

# Towards universal coverage: a policy analysis of the development of the National Health Insurance Scheme in Nigeria

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This article examines why and how a national health insurance (NHI) proposal targeting universal health coverage (UHC) in Nigeria developed over time. The study involved document reviews, in-depth interviews, a further review of preliminary analysis by relevant actors and use of a stakeholder analysis approach. The need for strategies to improve healthcare funding during the economic recession of the 1980s stimulated the proposal. The inclusion of Health Maintenance Organizations (HMOs) as financing organizations for national health insurance at the expense of sub-national (state) government mechanisms increased credibility of policy implementation but resulted in loss of support from states. The most successful period of the policy process occurred when a new minister of health (strongly supported by the president that displayed interest in UHC) provided leadership through the Federal Ministry of Health (FMOH), and effectively managed stakeholders' interests and galvanized their support to advance the policy. Later, the National Health Insurance Scheme (the federal government's implementing/regulatory agency) assumed this leadership role but has been unable to extend coverage in a significant way. Nigeria's experience shows that where political leaders are interested in a UHC-related proposal, the strong political leadership they provide considerably enhances the pace of the policy process. However, public officials should carefully guide policymaking processes that involve private sector actors, to ensure that strategies that compromise the chance of achieving UHC are not introduced. In contexts where authority is shared between federal and state governments, securing federal level commitment does not guarantee that a national health insurance proposal has become a 'national' proposal. States need to be provided with an active role in the process and governance structure. Finally, the article underscores the utility of retrospective stakeholder analysis in understanding the reasons for changes in stakeholder positions over time, which is useful to guide future policy processes.

**Keywords** Health Maintenance Organization, National Health Insurance Scheme, Nigeria, policy analysis, universal health coverage

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## KEY MESSAGES

- The study confirms the central role of a policy entrepreneur or political champion in taking forward major policy initiatives such as universal health coverage (UHC).
- While the private sector's technical expertise was critical, its subsequent policy influence highlights the importance of public oversight and clearly defined roles for private sector involvement.
- In a federal system such as Nigeria, states have a crucial role and need to be considered in governance arrangements to progress UHC.
- Retrospective stakeholder analysis has value in characterizing stakeholder interests, influences positions and understanding reasons for changes over time.

## Introduction

Global attention has recently converged on the need for countries to achieve universal health coverage (UHC), which aims to guarantee that all persons are able to access needed and effective healthcare without facing financial ruin by using services [World Health Organization (WHO) 2013]. In the attempt to move towards UHC, several low- and middle-income countries are developing more sustainable revenue sources, expanding pooling arrangements and employing more efficient and sustainable purchasing strategies [Health Insurance System Research Office (HISRO) 2012; Lagomarsino *et al.* 2012; McIntyre *et al.* 2013]. Their experiences represent a growing evidence of the application of mandatory (social), private and community-based health insurance in low- and middle-income countries and their potential contribution to UHC. The evidence from some countries suggests that strong political support, effective programmes, supportive context, robust public accountability mechanisms and strong technical capacity are vital to developing and implementing effective UHC-related proposals (Savdoff *et al.* 2012; Balabanova *et al.* 2013; WHO 2014). Yet WHO has clearly stated that additional insights into policy processes in different policy contexts in low- and middle-income settings are needed (WHO 2013).

Nigeria has a long history of trying to achieve healthcare coverage for its population that is distributed in 36 states and the federal capital territory (Abuja). After gaining independence in 1960 and adopting a constitution based on federalism (Adamolekun 1991), a series of military governments eroded state autonomy from federating to solely administrative units (Osaghae 1992). Starting from 1984, successive military regimes attempted to expand national health insurance. In 1999, a military decree that legally established a National Health Insurance (NHI) Scheme (NHIS) was enacted (NHIS 2013). It was envisaged that public sector employees (at federal and state levels) would be mandatorily included, with private sector employees and other members of the society following subsequently. However, the status of state employees was ambiguous with respect to the decree because of the position of states (as federating units) within the federal system, allowing state governments to either adopt or not adopt some health policies established by the federal government, including the NHIS proposal (Onoka *et al.* 2013).

The NHIS commenced implementation of its main programme—the 'formal sector social health insurance

programme' (FSSHIP)—in 2005, under a democratic federal government based on the NHIS law that was enacted during the military era (Dogo-Mohammad 2011; NHIS 2013). Employees were required to contribute 5% of their basic salaries, with a 10% equivalent contribution by the employer. The revenue complements the supply-side general budgetary allocations that the government makes to the health sector, which mostly covers personnel salaries and capital expenditure. Based on a full purchaser/provider split model, 76 privately owned Health Maintenance Organizations (HMOs) currently serve as operators of the scheme (NHIS 2013), while over 4000 facilities are registered as healthcare providers (HCPs) (NHIS 2013). Nearly all federal government employees and their dependants have been covered by the programme (Dogo-Mohammad 2011, 2012) and largely account for the 5 million Nigerians (3% of the population) covered [Dutta and Hongoro 2013; Joint Learning Network (JLN) 2013]. However, the NHIS has been unable to expand coverage beyond the federal government employees as planned.

At the time the FSSHIP (2005) was launched, the NHIS was given a presidential mandate to achieve UHC by 2015 through its programmes, requiring an expansion of the scheme. Consequently, the NHIS developed additional programmes for rural communities, informal sector employees, voluntary contributors, students of tertiary educational institutions and vulnerable groups (NHIS 2012).

There has been no systematic analysis of the processes leading to the development of national health insurance in Nigeria. Available literature has focused on appraising the content of the NHIS policy (Anarado 2002) and understanding impediments to adoption of the formal sector programme (FSSHIP) by states (McIntyre *et al.* 2013; Onoka *et al.* 2013). Hence, this article presents the first analysis of the Nigerian policy process relating to the national health insurance policy. Using a stakeholder analysis approach (Brugha and Varvasovszky 2000; Varvasovszky and Brugha 2000; Gilson *et al.* 2012), it examines why and how the policy developed by reflecting on the roles of actors, their context, and 'how' they influenced the process and outcome to ensure that a critical intermediary role emerged for private HMOs. It provides evidence from Nigeria to enhance the understanding of the politics of such reform processes, which is vital to the success of policy reforms for UHC in low- and middle-income settings.

## Methods

This case study of the NHI policy development in Nigeria was based on the theoretical proposition that actor interests, power and position influenced changes in the NHI policymaking process over time, the content (policy design) and the outcome (coverage). Case studies are preferred when a study involves finding answers to 'how' and 'why' questions (Yin 2009) in order to support or dismiss a hypothesis or theory. This study draws on the insights from Baumgartner and Jones (1993) theory that suggests that processes of policymaking comprise phases of rapid changes and stasis. Change occurs when a policy problem and its solutions are conceptualized in a different way or when new actors emerge. Actor influences on context, content and process of policy reforms were then explored based on the policy analysis framework of Walt and Gilson (1994). This analysis structured the development of NHI policy into several phases, examined policy content, and sought to understand how changes occurred, in view of actors' interests, positions and influences.

The study used a stakeholder analysis approach because of its focus on the behaviours of individuals, groups or organizations concerned, affected by or involved in development of a policy of interest (stakeholders), and the motives, interrelationships and influences they exert in the policy development process. A broad range of stakeholders are often involved in UHC related reforms and prioritizing those for a stakeholder analysis is essential but challenging (Gilson *et al.* 2012). For this study, the initial set of stakeholders included groups or individuals (not covered within groups) directly involved in the policy development. These were identified from a number of sources: the NHIS website (NHIS 2013), operational guidelines (NHIS 2005) and academic and grey literature (Awosika 2005). This generated a list of 18 groups, which was narrowed based on key informant interviews which identified consistently named groups that played roles in the policy development process, and key individuals that were employers, employees, policymakers and leaders or managers of various stakeholder categories (Table 1). Table 1 shows the final set of stakeholders (10) used for the study while Table 2 summarizes the methods used for data collection. Using a set of semi-structured interview guides, stakeholders were interviewed between October 2012 and July 2013, and provided consent to the interview and for it to be recorded.

Transcripts of voice records, field notes from interviews and the output of document reviews were imported into QRS NVivo 10 software. Although theory guided the data collection, an inductive approach was used for data analysis to provide insight into the accumulated dataset and to enable a movement from specific data contents to broad theories and generalizations (Miles and Huberman 1994; Pope *et al.* 2000; Thomas 2006). The emerging themes were then compared against the set of themes and questions (based on the theoretical proposition) that guided data collection. Data codes generated were organized to focus on actors in order to analyse their interests, positions and influences on the policy process. Further analysis focused on the influence of policy context over stakeholder interactions over time (Varvasovszky and Brugha 2000) and the dynamics of the policy process (Gilson *et al.* 2012).

**Table 1** Stakeholders involved in the NHIS policy reform

Stakeholders	Interests
NHIS	Public institution with regulatory and operational responsibility for the policy
Federal Ministry of Health (FMOH) and the minister of health	Key reform programme of the FMOH
HMO	Intermediary operators of the scheme
HCP	Health service delivery
Federal government employees (i.e. civil servants' unions or Labour unions)	Beneficiaries
Private employers/National Employers Consultative Association (NECA)	Payers for private employees
Banks	Source of mobilizing credit and the need to retain funds meant for their own employees.
Development partners (DP)	Technical and financial support

The study depended on interviewee recall of past events and availability of historical documents, which are challenges inherent in analysing policymaking (Walt *et al.* 2008). Hence, data emerging from the analysis were checked against documents reviewed and existing literature. Analyst's assumptions and judgements can also disrupt policy analysis (Walt *et al.* 2008). This was addressed through use of a research supervision team comprising individuals with previous experience with health financing reforms, and triangulation of preliminary results with key actors interviewed.

Policymaking is a dynamic process, and is characterized by changing positions and influences of policy actors over time (Walt and Gilson 1994). While some argue that stakeholder analysis techniques become problematic if used to study policy processes that span over long periods of time, stakeholder analysis of historical events provides the opportunity to analyse the changing positions and influences of actors within the policy process (Varvasovszky and Brugha 2000). This made this approach particularly suitable for this study.

The Ethics Review Committee of the London School of Hygiene and Tropical Medicine and the National Health Research Ethics Committee of the Federal Ministry of Health (FMOH), Nigeria, approved the study.

## Results

This section first presents the historical antecedents to the reform. The following analysis then organizes and presents the policy development process in four phases: (1) an initial phase of 'Consultation' to shape the policy, (2) a subsequent phase of 'Constitution' of the policies to guide the key programmes, (3) the 'Commencement' and early implementation of the FSSHIP and (4) a further phase of 'Consolidation' of the co-ordinating institution for the policy.

**Table 2** Methods used for data collection

Data source	Approach
Document review	Inductive analysis of relevant documents
Media review	Review of reports and comments of stakeholders in major Nigerian Newspapers available online, augmented by media reports from 'UHC forward' website (Joint Learning Network, 2013)
In-depth interviews (IDIs)	35 IDIs held with individuals that were directly involved in the policy process IDIs provided primary data on the development of NHI in Nigeria, roles of stakeholders in shaping the policy, formulating the laws and operational guidelines for the NHIS and implementation IDIs also helped explain documentary evidence
Publications	Review of relevant journal publications on the NHIS available in the literature
Review of preliminary reports	Review by a team of supervisors at the London School of Hygiene who were familiar with the context and reform. Feedback received from seven previously interviewed individuals chosen from all stakeholder categories to review the preliminary report after the analysis was completed
Researcher	Preliminary exposure to the focus of analysis, serving as a university researcher and having conducted a previous study focusing on the impediments to adoption of the FSSHIP at the sub-regional (state) level (Onoka <i>et al.</i> 2013)

### Historical antecedent

Following Nigerian independence in 1960, efforts were made to develop a locally-led health service by the minister of health in 1962 through a parliamentary bill for a Health Service Scheme in Lagos (Nigeriafirst 2003; Awosika 2005; FMOH 2008; NHIS 2013). The plan included a pre-paid contributory element or a 'health financing arrangement', which led some analysts to reference it as the first recognition of the need for health insurance. The bill was defeated in parliament.

The global economic downturn during the 1980s, a fall in oil prices and dwindling public resources impacted negatively on health services in public health facilities in Nigeria (Metz 1991; Orubuloye and Oni 1996; Kajang 2004; Reid 2008). Because the federal government 'could no longer afford to provide free health', it opted to consider use of contributory mechanisms to complement other sources of healthcare funding for all Nigerians [Dogo-Mohammad 2006; Office of the Head of Civil Service of the Federation (OHCSF) 2013]. Two committees set up by two successive Ministers of Health, then recommended NHI as a desirable (1984) and feasible (1985) option for financing healthcare in Nigeria (Dogo-Mohammad 2006; NHIS 2013). This set the stage for the development of a NHI policy.

### Consultation

Critical deliberations over the actual content of the proposed NHIS occurred between 1985 and 1998 and led to development of a preliminary model for the scheme, introduction of the private sector and modification of the model to incorporate HMOs.

#### *A preliminary model*

A new minister of health convened a broad consultative meeting in 1985 to provide guidance on development of NHI. Stakeholders included labour union (representing civil servants), HCP associations, private employers, development partners and relevant government agencies (NHIS 2013). In 1988, another ministerial committee developed 'a realistic and acceptable model' for implementing a social health insurance programme in Nigeria (FMOH 2008; NHIS 2013). The resulting

model included 'detailed requirements and procedures' for the scheme, and a health insurance board managed by States as the intermediary operator (Umez-Eronini 2001; CareNet Nigeria 2002b; Nigeriafirst 2003; Dogo-Mohammad 2006). Stakeholder consensus was built around the model with the National Council on Health (NCH), the highest health policy advisory body in Nigeria, recommending its adoption. Development partners, such as the International Labour Organization, provided technical support for policy development. The Federal Executive Council approved the report the same year (1989) for immediate implementation. However, the political impetus for implementation was lacking, as crippling economic conditions impacted negatively on the government's interest in launching the NHIS.

#### *Introduction of the private sector*

During the period of economic downturn of the 1980s, both the public and private sectors gradually became reliant on private providers. This resulted from the poor public health infrastructure and delivery systems, and encouragement from development agencies including the World Bank and the International Monetary Fund that promoted the philosophy of public-private partnerships (Ruger 2005). More specifically, the substantial use of private HCPs led private employers to look to the private sector for insurance solutions for employees' health needs. They developed contracts with and retained preferred providers that were invoiced for primary care, based on fee-for-service schedules. This practice became known as 'retainership' (Alubo 2001; CareNet Nigeria 2004; Onwujekwe and Velenyi 2010). Over time, the retainership system became bedevilled with moral hazard and rising costs, as company employees connived with and received unnecessary care from HCPs, leading to its abandonment by private firms (Arigbabuwo 2013).

*"So when these people (employees of private firms) go to the hospital, the same providers that used to welcome them with open arms under retainership system, that will encourage them to come*



*back for more, are now telling them 'No, no, you cannot do that (request services that you want) anymore.'* (HMO manager)

*"After the collapse of the retainership system due to a lot of fraud and inadequacies of the system, it became obvious to doctors in private practice they needed to look at other sources of income. So some of them formed the foremost HMOs."* (Policymaker)

A National Health Summit in 1995 built consensus around introduction of private options in public health systems, and specifically, the inclusion of private sector HMOs and providers in the proposed NHIS (CareNet Nigeria 2002c). This was facilitated by the strong participation of HMO enthusiasts with previous exposure to the managed care system in the United States of America, and lobbyists from the insurance industry that had struggled with previous attempts at providing health insurance (CareNet Nigeria 2002a). To them, the proposed scheme offered enormous opportunities, as long as they could secure reasonable membership. Within one year of the summit's recommendation (1996), the first HMO commenced operations, the second in 1997 and two others soon after. These were owned by owners of large HCP facilities, health management firms and individuals with a background in commercial insurance.

#### **Modification of model**

Despite initial scepticism about their sustainability in Nigeria (CareNet Nigeria 2008), the first set of HMOs attracted members from the formal private sector and competed with HCPs for wealthy multinational companies. They seemed capable of providing quality services, through a cheaper, more predictable, and administratively less intensive mechanism than retainership. Due to their perceived potential for success, policymakers saw HMOs as a solution to the inability of public systems to implement a NHI policy, and convinced the NCH to include private sector actors in the developing NHIS. The NCH mandated civil servants at the FMOH to modify the proposal. These bureaucrats turned to individuals with interests in the HMO industry for advice with the result that HMOs replaced State Health Insurance Boards as the intermediary operator of the scheme (Umez-Eronini 2001).

*"I mean those people had an eye towards doing HMO business . . . they were the forefathers sort of and put those thoughts (new operational modalities) together; there was not better wisdom at that time; so it was accepted, and was crafted into the Act"* (Former FMOH official).

#### **Constitution**

Despite progress in policy development, there was still no legal authority for implementation of the NHIS (CareNet Nigeria 2002b). Following a change to a new military government in 1998, the Head of State undertook reforms to restore politically and socially relevant institutions and legislation, pressured by global interest groups and a resurgent population. Though the draft NHIS policy had not been reviewed by the NCH, bureaucrats took advantage of the opportunity to submit it and it was signed into law. From the outset, it was evident that the military decree had been signed without stakeholder consensus.

In the new atmosphere of engagement and public expression in the country that followed a transition to democratic government in 1999 (Dagne 2005), contentious issues regarding the NHIS policy surfaced. These included the use of HMOs as operators, appointment of a non-medical doctor as executive secretary, exclusion of state governments as key stakeholders, and the proposed 5% salary deduction for employee contribution (Moghalu 2004; Asoka, 2011). A public hearing on the Act was organized by parliament in 2000 (CareNet Nigeria 2002c). Although these issues were unresolved, the NHIS governing council was inaugurated in 2001, but lacked the capacity to implement the programme as mandated by the president.

*"Neither the NHIS nor the governing council appeared to have capacity to develop or implement the programme. The council chairman had no knowledge of insurance; the rest of the members were politicians"* (Policymaker).

Initial attempts to commence the programme were constrained by changes in the policy environment and stakeholder positions because of several contentious issues (Table 2). For example, states withdrew their support for the policy, insisting they had not been consulted in development of the programme and were left without a governance role in the scheme. National leaders of the civil servants' union urged members to resist attempts at making deductions from their salaries for the FSSHIP, citing failures in previously established federally driven contributory schemes (Asoka 2011). Equally, private employers became less interested as the law now stipulated health insurance as 'optional' rather than 'mandatory' for them. In contrast, HMOs backed by favourable legislation sustained their interests and increasingly gained experience in managing beneficiaries, private employers, companies, and HCPs. One HMO attracted funding from the International Finance Corporation to enable expansion of its capacity to handle larger enrollee numbers. This was interpreted as a display of confidence in HMOs by a major international organization. HMOs also retained their role as a reliable source of advice to policymakers, and consequently grew in influence.

#### **Commencement of the FSSHIP**

*"We will break the circle of planning and motion without movement. We must start this scheme even with some imperfections, and fine-tune these as we go along"* [A former Executive Secretary of the NHIS as quoted in CareNet Nigeria (2005), reflecting the mood at the time implementation commenced].

By mid-2003 when the civilian government commenced its second 4-year term, they faced a number of obstacles to policy implementation. These included provider resistance, a restive labour union, uncertainties about employer contribution from the federal government and states (referred to as 'political will'), a withdrawn private sector, and uncertainties about the co-ordination and direction of the policy process. By 2003, a new minister of health, a health economist with a background in international health, was appointed by the president (Asoka 2011). He also dissolved the existing NHIS council and did not appoint a new one during the Minister's 4-year tenure. The

**Table 3** Key co-ordinating roles played by the minister of health and the president to address contentious issues constraining NHIS implementation

Stakeholder	Issues	Intervention
FMOH/NHIS	Uncertainties about co-ordination for the agenda Crisis of confidence because of roles, and responsibilities arising from the NHIS Act that were obstacles to commencement of implementation	Used FMOH as a platform for mobilizing and co-ordinating stakeholders, including technical experts and for oversight on the NHIS Set up a ministerial expert committee led by technical analysts to review the activities of the NHIS, make recommendations for its repositioning and to develop 'a blueprint for the accelerated implementation of the scheme so that Nigeria will achieve an almost universal coverage by 2010' (FMOH, 2003)
States	Absence of role in the NHIS Act apart from being mentioned as 'employers of labour'	Developed a health financing policy that allowed states to form their own health insurance schemes At his first NCH, states that had a desire to develop their health insurance scheme were encouraged to do so Drafted a new NHIS law to create a role for states
Private employers	Resistant to inclusion in the pool for public sector	The ministerial expert report included the setting up of a private sector fund to serve as a pool for private firms, with HMOs fully handling the financing responsibilities, and a National health insurance commission serving as the regulator
Labour union	Opposed to deduction of employee contribution from salaries	On the minister's request, the president also agreed that employee contributions should be delayed to allow the labour union time, and while enjoying the benefits, to reconsider their stand
Private providers	Resistance to use of HMOs	Allowed the NHIS to include public secondary and tertiary hospitals for both primary and referral care with the hope that private providers would become interested over time
HMO	Faced opposition mainly from HCPs	The minister was accommodating and sympathetic towards HMOs because of their antecedent operating experience.
Development Partners	Not mobilized	Through the ministry of health, support for the HSR, including advice for the NHIS development was readily galvanized from development partners, including the World Health Organisation (WHO), United Nations Fund for Population Activities (UNFPA), United States Agency for International Development (USAID), and United Kingdom's Department for International Development (UK DfID), and also from a team of technical analysts drawn from universities and private consultancies. They subsequently played roles in development of a '10-year development plan for the health sector (2007–2016)', which for the NHIS component included 'a plan of action in line with health sector reform agenda'

minister declared his intention to commence implementation of the NHIS programme by 2005 and with immense support from the president, proceeded to address the contentious issues in various ways summarized in Table 3. The FSSHIP commenced on 6 June 2005 (Dogo-Mohammad 2006; NHIS 2013; OHCSF 2013) and the president was registered as its first enrollee (Ukwuoma and Okumephuna 2005).

To enable the takeoff of the FSSHIP, the NHIS in 2004 accredited and registered HMOs, and allocated departments and agencies of the federal government to selected HMOs. It accredited and registered providers, and registered and printed identity cards for beneficiaries (NHIS 2007). For a full account of co-ordinating roles played by the minister of health that facilitated the actual launch of the FSSHIP, see Table 4. Employer contributions for unregistered beneficiaries built up within the NHIS as HMOs were only allocated funds for registered beneficiaries. The enormous and growing pool of funds for unregistered beneficiaries was under the control of the NHIS managers who, contrary to agreements made with stakeholders, opened an account on behalf of the NHIS in a commercial bank rather than the Central Bank of Nigeria.

Consequently, the NHIS became a more attractive and influential organization.

The HMO industry also grew into an influential interest group backed by powerful individuals in the country, and increased in number (see Table 4). Many politicians (including senators), banks, and wealthy individuals also appeared to 'set up HMOs because they saw it as gold mine' (Policymaker). Banks were believed to have set up HMOs because 'insurance premiums constitute a major source of deposit mobilization' (CareNet Nigeria 2007). One bank seemed quite creative. After the NHIS managers chose a commercial bank for the large amount of funds released by the government, the same bank appointed a former senior NHIS staff member as head of its own new HMO. Existing HMOs and some policymakers, believing that managers in the NHIS benefited financially from the arrangement, labelled the behaviour 'antitrust' (HMO owner).

The minister of health sought to sustain an effective working relationship with the primary operators (HMOs). To maintain harmony between NHIS and HMOs, he enforced changes in key staff within the NHIS Secretariat between 2003 and 2007. His support for HMOs threatened the influence of

**Table 4** Key co-ordinating roles played by the minister of health that facilitated the actual take-off of the FSSHIP

Activity	Issues	Intervention
Accreditation and registration of HMOs by the NHIS	Resistance of the initial attempt by NHIS managers to use only one HMO that they considered capable of operating the FSSHIP	Directed the NHIS to accredit all existing HMOs and to develop criteria for HMO selection NHIS accredited and rated existing HMOs (using a private audit firm) based on technical and financial capacity Out of 40 applicants, 25 had sufficient data to be rated, 13 were selected to operate the FSSHIP. Over time, the number of accredited HMOs rapidly grew to 35 by 2007, 62 by 2010 and 76 by 2013 (but only 41 were allocated FSSHIP enrollees)
Attraction of and collection of contributions from departments and agencies of the federal government	A new inexperienced HMO suddenly signalled it had signed up with nearly half of all government agencies, raising fears that it may have connived with public officials for financial gains	Directed that Ministries, and agencies of government should be allocated based on the criteria used for HMO selection. Agreed that employer contribution should be withdrawn directly from the central government account and lodged in a Central Bank account from which the NHIS would allocate them to HMOs
Accreditation and registration of providers	Initial unwillingness of providers to join	Directed the inclusion of all the federal government health-run tertiary facilities (teaching hospitals and medical centres) as providers with the hope that private HCPs would become interested in the long-run Many private HCPs later joined the scheme and were accredited and registered for operation by the NHIS
Registration of beneficiaries	Slow registration of beneficiaries by the NHIS after full release of employee contributions by the federal government for all employees, and complaints about irregularities in registration process	NHIS executive secretary was replaced and a new one continued the process of beneficiary registration, this time involving HMOs based on the minister's directive
Production of identity cards for beneficiaries	Crisis of confidence because of alleged inappropriate financial transactions by the executive secretary for card production Slow production of identity cards after NHIS acquired production equipment	Executive secretary replaced with trusted candidate from FMOH to restore the confidence of technical experts, HMOs and other key actors, and to remobilize and refocus stakeholders and the NHIS on the reform The role of card production was retained within the NHIS to prevent fraudulent production despite the demand by HMOs and other analysts that such roles ought to have been reserved to HMOs

the NHIS managers, and aroused the suspicion that he had financial interest in the HMO industry. Nonetheless, as the quote by an HMO owner below demonstrates, his intentional engagement of HMOs helped sustain their willingness to implement the FSSHIP and their confidence in the government programme.

*“Because that kind of money (retained by the NHIS) was so much, it gave him (Executive Secretary) so much power and arrogance and fearlessness. Thanks to (the President) who was in charge and (the Minister of Health) who anytime we raised issues, would call him (Executive Secretary) to order”* (HMO Owner).

### Consolidation

Early in 2007, the president appointed a new NHIS executive secretary. The NHIS leadership earned the confidence of HMOs early because of the influence of the minister of health, and continued to look to them for technical advice. Following a change of government in 2007, a new minister of health (a clinician) was appointed and was expected to continue exercising oversight on the NHIS, but his interests (and that of the FMOH under his leadership) differed from his

predecessor's. This period was characterized by little attention from the FMOH, and the absence of a governing council. At the same time the NHIS received funds from the Millennium Development Goals office of the president in 2008 to commence a wholly subsidized maternal and child health programme in public health facilities using HMOs as financial intermediaries (CareNet Nigeria 2008; Briscoe and McGreevey 2010; International Social Security Association 2011a,b; Dogo-Mohammad 2012). It also accredited and registered additional HMOs even though the criteria for accreditation were not defined.

Towards the end of the decade, the NHIS leadership gradually disengaged from dependence on FMOH for leadership and on HMOs for technical advice. The executive secretary was involved in a legal tussle with the federal government over an attempt to interrupt his tenure, which made the minister of health and FMOH officials even more reluctant to engage with the NHIS. In 2011, the NHIS signalled a break from the past by independently developing stricter guidelines for HMO accreditation. Having lost the influence they had through the minister of health during the 'Constitution' phase, HMO leaders noted the changes in the balance of power but admitted that divisions existing amongst HMOs constrained their ability to oppose new

regulations, leaving the NHIS to now ‘do what they want to do’ (HMO manager). The NHIS also engaged directly with HCPs. Under the scheme, it accredited and monitored HCPs at federal and state levels, independent of federal and state ministries of health that statutorily regulate them.

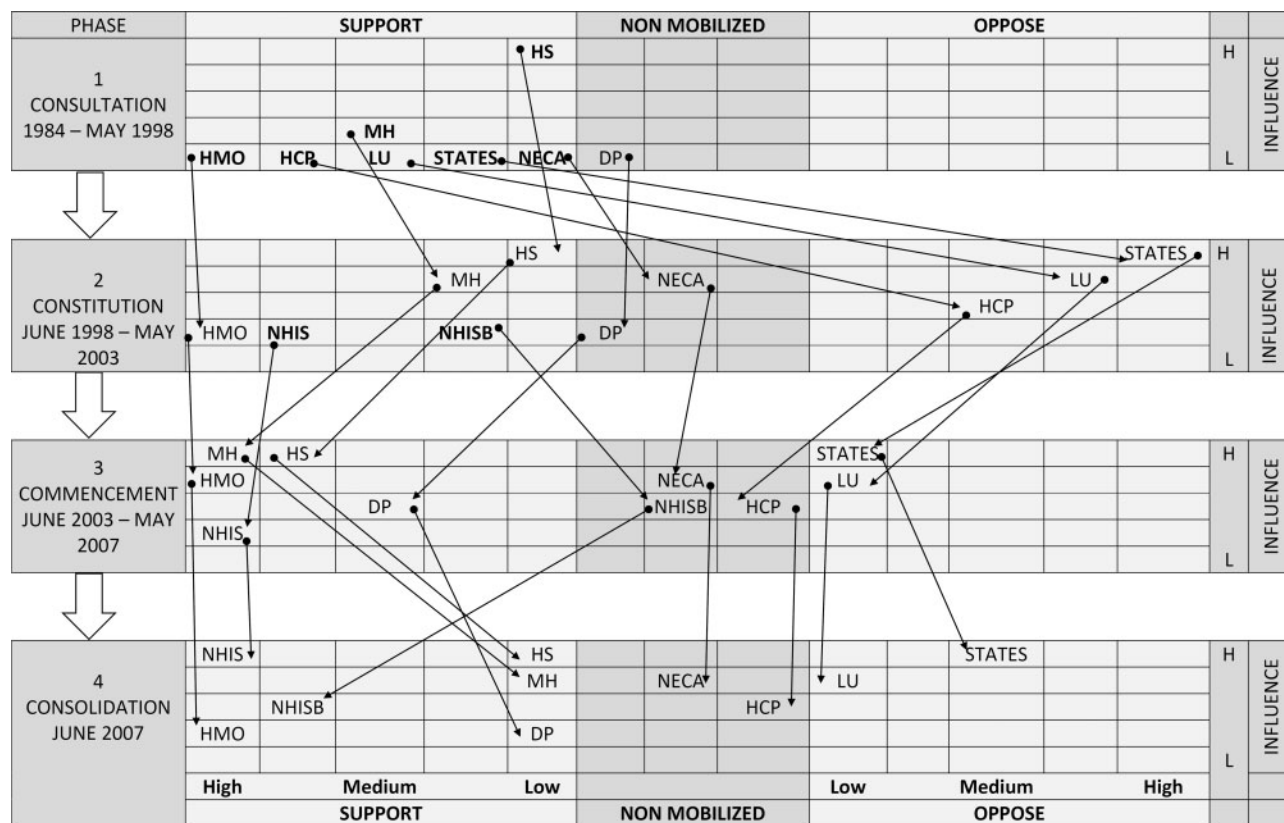
Through advocacy visits to states, the NHIS encouraged adoption of the NHIS programme by states, and discouraged attempts by some States to commence state-level health insurance schemes. This position was however contrary to that of the National Health Financing Policy (FMOH 2006), and HMOs saw such schemes as opportunities to expand their business interests. States that piloted such schemes (mainly with the technical support of HMOs) responded by giving them various names—‘Managed care scheme, social health protection and health services scheme...but they all had features of the NHIS except in name’ (Policymaker).

Despite conflicts of interests that characterized the consolidation phase, the NHIS, having established itself as the prime driver of the agenda for health insurance, forged on with its implementation. Nearly 5 million beneficiaries (already covered during the commencement period) were registered, but the actual figure is believed to be less than 3 million because ‘many civil servants that were given cards have retired and dropped out of the system and new ones are still being registered’ (Policymaker). Given the paltry public interest in its programmes, and the inability to extend coverage to state government employees (Onoka *et al.* 2013), the NHIS began to develop more programmes (11 in total) with separate pools,

for ‘different segments of the society’ (NHIS 2012). It also led the effort to galvanize stakeholders’ support to revise the NHIS Act, to make uptake of health insurance by all Nigerians mandatory. However, public sector bureaucracies involved in the legislative process and delays in reaching stakeholder consensus have frustrated this effort.

### Analysing stakeholder positions and influence on the policy process based on the four identified phases of policy development

The need for strategies to improve healthcare funding during the economic recession of the 1980s stimulated the development of the NHIS. However, the policy development stalled in the ‘consultation phase’ owing to a number of factors (see Figure 1). The military government was absorbed in a failed political transition programme, and also superintended over the substitution of public welfare systems as part of a structural adjustment programme demanded by international creditors (Orubuloye and Oni 1996; Barnes *et al.* 2008). Thus, the NHIS policy was not a priority of the financially constrained military government, nor of the minister of health who was more concerned with using available resources to develop primary healthcare systems.



**Figure 1** Changing positions and influence of stakeholders regarding the national health insurance policy  
 MH, minister of health; HS, head of state/president; NHIS, National Health Insurance Scheme; HCP, healthcare provider; DP, Development Partners; LU, Labour Union; NHISB, Governing board of the NHIS; NECA, private employers; STATES, state governments.



During the ‘consultation phase’, HMOs emerged as a policy solution to overcome the perceived incapacity of public systems to implement the proposed NHI. The reliance on individuals that had interests in the HMO industry for policy development and technical advice allowed HMOs to influence the reform process, based on their knowledge of international managed care operations and experiences in the field. Even though Ministry of Health officials still modified HMO inputs, key responsibilities such as revenue collection from all public and private employers and employees under the scheme was statutorily provided to HMOs in the legislation, even though this was never implemented. However, their entry led to modification of NHIS Act in a way that favoured their interests at the time, and to significant changes in the position and influence of critical stakeholders (state governments) on the NHI policy.

*“At that time many other key stakeholders were not really interested in what was happening. So they (HMOs) moved in and they were able to influence the operational guidelines and policy”* (NHIS official).

*“We were the ones that wrote many of these things for them. You know we wrote the guidelines... we wrote many of the operating standards and manuals of the NHIS”* (HMO owner).

During the ‘commencement phase’, the primary factor leading to the launch of the FSSHIP was the leadership role played by the new minister of health in 2003 (Tables 3 and 4). Those roles were facilitated by some factors, foremost the strong political support of the president. Like the minister, the president saw establishment of NHI as a major political objective. The key financial challenge of making employer contributions was overcome by the government’s release of 24 billion naira (US\$ 160 million) for all federal employees (whether registered or not) to the NHIS, as employer’s contribution. This was in line with the minister’s advice to the president that funds designated for the ‘medical-benefits’ component of the federal government’s new monetization policy for civil servants should be used for the FSSHIP. Additionally, the absence of a governing board, sanctioned by the president, enabled the minister to lead the reform directly, using the FMOH, trusted lieutenants and technical consultants.

The ‘health sector reform’ programme led by the minister through the FMOH, which included the development of a National Health Financing Policy, attracted development partners who then made inputs into the NHIS policy. The health financing policy was structured to discourage retainership systems, promote purchaser/provider split for the NHI, allow private health insurance, encourage formation of state health insurance schemes, and expand the NHIS to include informal sector groups (FMOH 2006). These changes led to shifts in stakeholder positions (Figure 1). HMOs became more powerful, at the expense of the NHIS managers, while civil servants remained opposed to making employee contributions. Nonetheless, the overall outcome was that all federal government employees were covered by the FSSHIP.

During the ‘consolidation phase’, the seeming disinterest of subsequent Ministers of Health and the FMOH, the decline in supervisory oversight, and the absence of a governing council, allowed the NHIS to position itself as the primary reform driver.

Even though the NHIS sought to provide leadership, it seemed unable to galvanize support from other stakeholders effectively, as had been the case when the minister of health provided leadership through the FMOH. Having kept both the federal and state ministries of health at bay, the NHIS independently carried out statutory responsibilities of these institutions such as registration, accreditation and monitoring of providers for its programmes without their input or involvement. Additionally, there was apparently an intention by the NHIS managers to develop a NHIS that would centrally manage the health insurance pool for the entire country, or at least for employees of the federal government and their families, and those states that were willing to send both employer and employee contributions to its central pool. These behaviours further distanced stakeholders from the NHIS and contributed to limited interest in its plethora of programmes. The overall outcome of these changes was that coverage expansion stalled.

### **Analysing the influence of context on the policy development process**

The context of policy development influenced the process in two critical ways. First, the lack of technical capacity amongst government bureaucrats at a moment when development assistance was also lacking facilitated the reliance on private sector actors for input into public policies meant to regulate their own operations. These actors with explicit private interest in the outcome of the reform altered the policy content, making uptake voluntary and using HMOs as intermediaries, while a further capture by elites that owned new HMOs ensured that HMOs remained a powerful group. This development was contrary to the earlier recommendations about inclusion of states as key stakeholders in implementation, which was later endorsed by local experts set up to review the NHIS programmes in 2004 (FMOH 2003).

Second, the NHIS policy documents were developed under the centralized ‘command system’ of governance of the military era, but implementation could not commence until the democratic era. The change to a voluntary system failed to consider the feasibility of implementing such a system in a country where states, representing federating units, have power over choice of reforms (Onoka *et al.* 2013). Under military governments, state military governors would naturally obey the command of the head of state (Osaghae 1992), and would enrol state government employees. In contrast, the democratic environment allowed the re-emergence of contentious issues, negotiations with stakeholders on matters for which they previously only played advisory roles and the possibility of stakeholders assuming positions that in some cases opposed those of the federal government. Consequently, not only did the private sector that promoted the idea of voluntary enrolment take advantage of the design to overlook the FSSHIP, the NHIS has also been unable to compel state governments to enrol (Onoka *et al.* 2013).

### **Lessons for UHC reforms**

The analysis here reveals the dynamism inherent in policy change, and the complexity of the policy process due to

stakeholder interests and exertion of power over a UHC-related proposal. Overall, the analysis supports the theoretical proposition guiding the study and shows that actor interests shaped the policy content, actor positions and power determined the pace of the reform, and changes in actor positions (states and private employers) affected the coverage achieved by the NHIS reform. A number of useful lessons are apparent for UHC reforms.

Health financing policy processes can progress quickly when high profile political actors drive the process. The political interests of the minister of health and the president in the agenda, and the power they brought to bear in the process, were critical facilitators of the policy process. Similar observations have been made by other studies (HISRO 2012; McIntyre *et al.* 2013). In contrast, reforms can stall without political support, as observed in South Africa, where health financing reforms of interest to the minister of health and the president progressed at the expense of a NHI proposal (Gilson *et al.* 2003; Thomas and Gilson 2004). Those managing UHC reforms should have the power to galvanize stakeholder support, manage conflicts and provide effective leadership for the agenda in order to achieve policy intentions.

Private sector actors with interest in a policy reform that play policymaking roles through public–private partnerships may significantly influence the policy content and outcome of UHC reforms in their favour. Private sector actors may have varied interests in the policy outcome (Pillay and Skordis-Worrall 2013), and may gain insider roles in the process as its supporters (Thomas and Gilson 2004; Pillay and Skordis-Worrall 2013). In this study, the insider role that HMOs gained allowed them to substantively influence the nature of the regulatory system that was meant to guide their operations. The finding confirms similar observations in the literature (Iriart *et al.* 2001). The additional finding that elites, including those in the government that had private interests in the HMO industry, were amongst the private sector further portends the likelihood that regulation will be impeded by vested interests. Such situations contribute to failure of regulation (Sheikh *et al.* 2013) and justify deliberate stakeholder management (Thomas and Gilson 2004).

The dependence of policymakers on potential or established HMO owners for technical aspects of the reform enabled the advancement and integration of HMO interests into policy. Public officials in many low- and middle-income countries often depend on private sector actors whom they are meant to regulate either to overcome deficiencies in capacity (Walt *et al.* 2008), or to gain support for the policy. The evidence here suggests that such dependence can be harmful to the goals of universal coverage. For instance, the loss of the opportunity to mobilize revenue from states and achieve a larger pool compromised the potential for greater redistribution and equity in the national health insurance scheme. This compares to South Africa (Thomas and Gilson 2004) and Thailand (HISRO 2012), where technical analysts rather than private sector actors were key reform actors where available, and participated significantly in the policy process. Their inputs substantially enhanced the content of health insurance proposals to make them sensitive to issues of re-distribution and equity, which are cardinal UHC principles. Policymakers can take advantage

of the growing technical capacity within local and international research institutions, in addition to the guidance that abounds in the literature about effective financing strategies (WHO 2010, 2013, 2014), to confirm that strategies included in financing proposals do not undermine UHC goals.

However, collaborating with private sector actors also can have considerable advantages. The interest of HMO owners in the NHIS during periods of pessimism about its sustainability, contributed to the advancement of the NHIS policy. Additionally, the government benefited from private investments in capacity development. HMOs served as platforms to generate and spread experience in health insurance implementation in Nigeria, and this is useful in developing countries where public sector capacity is often limited. Given such positive contributions, the responsibility rests with public officials guiding UHC reforms to effectively harness the positive contribution of the private sector. They need to be clear about policy intentions and the expectations of interest groups (possibly through stakeholder analysis) and carefully guide policy processes involving public–private partnerships in order to avoid policy derailment.

Nigeria's experience provides evidence from a context where federalism is practised and authority shared between federal and state governments. It shows that securing federal level commitment does not guarantee that a national health insurance proposal will become a 'national' proposal. The technical proposal failed to recognize this critical contextual factor and thus the importance of states in a federal system in governing a national health insurance system, which then impacted negatively on efforts to extend coverage. The federal context of health financing reform in Nigeria demonstrates the importance of context, and the need to align health financing proposals for UHC to the context within which they are developed, in order to enhance their chances of success (Savedoff *et al.* 2012; McIntyre *et al.* 2013; WHO 2014). Re-examining the model, which drew a consensus and had a clear role for states in 1989, will be worthwhile. As suggested elsewhere, states should play a role in fund management and participate in provider and HMO registration, accreditation and monitoring (Onoka *et al.* 2013). On behalf of the federal government, the NHIS could then provide conditional financial support to cover gaps in poorer states, or deploy funds for uncovered people through state level pools while establishing an explicit mechanism for efficiency and accountability.

For UHC reforms to be successful, effective sector-wide leadership is required to achieve stakeholder interest and support. Experiences elsewhere have highlighted the importance of co-ordinating UHC reform as a holistic health sector agenda that also addresses critical challenges with access to health services (HISRO 2012). In Nigeria, the healthcare delivery systems are controlled by the FMOH (for federal institutions), and the state governments (through the State Ministry of Health). However, the assumption of leadership for the UHC agenda by the NHIS that operated a parallel financing system challenged the authority and relevance of both the Federal and State Ministries of Health in financing healthcare delivery systems that were under their purview. Effective leadership for UHC in Nigeria will imply having a UHC agenda primarily driven by the FMOH, since relevant

stakeholders in the health sector including state Ministries of Health, HCPs, and development partners have direct link with and are guided by the FMOH rather than the NHIS. Such approach will allow health financing reforms to be accompanied by reforms in health delivery systems and health sector governance, to ensure effective functioning of the health system. The framework will also allow federal government and local and international donors to provide targeted financial support to extend coverage to those outside the formal sector, and to vulnerable groups (including pregnant women, children and the poor), rather than implementing separate programmes or pools through ministries of health. Such a model that could serve to ensure primary care provision at the state level in Nigeria has been suggested elsewhere (Onoka 2011). Perhaps the inability of the NHIS to mobilize the broader health sector explains the stagnation in expanding coverage beyond federal employees.

This article emphasizes the point that the policy making process is a highly dynamic and pliable process that involves considerable engagement and negotiations that take time, rather than a quick rational process. However, it also shows that over the time that policy proposals develop, the opportunities that arise due to changes in the policy environment can be strategically harnessed to advance UHC policies by policy entrepreneurs. Political transition can influence the policy process through the emergence of new actors, changes in the position and opinion of existing ones, and the opportunities that emerge for invigorating the policy process. A supportive political milieu facilitated the commencement of the NHIS programme in this study even when some technical issues were still unresolved. Political changes in both Zambia and South Africa similarly created the opportunity for radical and rapid changes in health policy reforms (Gilson *et al.* 2003) and were strategically harnessed by policy entrepreneurs to advance Thailand UHC reform (HISRO 2012). To enable such opportunities to be maximized, those interested in UHC reforms need to maintain their engagement with the policy environment and be ready with well-articulated proposals either to introduce or improve on UHC reforms when opportunities emerge.

Finally, the study underscores the usefulness of policy analysis, and particularly stakeholder analysis techniques in understanding actor interests, roles, and influences over a UHC policy process, and to gain insights into factors that contribute to policy success or failure. The application of stakeholder analysis enriched this study by enabling the assessment of policy development over four periods during which the health sector was led by two ministers with disparate interests, and over periods of military and democratic governments, revealing the importance of actors and context, respectively, in shaping policy processes. The analysis also showed how actor positions changed for reasons including political situations that propelled HMOs to a powerful position in the policy proposal and States into opposing actors, adoption of less resistant positions by States following the entry of a new leader for the policy process, and later, their reversal to a more resistant position with the emergence of a leader (NHIS) for the reform. The analysis shows that retrospective stakeholder techniques can help in characterizing stakeholder interests, positions and influences, understanding the reasons for changes in stakeholder positions

over time. The reasons identified can help to guide future policy processes, including the development of actor management strategies (Thomas and Gilson 2004).

## Conclusions

The experience of developing a national health insurance scheme in Nigeria presents useful insight into the politics of processes that underlie UHC reforms in low- and middle-income countries and the importance of context in determining the pace and content of such reforms. The opportunity created in the policy space for HMOs to participate in policymaking allowed them to integrate their interests in the policy in a way that provided them with the important role of intermediary operator of the national health insurance policy, and compromised the potential for effective regulation and mobilization of funds from states to extend coverage. Hence, the failure of technical proposal to recognize the importance of sub-national governments in developing the national health insurance policy presented a contextual constraint to attaining policy expectations. Strong political support that hastened the policy process emerged due to changes in the context in terms of a political transition to democracy. However, it facilitated the establishment of a policy that poorly reflected the context within which implementation was to happen, the outcome of which is the difficulty in expanding the breath of coverage. The evidence emphasizes the need for public officials in low- and middle-income countries undertaking health financing reforms for UHC to be clear about policy expectations, identify and analyse the prevailing contextual factors and to guide the process, especially where private actors are also involved. Finally, the article highlights the utility of policy analysis, and in particular, retrospective stakeholder analysis in understanding the changes in actor positions and influences over time and the impact of those changes on health policy process and outcomes.

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