Nigerian health law scholarship by advancing a capabilities-based critique of the NHIA and proposing targeted regulatory and financing reforms aimed at reducing financial hardship, improving continuity of care, and enhancing functional health outcomes for persons living with chronic NCDs.

Keywords: Non-Communicable Diseases, Capabilities Approach, Universal Health Coverage, Healthcare Financing, Nigeria‘s National Health Insurance Authority

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1.0 Introduction

Healthcare financing has been a major concern in my many health systems and health policy over several decades. Despite various reforms, it appears that the pursuit of equitable financing options especially in developing and low-income countries is still unsettled.[122] This challenge is particularly pronounced for persons suffering from Non-Communicable Diseases (NCDs) also known as chronic diseases, which are diseases characterized by slow progress that are debilitating. NCDs are largely non-curative but require long term, complex, continuous and requiring expensive procedures, and medicines. The four major types of Non-Communicable Diseases are cardiovascular diseases (CVDs), cancers, chronic respiratory diseases (such as chronic obstructed pulmonary disease and asthma) and diabetes. Some NCDs, like cancer, are life threatening while others, like sickle-cell anemia, diabetes can live a near normal life with adequate medications etc.[123] As at date, chronic NCDs pose the most serious global health challenge. Current statistics show that over 70% of all deaths globally are caused by NCDs with half of these deaths occurring in those between the ages of 30 and 69.[124] Currently, the African region is experiencing a high burden of NCDs which is projected to surpass communicable, maternal, perinatal and nutritional diseases by 2030.[125] Further by 2030, NCD related deaths are projected to surpass the combined deaths of communicable and maternal and prenatal deaths.[126] NCDs are also rising faster in younger populations in low and middle income countries than in high income countries. In a recent publication, health experts noted that CVDs are now responsible for 33% of deaths in Nigeria.[127] This burden is expected to increase by 2030, with 23

[122] E. Alfred, GO. Akpata, AE Akintoye. _Health Care Financing in Nigeria: An Assessment of the National Health Insurance Scheme (NHIS).' *European Journal of Business and Management* (2016) (18) (27) 27-34 Available from https://www.iiste.org/Journals/index.php/EJBM/article/view/33191 accessed 29 November 2025

[123] W. Nwankwo, O. Aje-Famuyide, AS. Olayinka. _Driving Equitable Access to Healthcare for NCD Sufferers in Nigeria through a Legal Informatics Approach. *International Journal of Business and Applied Social Science (IJVASS*) (2019).(2) (5):77-97 https://doi.org/10.33642/IJBASS.V5N2P8 accessed 10 December 2025

[124]World Health Organization. WHO. Global Status Report on Non-communicable Diseases. 2011. Geneva: World Health Organization. https://www.who.int/nmh/publications/ncd_report2010/en/ Accessed 15 July 2019.

[125]WHO. Regional Office for African. Aug. 2023. Country Disease Outlook. Accessed May 17 2024 from https://www.afro.who.int/sites/default/files/2023-08. A. Boutayeb, S. Boutayeb 2005. The burden of non-communicable diseases in developing countries. *Int. J. Equity Health* (4) (1) https://equityhhealthj.biomedcentral.com accesse 25 June 2018

[126] World Health Organization. World Health Statistics. 2013. (WHO 2013) 15

[127] N. Onyedika-Ugoeze _Experts Lament the High Burden of Cardiovascular Disease in Nigeria.' (Editorial *The Guardian Nigeria News*. 23 Sept 2021. https://cutt.ly/lwOma5UQ. Accessed Nov. 15, 2022. See also, S. Isezuo, MU. Sani, A. Talle, A. Johnson, AM Adeoye, MS Ulgen, et. al. _Registry for Acute Coronary Events in Nigeria (RACE-Nigeria): Clinical Characterization, Management, and Outcome.' *Journal of the American Heart Association* (2022) 11.1: e020244. Retrieved Jan. 18, 2023, from https://cutt.ly/wwOmfBJl.

million mortality from CVDs.[128] The primary causes of the rising CVD burden are high blood pressure (commonly called hypertension), diabetes, dyslipidemia (high cholesterol), and obesity. According to WHO, 1.3 billion adults have high blood pressure, two-thirds of which are in LMIC.[129] Studies have shown that high blood pressure and diabetes have more than doubled in Africa.[130] Particularly in Nigeria, which has higher rates than Europe and the United States.[131] With the facts and figures above, it is clear that non-communicable diseases have already become a persisting major challenge facing Nigeria's health care presently.

Three interrelated concerns shape the analytical focus of this article. The first relates to the criteria by which the effectiveness of healthcare financing systems should be assessed, particularly the interlinked dimensions of equity, access, and coverage that underpin universal health coverage (UHC). The second concern centres on the relationship between healthcare financing and poverty. Although public health insurance schemes are frequently presented as instruments for poverty reduction and financial risk protection, limited coverage, exclusionary design features, and weak implementation have constrained their effectiveness for persons living with chronic NCDs. The absence of adequate social protection in healthcare leads to high OOP expenditures, increasing the risk of catastrophic spending and impoverishment, and ultimately inhibiting progress towards achieving the poverty reduction and health related goals of the Sustainable Development Goals (SDGs).

According to the World Health Organization, it is estimated that over 150million are forced into poverty every year due to out-of-pocket health care expenditure. Catastrophic health spending

[128]D. Peiris, A. Ghosh., J. Manne-Goehler, LM. Jaacks, M. Theilmann, ME Marcus, et. al. _Cardiovascular Disease Risk Profile and Management Practices in 45 Low-Income and Middle-Income Countries: A Cross-Sectional Study of Nationally Representative Individual-Level Survey Data'. *PLoS medicine* (2021) (18). (3) e1003485. Retrieved Oct. 15, 2022, from https://cutt.ly/9wNvVeqA.

[129] WHO. March 2023. Factsheet on Hypertension https://cutt.ly/0wOmjZNj. Accessed Aug. 16, 2023

[130]AE Schutte, N. Srinivasapura Venkateshmurthy, S. Mohan, and D. Prabhakaran, D. _Hypertension in Low- and Middle-Income Countries.' *Circulation Research* (2021) (128) (7) : 808–826. https://cutt.ly/EwOmlDbw. Accessed 18 May 2023.

[131]S Van de Vijver, H. Akinyi, S. Oti, A. Olajide, C. Agyemang, I. Aboderin, and C. Kyobutungi, C. _Status Report on Hypertension in Africa--Consultative Review for the 6th Session of the African Union Conference of Ministers of Health on NCDs.' *The Pan African Medical Journal* (2013) (16) (1) 38. https://cutt.ly/iwOTsuch. accessed May 18, 2022.

occurs when out-of-pocket (OOP) expenses for healthcare affect household living expenses[132]. The implications of the above are that the bulk of health expenditure is bore by households without insurance which shifts the bulk of the expenditure to private individuals irrespective of the ability to pay. Nigeria has the highest number of persons living in extreme poverty which adversely affect their health.[133] The third point of concern is the preparedness of health systems to adapt the appropriate model of care in accordance with the needs of the NCDs. This raises important questions about the extent to which existing legal and institutional arrangements are capable of supporting sustainable, equitable, and NCD-responsive healthcare financing.[134] With these anomalies, there is a need for reform direction to improve the effectiveness of health care delivery.[135]

Scholarship on social determinants of health has expanded considerably in the last decade with increasing attention paid to the relationship between socio-economic conditions and health outcomes. International bodies such as the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) have also emphasized the importance of addressing social determinants of health in pursuit of health equity. Notably, the WHO Commission on Social Determinants of Health in its report, *Closing the Gap in a Generation: Health Equity Through action on the Social Determinants of Health* advocated for a shift from the narrow focus on disease control to broader interventions aimed at improving living conditions and reducing social inequalities.[136] Similarly, Marmot argues that reducing health inequalities require not only disease control measures, but also poverty alleviation, social development and strengthened healthcare systems. [137]

The SDGs further reinforce this perspective by seeking to consolidate and extend the achievements of the Millenium Development Goals (MDGs). In its preamble and Plan of Action, the SDGs identify the eradication of poverty, including extreme poverty as the greatest

[132] K. Vu Duy, H. Van Minh, K. Bao Giang, A. Dao, Le Thanh Tuan, Nawi Ng, Socio Economic Inequalities and Impoverishment Associated with Non-communicable Diseases in Urban Hanoi, Vietnam, *International Journal for Equity in Health* (2016) (15):169
[133] Share of Global Poverty in Africa by Country 2026 https://www.statista.com/statistics/1228553/extreme-poverty-as-share-of-global-population-in-africa-by-country/ accessed 19 May 2026
[134] W. Wilson Nwankwo, O. Aje-Famuyide, Akinola S. Olayinka. 2019. Supra.
[135] *Ibid*
[136] World Health Organization. Commission on the Social Determinants of Health (2008) Geneva.
[137] M. Marmot. Social Determinants of Health Inequalities, *Lancet,* (2005 (365) (9464) 1099-1104

global challenge and an essential requirement for sustainable development. Poverty, however is multidimensional and may arise from several interrelated factors, including healthcare expenditure. One recognized dimension is iatrogenic poverty, which refers to poverty induced or exacerbated by spending on medical treatment,‖ The World Health Organization estimates that over 150million are forced into poverty every year due to out-of-pocket (OOP) health care expenditure, a term described by the WHO and the International Labour Organization (ILO) as catastrophic health care spending.

Catastrophic healthcare expenditure has been widely examined in health financing literature. Vu Duy Kien et.al defines catastrophic payments as healthcare expenditures that consume a substantial fraction of the household income. [138] Similarly, catastrophic health spending occurs when OOP health expenses significantly disrupt household living expenses[139] The World Health Report suggests that families who spend 50% or more of their non-food expenditure on health care are likely to be impoverished. [140] Paul and Jonathan further argue that catastrophic OOP health expenditure is the singular major reason for households descending into poverty, given the severe financial consequences associated with healthcare costs. [141] In the same vein, Ichoku contends that healthcare expenditure becomes catastrophic when it exposes households to the risk of poverty or deepens existing poverty conditions. [142]

Several studies have highlighted the implications of OOP healthcare finance. Bolaji Samson and Samina Khan in their study on catastrophic health expenditure observed a high reliance on OOP health payment in Nigeria. Their findings revealed that OOP expenditure is linked to increased poverty headcount, pushing many households below the poverty line; [143] and remains alarmingly

[138] Vu Duy Kien et al, Socioeconomic Inequalities in Catastrophic Health Expenditure and Impoverishment Associated with Non-communicable Diseases in Urban Hanoi, Vietnam, International Journal for Equity in Health (2016) (15) : 169 http://soi.org/10/1186/s12939-016-0460-3 accessed on 6 November 2018

[139] *ibid*

[140] The World Health Report 2000, Health Systems: Improving performance. Geneva: World Health Organization; 2000

[141] Paul Certler and Jonathan Gruber. _Insuring Consumption Against Illness .‘ *American Economic Review*, (2002) (92) : 51-70

[142] HE Ichoku, W. Fonta. _The Distributive Effect of Health Care Financing in Nigeria: A Case Study of Enugu State.‘ PMMA Working Paper, No. 2006-17, https://dx.doi.org/10.2139//ssrn/985332

[143] BS Aregbesola, SM Khan, _Out-of-Pocket Payments, Catastrophic Health Expenditure and Poverty among Households in Nigeria‘ *Int. Journal Health Policy Manag.* (2018) (7) : (9): 798-806 doi:10.15171/ijhpm.2018.19 accessed on October 23, 2018

high among Nigerian populations.[144] This has been confirmed by Riman and Akpan's study which revealed that the heavy reliance on OOP expenditures reduce healthcare utilization, thereby exacerbating the already inequitable access to quality healthcare and household financial risk.

Studies focusing on chronic diseases indicate that long term illnesses bear particularly heavy burden. Christopher's study on the financial burden imposed on households affected by chronic diseases affirmed a higher level of expenditure explained by the long nature of treatment, (which can be made complex by acute episodic comorbidity). The study further confirms that households with higher economic quintiles tend to spend a larger proportion of household resources on healthcare than poorer households, although poorer households often experience more severe welfare consequences from such spending. [145] In Nigeria, healthcare financing every family is responsible for the health care of its members, principally through direct payments for health expenditure. Toyin Falola observes that the family functions both as a welfare and insurance agency[146] Accordingly, it may be safe to conclude that the greater financial burden of healthcare is bore by families or individuals.

It is against this backdrop that this article examines whether Nigeria's healthcare financing framework under the National Health Insurance Act (NHIA) adequately advances equitable access to healthcare for persons living with NCDs within the framework of UHC and the capabilities approach. UHC, as articulated in SDG 3.8, conceptualizes health system performance in terms of financial risk protection, access to quality essential health services, and access to affordable medicines.[147] As Nigeria re-commits itself to adequate health financing under the NHIA, it is necessary to assess the state of preparedness of the Act using the relevant benchmarks to make a forecast for persons living with NCDs. The paper finds that although the NHIA is an important policy reform toward expanded coverage, there are still structural

[144] EE. Ichoku, and WM. Fonta. _Catastrophic Healthcare Financing and Poverty: Empirical Evidence from Nigeria. *Journal of Social and Economic Development*, (2009) (11) (2) 1-16

[145] JC Counts, J. Skordis-Worrall. _Recognizing the Importance of Chronic Disease in Driving Healthcare Expenditure in Tanzania: Analysis of Panel Data From 1991 to 2010.' *Health Policy and Planning* (2016) (31) (4)(1): 434-443

[146] Toyin Falola. *Culture and Customs of Nigeria*. Greenwood Press, 2001

[147]OA. Aje-Famuyide, F. Anene. Universal Health Coverage and the Right to Health in Nigeria *University of Ibadan Law Journal* (10) (1): 243-263 See also, United Nations. Sustainable development. https://sustainabledevelopment.un.org/sdgs

limitations that constrain its effectiveness in providing adequate financial protection for persons living with NCDs.

This study is intended to contribute to the existing body of knowledge in the field of health law, health policy and health care financing by examining the implications of Nigeria's National Health Insurance Act (NHIA) for persons living with NCDs. This study is expected to develop a policy-oriented framework that may assist policymakers in designing and implementing inclusive healthcare financing strategies and programmes capable of addressing the needs of persons suffering from NCDs irrespective of their economic status or educational background. Given that the reduction of global poverty and inequities in access to NCD treatment require sustained national investment, it is necessary to formulate policies around the treatment-services for NCDs that are nuanced, stratified and scalable.

In what follows, section 2 provides the context to the study using the capabilities framework. Applying this framework, section 3 of the article interrogates the NHIA's benefit package design, cost-sharing arrangements, and regulatory architecture to assess their adequacy in addressing the long-term financing needs of persons living with chronic NCDs.

2.0 Conceptual Analysis and Theoretical Framework

Persons living with NCDs have a recurring theme which is the burden of chronicity of the disease which brings about long term treatment and reduced quality of life.[148] However, other dynamics complicate the disease burden; the management and treatment of chronic illnesses require multiple healthcare services, costly management drugs, poor access to continuous specialized treatment and fragmented healthcare services, more often than not, resulting in financial catastrophe, placing substantial burden on the patients and their families.[149] Additionally, LMICs including Nigeria, continue to face rising healthcare cost, limited resources, under-funded health financing systems, workforce shortages, service fragmentation, workforce,

[148] Supra at footnote 2
[149] Seen at http://www.who.int/mediacentre/factsheets/fs355/en/

and persistent inequities in access to quality healthcare.[150] Therefore, an adequate health plan covering medical bills, and treatment frequently incurred is required to protect against financial catastrophe.[151] Where essential health services are not available, affordable, inadequate and of good quality, governments are required to provide such services through legislative and regulatory reforms to realign financing structures with population health needs

Healthcare financing refers to the mechanisms through which resources are generated, allocated, and utilized to ensure access to health services. The World Health Organization (WHO) frames healthcare financing primarily from a health systems and public health perspective when it defines healthcare financing as the collection, pooling and purchasing funds to improve health outcomes and protect individuals from financial hardship associated with healthcare costs. From this perspective, the global body focuses on how financing mechanisms can achieve universal health coverage, improve health outcomes and protect individuals from catastrophic health expenditures.

The World Bank too, conceptualizes health care from a development and fiscal sustainability perspective focusing on resource mobilization, cost-effectiveness, economic productivity and the role of health financing in broader development goals. According to World Bank, healthcare financing is the mobilization of sustainable financial resources to achieve equitable and efficient healthcare delivery. Both institutions however commonly agree on principles such as sustainability, pooling of risks and improving access to essential services. Scholars such as Joseph Kutzin has conceptualized healthcare financing within the its health outcome impact, describing it as a system of revenue generation, and risk pooling intended to advance UHC.[152] Within the context of persons living with NCDs, healthcare financing comprises of legal, institutional and fiscal arrangements that guarantee continuous, affordable, equitable access to long-term prevention, diagnosis, treatment, and rehabilitative health care services without incurring catastrophic expenditures.

[150] JO. Ashaolu,, RE, Gunen, KR. Isacc, et.al. Breaking Barriers: Addressing Systemic Inequities in Chronic Disease Care for Displaced Populations. Conflict and Health. (2026) (20) :26 https://doi.org/10.1186/s13031-026-00767-4
[151] W. Wilson Nwankwo, O. Aje-Famuyide, Akinola S. Olayinka. 2019.
[152] J. Kutzin. Health Financing for Universal Coverage and Health System Performance: Concepts and Implications for Policy. *Bulletin of the World Health Organization.* (2013 (91) (8), 602-611.

The objectives of healthcare financing are anchored on equity, accessibility, affordability and quality, and these constitute the framework by which health systems are assessed. Equity in financing implies fair distribution of financial contributions and health benefits according to ability to pay and need, as reflected in the principles of progressive financing and risk pooling.[153] Accessibility refers to the extent to which financial mechanisms enable physical and financial access to essential services without administrative, geographic or economic barrier.[154] Affordability denotes the protection of individuals from catastrophic and impoverishing health expenditures, ensuring that out-of-pocket payments do not prevent service utilization.[155] Quality healthcare delivery links financing arrangements to the provision of effective safe and evidence-based services, ensuring value for money and improved health outcomes.[156] These objectives, put together, operationalize universal health coverage (UHC) by aligning resources mobilization and purchasing functions with distributive justice and system efficiency in healthcare financing for persons living with NCDs.

Theoretical Framework

This work adopts Amartya Sen‘s capabilities theory as its theoretical foundation for evaluating healthcare financing under Nigeria‘s National Health Insurance Authority Act (NHIA) 2022 particularly as it affects persons living with NCDs. The capabilities approach integrates the vision of the good life rooted in Aristotelian philosophy and provides an evaluative framework for assessing individual well-being, appraising social arrangements, and guiding policies and social reforms aimed at expanding substantive freedoms.[157] Developed by Amartya Sen, the approach offers an alternative to resource-based utilitarian theories of justice by focusing on individuals‘ substantive freedoms, which is their real opportunities to achieve valuable functionings. Sen, in his seminal work, *Equality of What?* argues that the capabilities approach is

[153] World Health Organization. *Health Financing for Universal Coverage.* (WHO 2010)
[154] J. Kutzin. Health Financing for Universal Coverage and Health System Performance. Supra.
[155] World Bank. World Bank Development Report: Investing in Health (World Bank 1993)
[156] World Health Organization. Quality of Care: A Process for Making Strategic Choices in Health Systems (WHO 2006).
[157] A. Sen. *Development as Freedom*. (Oxford University Press. 1999). Sridhar Ventkatapuram. *Health Justice: An Argument from the Capabilities Approach*. (Polity Press 2011)

concerned with evaluating wellbeing in terms of a person‘s actual ability to achieve valuable functionings as part of living.[158]

Sen draws a distinction between functioning and capabilities. Functioning refers to the state of being, and doing, that individuals have reason to value, such as being educated, having freedom of movement, participating in social life, access to water. In the context of health, functioning is the state of being free from disease and preventable morbidity. Capabilities, on the other hand, refers to the freedoms or opportunities to achieve these functionings. Capabilities therefore represent the real possibilities available to individuals to achieve functioning, rather than merely the formal means or resources at their disposal.[159]

Applied to health, the capabilities approach conceptualizes good health as a fundamental freedom that enables individual to pursue valued ways of living. Sridhar extends Sen‘s framework by developing a health justice paradigm grounded in the moral entitlement to health. According to Venkatapuram, ‗to be healthy is a kind of freedom‘, because health enables individuals to exercise agency, and participate meaningfully in society.[160] From this perspective, illness and premature death are understood not merely as biomedical outcomes, but as consequences of unjust social and institutional arrangements that restrict individuals‘ health capabilities.

Accordingly, all persons may be understood as having legitimate claims to be determinants of health, including biological, physical, environmental, social and institutional conditions necessary to achieve health capability. Access to healthcare services, medicines, palliative care, adequate nutrition, and a healthy living environment therefore constitute essential conditions for the realization of health capabilities. For example, being free from disease constitute a functioning, while access to healthcare, nutrition, and supportive social conditions constitute the capability to achieve good health. These health-related capabilities are foundational because their absence constrains human agency, and limits the ability of individuals to live they value.

[158] A. Sen. Equality of What? The Tanner Lecture on Human Values. Delivered at Stanford University, May 22, 1979. Lake City: University of Utah. Press Pp197-220
[159] Supra.
[160] S. Venkatapuram. 2007. *Health and Justice: The Capability to be Healthy*. University of Cambridge 2007.

Thomas Pogge extends this reasoning to institutional design. He argues that states and global social and global arrangements that produce severe deprivation are morally defective.[161] Applied domestically, Pogge seems to suggest that deficiencies in policy and financing structures are not mere technical deficits but also constitute moral harm especially when they result in preventable death or disease. In this context, he suggests recommendations that support institutional interventions and reforms to prevent injustice.[162]

There is a global shift in focus for a capabilities approach as the approach aligns with the principles of the Universal Health Coverage (UHC) which seeks to ensure access to quality health services, financial protection, and equity.[163] UHC operationalizes these principles through the dimensions of service availability, population coverage, and cost protection, with particular attention to marginalized populations**.** The UN General Assembly offered a fuller multidimensional goal of UHC that: [all] people have access, without discrimination, to nationally determined sets of the needed promotive, curative and rehabilitative basic health services and essential, safe, affordable, effective and quality medicines, while ensuring that the use of these services does not expose the user to financial hardship, with a special emphasis on the poor, vulnerable and marginalized segments of the population.[164] Attaining UHC encompasses a range of strategies which WHO has captured in the three dimensions of the UHC namely: the health services that are needed, the number of people that need them and the costs to whoever must pay – users and third party funders.**[165]**

The capability approach is appropriate and desirable for reforming policies for NCDs because the focus of the approach is the capability and not on health outcomes. Second, the capabilities approach is committed to opportunities that improve wellbeing. To Sen, an individual‘s capabilities is _not so much in ranking living standards, but in deciding on a cut-off point for the purpose of assessing poverty and deprivation‘[166] This means that capabilities entails the potentials that are available to a person to achieve human functioning, such as being in good

[161] T. Pogge, *World Poverty and Human Rights, Cosmopolitan Responsibilities and Reforms* 50-51 (2008), 2nd Edition (Malden, MA: Polity Press, 2008)
[162] *Ibid*
[163] Aje-Famuyide OA., Anene F. Universal Health Coverage and the Right to Health in Nigeria. Supra.
[164] United Nations General Assembly, Global Health and Foreign Policy, UN Doc. A/67/L.36 920120 para. 10
[165]Ibid.
[166] A. Sen. 1987b. *The Standard of Living*, in Sen, Muellbauer, Kanbur, Hart and Williams, *The Standard of Living: The Tanner Lectures on Human Values.* Cambridge: Cambridge University Press. 109.

health, or in the case of persons already suffering from NCDs, avoiding preventable morbidity, premature mortality, escaping impoverishment through OOP medical expenditures, and enhancing real freedoms. Furthermore, in terms of the treatment of NCDs, there is a full range of factors that make the treatment and restoration of effective, restore the human dignity of the sufferers, access to palliatives, medicines, and a host of other health goods necessary for the treatment and management of care.

Another cardinal point advocated by the capabilities approach is ensuring access to health goods; this directly connects to the objectives of the UHC through the protective security of health insurance. The international community has not recommended any particular health financing model or structure for a government so long as it promotes financial protection for end-users, instead states retain the discretion to design suitable arrangements, depending on the political-economic dimensions of their health systems.[167] Whatever the model, it is the aim of UHC that, ―economic burden of health care should be justly shared by all through the redistribution of funds from the well to the ill and the rich to the poor, using progressive financing and community rating‖.[168] From a capabilities perspective, the moral evaluation of a health financing system does not turn on its institutional form but on its effectiveness in expanding individuals' substantive freedom to access necessary care without impoverishment. This is apt especially within the NCD context, which is associated with disparities of vulnerability, risk, access to services and health outcomes which is often associated with low socio-economic status, there is a need to reduce inequalities in key NCD outcomes.[169] Thus, there is an obligation on systems to integrate policies to avoid morbidity and premature and preventable mortality. As stated above, the UHC and the capabilities approach have a common objective of fostering freedoms and dignity of individuals. They highlight the importance of freedom, equality and non-discrimination that are needed to live a functional life. It is therefore important for these highlights to be part of the strategies to address funding and healthcare mechanisms for persons living with NCDs.

[167] World Health Organization. *The World Health Report 2010: Health Systems Financing – The Path to Universal Coverage.* (WHO 2010)
[168] Supra. WHO 2010.
[169] K. Dain, Universal Health Coverage: An Empty Promise without Focusing on Chronic Conditions 10 November 2014 at http://www.devex.com retrieved on 22/9/2018 at 9.23pm

The next section addresses the integration of capabilities approach and the universal health coverage (UHC) in the analysis of funding and access to care for persons with NCDs under the present National Health Insurance Authority Act 2022.

3.0 Conversion factors in Nigerian legal framework on healthcare financing,

The National Health Insurance Authority Act is a laudable achievement of the government of the day in terms of the improvements from the repealed National Health Insurance Scheme (NHIS). Signed into law in 2022, the National Health Insurance Authority Act (NHIA) seeks to ensure effective implementation of a mandatory national health insurance policy to ensure the attainment of affordable, and equitable health care in Nigeria under the universal health care.[170] There are three blocks relating to targets to achieve a universal health coverage (UHC) – quality healthcare services, financial risk protection and equity access. The jurisprudential underpinnings of UHC are two pronged- financial protection and accessible healthcare and these will serve as a yardstick to measuring the degree of coverage for persons living with NCDs.

3.1 Financial protection

The principle of non-discrimination lies at the core of the UHC and capability approach. This principle ensures there is equal access to quality health services for all, regardless of race, gender, income, disability or health condition.[171] The NHIA sets the legal basis for achieving universal health coverage in Nigeria by mandating health insurance schemes in Nigeria. The goals of the NHIA are, among many others, to ensure access to quality healthcare services; provide financial risk protection; reduce rising costs of healthcare services and ensure efficiency in health care. The merit of this provision of the NHIA lies in the fact that financial protection from OOP medical expenses should be available to the 230million Nigerians including vulnerable and indigent populations. The NHIA shifts focus from mere provision of healthcare resources by guaranteeing access to essential health services and mitigating financial burden of long-term treatment. In accordance with section 14 (1), every person resident in Nigeria shall obtain health insurance coverage, including individuals in both the public and private sectors with five staff and above.[172] Pursuant to section 13 of the NHIA Act, each State and the Federal

[170] National Health Insurance Authority Act 2022
[171] SDG 3.8
[172] Section 12 (2) (a) - (c)

Capital there shall be a State health insurance and contributory scheme for all residents within their jurisdiction. To achieve comprehensive population coverage, the Scheme has specific programs for different segments of the society.

The first is the Public Sector Social Health Insurance programme for Ministries, Departments, Agencies in the Federal Civil Service and other relevant groups (PSSHIP).[173] PSSHIP expands the health capabilities of public sector employees, enabling them to maintain good health and sustain other valued functionings. The Public Sector Social Health Insurance Programme (PSSHIP**)** covers Ministries, Departments, Agencies within the Federal Civil Service, and other relevant public sector groups. Participation in the programme is mandatory for all government workers, under a co-contributory arrangement with their employer. Contributions can be calculated based on either a basic salary approach or a consolidated employee salary approach. Under the basic salary approach, the employer pays a 10% of the basic salary while the worker pays 5% of the basic salary. The consolidated employee salaries entail a situation where payment is made on a ratio of 3.5:1.5 of the consolidated employees' salaries between employee and the employer. A corollary of the PSSHIP is the organised private sector social health insurance programme (OPSSHIP) which provides health insurance coverage for private sector workers and their families.[174]

3.2 Vulnerable Group Fund

It is commendable that the NHIA prioritizes vulnerable persons and indigent persons by establishing a Vulnerable Group Fund (VGF) and the Basic Health Care Provision Fund (BHCPF) to improve financial access to health care by subsidizing health insurance coverage for vulnerable persons.[175] This because vulnerable people with NCDs often face financial access gaps.[176] Unlike the PSSHIP, both programmes (VGF and BHCPF) are non-contributory and beneficiaries are not required to pay make any payment prior to accessing health care services under these products. The BHCPF is designed to enhance access to preventive, protective, promotive, curative and rehabilitative health care services for beneficiaries by providing

[173] Article 13 (3)
[174] Section 14 (1) Cap 2 NHIA Act
[175] Section 25 (1) NHIA Act 2022
[176] Section 25 (1) NHIA establishes the VGF.

affordable healthcare services for beneficiaries.[177] The VGF, under the BHCPF identifies an inexhaustible list of persons with disabilities (PWDs), prisoners, children under five, refugees, victims of human trafficking, internally displaced persons (IDPs), immigrants and pregnant women as beneficiaries of the VGFs.[178] The source of funding for the VGF and the BHCPF include health insurance levy, Special Intervention Funds, monies accrued to the VGF from investments made by the Council, grants, donations, gifts and other voluntary contributions.[179]

This provision is apt at this time because of the growing magnitude of chronic disease sufferers that cut across people of all ages, race, income levels, working and non-working population, and more significantly the poor members of the society and those living in vulnerable situations.[180] Moreover, it is common knowledge that chronic disease treatment increases financial burden on the sufferer, families and communities, because of the long term nature of treatment, care cost and loss of productivity that threatens household income and leads to productivity loss for individuals and their families and by extension the gross domestic product of the State in question. With these funding models, it is hoped that it will reduce inequalities by enhancing freedoms for the most disadvantaged. By guaranteeing access to essential health services and mitigating the financial burden of long-term treatment, VGF and BHCPF expand the health capabilities of vulnerable persons. This is particularly critical for individuals living with NCDs as the scheme not only facilitates the attainment of good health as a central functioning but also prevents the erosion of other capabilities that could result from catastrophic OOP expenditures, thereby reinforcing social justice through equitable health financing.

The NHIA will rely on data of the poor and vulnerable, and especially persons under the National Social Intervention Programmes to determine those who qualify as vulnerable groups. In addition, it will consider demography, housing system, environmental health, social-cultural system and to determine a comprehensive picture of people within this category.[181] As stated earlier, this program is commendable because it targets interventions to vulnerable populations, women, children, and the elderly. When assessing these programs from the capabilities approach,

[177] Section 11 NHIA Act
[178] Section 25 (1) NHIA Act 2022
[179] Section 25(2) (a) - (e)
[180] Paragraph 23, Political Declaration
[181] F. Ezeh. NHIA. Deconstructing the New Act. (2022) on https://thesun.ng/nhia-deconstructing-the-new-act/ accessed April 23 2025

the availability of funding systems programs that increases access of all persons to medical care, would most likely improve their health status. However, while NHIA mechanisms such as the Vulnerable Group Fund and Basic Health Care Provision Fund expand access for certain NCD patients, the selective nature of coverage for cancer and stroke illustrates persistent capability deprivation for those with multimorbidity, reflecting a misalignment between legislative intent and comprehensive population health needs.

4.0 Benefits Covered

Under section 24 (1), the NHIA, the authority is to work with States to provide a basic minimum package of care to all residents in Nigeria. According to the DG NHIA, _the interest of the NHIA is to cover basic health, essential package. For instance, if a symptom of sickness comes, the person could freely visit hospital for check-ups if he or she has health insurance cover.'[182] For beneficiaries of the BHCPF product, the Guidelines stipulate the eligibility for primary and secondary health facilities.[183] For these facilities to be adequate, the Authority shall collaborate with State health schemes and institutions to accredit and empanel primary and secondary health care facilities on approved benchmarks.

For there to be universal health coverage, a functional system must be robust enough to focus on both communicable and non-communicable diseases and must be affordable so that financial hardships are alleviated. Therefore, with respect to persons living with cancers, the NHIA provides free access for the first hour of care in an emergency unit, and the first three hour of care for stroke management to reduce the financial burdens that come with them.[184] In a related interview on the new NHIA Act, the Director General, NHIA stated that for the treatment of cancers, the NHIA has established a cost-sharing initiative to reduce the financial burden of treatment for persons undergoing treatment. Under this scheme, cost of treatment will be shared between NHIA and the cancer patient, whereby the patient will pay for 20 percent of the treatment. In another interview, the DG noted that, as part of the NHIA initiative to broaden access, eligible cancer patients undergoing radiotherapy will receive a subsidy of up to

[182] *Ibid*.
[183] Guidelines for the Administration, Disbursement and Monitoring of the Basic Health Care Provision Fund at page 29 (section 1.6)
[184] TM Ipinnimo, et al. The Nigeria National Health Insurance Authority Act and its Implication Towards Achieving Universal Health Coverage. *Postgraduate Medical* Journal. (2022) (29) (4): 281-287. supra.

N400,00.00, that is, a 50percent subsidy on radiotherapy expenses, capped at N400,000.00 to improve access to essential care.

As laudable as these provisions are, there are still challenges with the group of persons in terms of inadequacy of access to healthcare to protect Nigerians living with NCDs against financial catastrophe. Moreover, it is common knowledge that chronic disease treatment increases financial burden on the sufferer, families and communities, because of the long-term nature of treatment, care cost and loss of productivity that threatens household income and leads to productivity loss for individuals and their families and by extension the gross domestic product of the State in question. While this is a good initiative, a lot more still needs to be done to improve accessibility of treatment; NCDs require continuous access to treatment, reduced cost of prescription drugs, free from discrimination and urgent need of care and support. A one-off intervention or episodic funding does not align with the sustained support that is required to preserve capabilities of persons with NCDs. Another limitation is with respect to the selective model of the NHIA program. That is, only cancer patients and stroke patients are covered under this programme. Studies show that NCDs are usually, characterized by co-occurrence or multi-morbidity, which are conditions that occur as a consequence of one leading index condition in an individual.[185] That means, the presence of multiple chronic conditions in an individual may likely lead to other NCDs or other complications. The prevalence of multimorbidity of NCDs is about 60%, due to the shared risk factors of NCDs.[186] Several studies have confirmed the pattern of multi-morbidity in Nigeria between three to five multiple morbidities. [187]

4.1 Health System Accessibility

Access has geographic, financial, social, ethnic and psychic components. Access is also a function of the availability of health services and their acceptability. In practice, access, availability, and acceptability which collectively describe the things which determine the care people use, are very hard to differentiate. The National Library of Medicine defined it as —the

[185] OA Asogwa, D. Boateng, A. Marzà-Florensa, et al. Multimorbidity of Non-Communicable Diseases in Low-Income and Middle-Income Countries: A Systematic Review and Meta-Analysis. *BMJ Open*. (2022) 21:12:1: e049133. doi: 10.1136/bmjopen-2021-049133

[186] Supra..

[187] A. Ahmed, HTA Khan, M. Lawal, M. The Prevalence, Pattern, and Burden of Multimorbidity Among Older Adults in Niger State, Northern Nigeria. *Illness, Crisis & Loss*, (2024) *0*(0). https://doi.org/10.1177/10541373241268305

degree to which individuals are inhibited or facilitated in their ability to gain entry to and to receive care and services from the health care system. Factors influencing this ability include geographic, architectural, transportational, and financial considerations, among others.‖ This definition suggests that access to healthcare is not limited to financial accessibility but physical as well as the level of awareness of the existing health care services. Hence, a service has to be accessible before it can be utilized. UHC cannot be clearly implemented without the accessibility to treatments, crucial medicines and other necessary technologies.[188] The nature of NCD warrants the preparedness of health systems to meet the challenges of the disease. Within the NCD context, the NCD epidemic is rooted in disparities of vulnerability, risk, access to services and health outcomes which is often associated with low socio-economic status, there is a need to reduce inequalities in key NCD outcomes.[189]

NHIA has entered into partnership with multiple oncology facilities across Nigeria to improve access to high quality radiotherapy services, with a promise to _increasing the number of accredited radiotherapy centres, strengthening collaborations with pharmaceutical and medical equipment companies, and ensuring modern radiotheraphy technology is available nationwide.[190] Accessibility includes having healthcare professionals including doctors, nurses and pathologists. In terms of access to adequate treatment, there is need to improve position adequate access to hospice care for them. It has been revealed that, for some cancer diagnosis and treatment, there are still some tests which cannot be performed locally in Nigeria but are sent to other countries. This is because, some form of cancers, like breast cancer, is individualized and requires personalized medications tailored to individual conditions.[191] At present, there are few cancer treatment facilities in Nigeria making accessibility beyond the reach of many Nigerians.

Lisa describes chronic NCDs as a physical or mental health condition that generally lasts at least a year and results in a limitation of self- care, independent living and social interactions or the

[188] O. Aje-Famuyide, F. Anene. Supra.
[189] K. Dain, Universal Health Coverage: An Empty Promise without Focusing on Chronic Conditions. Supra.
[190] Rapheal. NHIA Launches Cost-Sharing Initiative to Ease Cancer Treatment on the SunNewspaper Online. At https://thesun.ng/nhia-launches-cost-sharing-initiative-to-ease-cancer-treatment/ accessed 16 June 2025; NHIA Introduces N400,000 Treatment Subsidy for Cancer Patients. Available on https://healthwise.punchng.com/nhia-introduces-n400000-treatment-subsidy-for-cancer-patients/ accessed 16 June 2025.
[191]Cancer Care in Nigeria: A Deep Dive into Numbers, Cost, Closing Care Gap. Available at https://businessday.ng/health/article/cancer-care-in-nigeria-a-deep-dive-into-numbers-cost-closing-care-gap/ accessed 25 May 2025

need for on-going interventions with medical products, services and special equipment[192]. For this reason, sometimes, it requires a re-design of health systems to address chronic illnesses as well as to treat patients holistically within the interaction of acute events, multiple comorbidities, palliative care, and survivorship. UHC cannot be clearly implemented without the accessibility to treatments, crucial medicines and other necessary technologies.[193]

The challenge of treatment and management of NCDs remain a mirage in the face of high cost of procedures and drugs and limited coverage for treatment. This is because, 20percent treatment cost for cancer patients OOP is still a catastrophic expense which can result in poverty for many households in Nigeria. According to an Oncologist specialist, the cost of radiotherapy in a government hospital is between N1.5million to N2million Naira. Further, cost of drugs, injections etc are exorbitant. Since majority of the Nigerian population is unable to afford healthcare, there is a high dependence on family for welfare. There are overwhelming scientific researches that show that health care, financed primarily through OOP payments have devastating financial impact on payers. Bolaji Samson and Samina Khan study to determine the extent to which catastrophic OOP health result in impoverishment in Nigeria revealed there is still high reliance on OOP health payment in Nigeria. The outcome of their study revealed that OOP leads to a rise in poverty headcount, the implication of which is that many households are pushed further below poverty line through catastrophic health expenditure. [194] Considering the fact that over half of Nigerians live on less than a dollar a day, the vicious circle of poverty is bound to continue.

5.0 Implications for Persons Living with Noncommunicable Diseases

Financing structure in any health system has significant implications for every individual. Under the NHIA, although health insurance is intended to provide financial risk protection and improve access to essential healthcare, coverage for NCD prevention, diagnosis and long-term disease management remains limited both in scope and effectiveness. As a result, many individuals living with chronic conditions, such as diabetes, cancers, cardiovascular diseases and respiratory

[192] Lisa Clemans-Cope et.al, The Expansion of Medicaid Coverage Under the ACA: Implications for Health Care Access, Use and Spending for Vulnerable Low-income Adults, *Inquiry*, (2013) (50) (2): 135-149 @ 136
[193] O. Aje-Famuyide, F. Anene.. Supra.
[194] BS Aregbesola, SM Khan, 2018. Out-of-Pocket Payments, Catastrophic Health Expenditure and Poverty among Households in Nigeria 2010, *Int. Journal Health Policy Manag*. 7:9: 798-806 doi:10.15171/ijhpm.2018.19

conditions continue to rely heavily on OOP, exposing them to catastrophic health expenditure and increasing the likelihood of treatment interruption or non-adherence.[195]

The gap in the financing design under the NHIA has severe implications extending to development concerns. First, a weak financial protection for NCD care limits progress towards achieving UHC.[196] In particular, the persistence high OOP health expenditure reflects inefficiencies in risk pooling and resource allocation within the health financing system. Consequently, persons living with NCDs face disproportionate barriers to accessing continuous, quality care, resulting in higher morbidity, premature morbidity and reduced productivity.[197] Inadequate coverage also has severe implications for the attainment of the United Nations SDGs, particularly goal 3.4 which aims to reduce premature mortality from NCD through prevention and treatment, while target 3.8 focuses on access to quality essential healthcare services and financial risk protection.

5.0 Conclusion

This study examined the extent to which the National Health Insurance Authority (NHIA) Act of 2022 provides adequate financial protection and healthcare coverage for persons living with NCDs in Nigeria. The study finds that, while the NHIA enactment of the National Health Insurance Authority (NHIA) Act of 2022 represents a significant policy advancement towards attaining UHC and aligns with Sustainable Development Goal 3.4, which seeks to reduce premature mortality from non-communicable diseases (NCDs), its provisions remain uneven in addressing long term and complex needs of individuals living with NCDs.

It is part of the findings of this study that the NHIA introduces important mechanisms, such as the mandatory health insurance schemes, co-contributory programs for the public and private sectors, and targeted support for vulnerable populations through the Basic Health Care Provisions Fund and the Vulnerable Group Fund, thereby showing the nation‘s commitment

[195] Ayodeji O, Benton M, Orton L, Weich S. The Lived Experiences of Individuals with Type 2 Diabetes Mellitus with Poor Glycaemic Control in Nigeria: A Qualitative Study. *Clinical Medicine Insights: Endocrinology and Diabetes*. 2025;18. doi:10.1177/11795514251384044

[196] World Health Organization, Tracking Universal Health Coverage: 2023 Global Monitoring Report (WHO 2023)

[197] World Health Organization. Noncommunicable Diseases Country Profile 2022 (WHO 2022)

towards expanding financial protection and improving access to healthcare services, particularly for disadvantaged populations. While these provisions demonstrate an ethical commitment to justice and equity, they simultaneously expose significant gaps in coverage for individuals with multimorbidity and other chronic conditions that are not explicitly prioritized. With the nature, scope and cost of NCDs, there is the need to close the care and financial gap for persons suffering for NCDs in terms of treatment challenge, palliative care and terminal gaps for NCDs. Cost-sharing initiatives, for instance, while mitigating immediate financial burdens for certain patients, may not adequately address the sustained nature of chronic disease management, which demands long-term access to medications, diagnostic services, and specialist care.

The study finds that although government, through the NHIA has taken up initiatives and collaborations to improve access; while well-intentioned, remain selective and uneven and there is still need for targeted measures to broaden the access for NCDs coverage for NCDs.

The study further finds that selective coverage, as shown under the NHIA, is problematic given the high prevalence of mortality and morbidity, which is estimated at between 60% - 80%, which necessitates continuous, integrated lifelong care. The selective focus on cancer and stroke, though vital, underscores a broader systemic challenge: the NHIA must evolve from episodic interventions to a continuous, inclusive model capable of responding to the multi-faceted and co-morbid realities of NCD patients. As a result, many individuals continue to experience high OOP health expenditures, treatment interruptions, and limited access to essential diagnostic and pharmaceutical services. These gaps in the NHIA weaken the financial protection function of the NHIA and expose households to catastrophic health spending and impoverishment as reflected in global evidence that millions are pushed into poverty annually due to healthcare costs.

These findings demonstrate that the although the NHIA incorporates important provisions, it still remains insufficient to respond to the chronic nature of NCD care. The current cost-sharing arrangement of the NHIA, while it may reduce financial pressure for selected conditions, does not adequately address the treatment/management needs of NCDs, thereby limiting the effectiveness of the financing mechanisms in achieving UHC.

The study demonstrates that persons living with NCDS remain the most affected group, as they continue to face financial hardship, interrupted care and reduced quality of life. Policymakers and the NHIA have the responsibility for expanding the depth of coverage to reflect the realities of NCD management.

In answering the research question, the study demonstrates that the NHIA, while progressive in design, does not yet provide adequate or equitable coverage for persons living with NCDs in Nigeria, particularly in relation to long term care, multimorbidity management, and financial risk protection.