A LEGAL APPRAISAL OF THE NATIONAL HEALTH INSURANCE SCHEME IN NIGERIA

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ABSTRACT

The National Health Insurance Scheme was established in 1999 in Nigeria with the goal of bringing healthcare closer to the populace. The scheme became effective in 2005, about six years after its introduction. Eight years later, the rate of participation in the scheme is still low. Presently the beneficiaries are federal government workers. Only three states out of thirty-six states of the federation have embraced the scheme and even in those states, the local government workers have not been included. The private sector and the majority of the populace who are in the informal sector are also not benefiting from the scheme. Though the scheme makes provisions for participation by the informal sector, the modalities for the implementation are cumbersome. Further, there is lack of awareness of the programme in the informal sector. The focus of this paper is an analysis of the legal framework for the health insurance scheme in Nigeria. Emphasis will be placed on the effectiveness of the programme, its acceptability among the populace and whether the scheme can achieve the desired goal of ensuring affordable access to health for all and sundry by 2015 as envisaged by the government and meet the 4th Millennium Development Goal. One of the major factors militating against the success of the scheme is the level of poverty of the majority of the populace. Another factor is the inadequacy of healthcare facilities and providers. The programme as being currently run is elitist and will not achieve the desired goal. The paper concludes that the health insurance scheme though laudable is not the key to Nigerian health problems.

Key words: National Health Insurance, Legal Framework, Acceptability, Rights.
“When your neighbour dies from measles, during child birth, in a car accident, rather than conclude it was as “God wanted it”, think, ask and act on the failures; the missed chance at vaccination, inadequate antenatal care or non-existent emergency services that might have prevented these deaths. The alternative would be to conclude that God really has a problem with us Nigerians; why else would he let so many of us die from causes no one else is dying from? We will ask the hard questions.” Nigeria Health Watch

1. INTRODUCTION

It is a popular saying that health is wealth and a healthy nation is a wealthy nation. Thus, health is an issue of central concern to all countries and societies as it is a crucial cornerstone for socio-economic development and progress. The struggle to provide good health care to all in the society is epitomised by the Alma Ata declaration of 1978 which states that health “is a fundamental human right” and its attainment is a “most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector”. Nigeria is signatory to this code which prescribes that “primary health care is the key” and that “governments have the responsibility”. Unfortunately, this goal of universal primary health care, as stated in the Alma Ata declaration has not been achieved in the country. Nigerians yearly die of preventable diseases through lack of access to quality healthcare and lack of finance.

Successive federal governments have made attempts to improve the quality of life of Nigerians through policies which were designed to provide qualitative medical facilities, to provide the desired medical services as well as funds to procure the required equipment and drugs. However, the goals of the government to provide qualitative healthcare has been elusive due to the high cost of health care delivery in the country. A vast majority of the population live below the poverty line and are unable to afford the necessary health care. In its efforts to make healthcare affordable to the populace, the federal government introduced the National Health Insurance Scheme. The scheme which was introduced in 1999 became operational in 2005 as part of efforts of the federal government to achieve universal health coverage with financial risk protection mechanisms. However, eight years after the launch of

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3 Ibid.
the programme, only about 4% of the population are covered by health insurance. These are mainly workers in the federal government employ and military officers. Out of 36 states in Nigeria, only three states have adopted the programme. The private sector and majority of the populace who are in the informal sector are yet to adopt the scheme. Considering that health insurance is a veritable tool in health financing, the apathy towards the scheme needs to be appraised and addressed. This paper looks at the Nigerian health policy, the legal framework and operational guidelines of the health insurance scheme. The human rights dimension of access to health is also addressed.

2. **NIGERIAN HEALTH POLICY**

In August 1987, the federal government launched its Primary Health Care plan (PHC) as the cornerstone of the country’s health policy. The policy was intended to affect the entire national population, with its main objectives including accelerated health care personnel development; improved collection and monitoring of health data; ensured availability of essential drugs in all areas of the country; implementation of an Expanded Programme on Immunization (EPI); improved nutrition throughout the country; promotion of health awareness; development of a national family health program; and widespread promotion of oral rehydration therapy for treatment of diarrhoea disease in infants and children. The federal government further instituted a National Health Policy in 1988 with the primary objective of improving the health status of the people and allowing Nigerians have access to wholesome, productive, social and economic lives. The National Health Plan document released by Nigeria’s Federal Ministry of Health proposed that:

The goal of the National Health Policy shall be to establish a comprehensive healthcare system based on primary healthcare that is promotive of protective, preventive, restorative and rehabilitative, to every citizen of the country within the available resources so that

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7 Ibid.

individuals and communities are assured of productivity, social well – being and enjoyment of living.¹⁹

Unfortunately, the current situation is worse now than when that statement was made about 26 years earlier.¹⁰ A majority of the populace still do not have access to healthcare and many are dying as a result of preventable diseases and causes. The current policy framework is derived from the National Health Policy, the draft National Health Plan, the National Vision 2010 Report.¹¹ The vision for health sector reform is to improve the health status of all Nigerians, and to attain a level of health care that would permit all Nigerians to live a socially and economically productive life. However the reality is the opposite as quality healthcare is still out of the grasp of the average Nigerian.

3. **HEALTH INSURANCE IN NIGERIA**

The basis for insurance is to protect the individual from the financial consequences of events with a low probability of happening but with the potential to cause substantial loss.¹² Prepayments and risk pooling through social health insurance has been advocated by international development organisations. Social health insurance is seen as a mechanism that helps mobilise resources for health, pool risk, and provide more access to health care services for the poor.¹³ Health Insurance is a social device for pooling the health risks and costs of an exposure unit with view towards predictability.¹⁴ The idea of a national health insurance was first mooted in 1962¹⁵ when the need for health insurance in the provision of healthcare to Nigerian citizens was first recognised.¹⁶ However, every mention of the scheme since then

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¹⁰ Nweze A. op cit.

¹¹ (Johnson 2000)


¹⁴ Ibid.


went under until the regime of General Abdul Salaam Abubakar who promulgated the National Health Insurance Scheme Decree No. 35 of 1999 “for the purpose of providing health insurance which shall entitle insured persons and their dependants the benefit of prescribed good quality and cost effective health services”. The objectives of the scheme as stated in Section 5 of the Decree are to:

(a) Ensure that every Nigerian has access to good health care services;
(b) Protect families from the financial hardship of huge medical bills;
(c) Limit the rise in the cost of health care services;
(d) Ensure equitable distribution of health care costs among different income groups;
(e) Maintain high standard of health care delivery services within the Scheme;
(f) Ensure efficiency in health care services;
(g) Improve and harness private sector participation in the provision of health care services;
(h) Ensure adequate distribution of health facilities within the Federation;
(i) Ensure equitable patronage of all levels of health care;
(j) Ensure the availability of funds to the health sector for improved services.

To achieve its objectives, the National Health Insurance Scheme pursuant to section 6 of the Decree developed various programmes to cover different segments of the society, and these are:

i. Formal Sector Social Health Insurance Programme (FSSHIP)
ii. Urban Self-employed Social Health Insurance Programme
iii. Rural Community Social Health Insurance Programme
iv. Children Under-Five Social Health Insurance Programme
v. Permanently Disabled Persons Social Health Insurance Programme
vi. Prison Inmates Social Health Insurance Programme
vii. Tertiary Institutions and Voluntary Participants Social Health Insurance Programme

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17 National Health Insurance Scheme Decree No 35 of 1999.
3.1. **Operational guidelines**

The Formal Sector programme covers employees of the formal sector, i.e., the public sector and the organized private sector. The Armed Forces program covers all members of the Armed Forces, the Nigeria Police Force, Nigerian Customs Service, Nigerian Immigration Service, Nigerian Prisons Service and other Federal uniformed services. Tertiary institutions cover students in the tertiary institutions whether full-time or part time. Voluntary Contribution Social Health Insurance Program (VCSHIP) is health insurance that is taken up and paid for at the discretion of willing individuals or at the discretion of employers on behalf of employees in organisation with less than 10 staff.¹⁹ The VCSHIP is designed for those who are not currently covered by any of the NHIS programmes and for those who may not have been satisfied with the existing healthcare services. It is meant to provide full or partial coverage for services that are excluded or not fully covered by statutory health system. Premium in the case of VCSHIP are not risk related and access to healthcare by voluntary contributors is always dependent on proof of contribution. Further, family members of person voluntarily insured in the social health insurance scheme are not covered as co-insured.²⁰

Contributors under the NHIS are entitled to:

i. Out-patient care (including consumables)

ii. Prescribed drugs as contained in the NHIS Essential Drugs List

iii. Diagnostic tests as contained in the NHIS Diagnostic Tests List

iv. Antenatal care

v. Maternity care for up to four (4) live births for every insured person

vi. Post natal care

vii. Routine immunization as contained in the National Programme on Immunization

viii. Family planning

ix. Consultations with a defined range of specialists e.g. physicians, surgeons, etc

x. Hospital care in a public or private hospital in a standard ward during a stated duration of stay, for physical or mental disorders;

xi. Eye examination and care excluding prescription glasses/spectacles and contact lenses

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²⁰ Ibid.
Dental care, i.e., pain relief and treatment
Prostheses, i.e., Nigerian-made simple artificial limbs.

It is worthy of note that the NHIS cover only routine illnesses. High risk diseases that cost a lot of money like cancer, HIV/AIDS, hepatitis, heart diseases are not covered under the scheme. That the scheme also exclude prescription glasses shows the insincerity of the scheme. Though this may be to curb excessive spending, the scheme could place a ceiling on the amount to be spent on prescription glasses rather exclude it from insurance.

3.2 Contributions
In case of the formal sector, contributions are earnings-related and currently represent 15% of basic salary. The employer will pay 10% while the employee will only contribute 5% of basic salary to enjoy health benefits. However in the case of the armed forces, the Federal government pays the full 15 percent contribution. The contributions made by/for an insured person entitles himself or herself, a spouse and four (4) biological children under 18 years of age, to full health benefits. Extra contributions will be required for additional dependants.\(^2\)

It is contended that limiting the age of children who can benefit from their parents’ contributions to 18 years does not take cognisance of the realities of the Nigerian situation. At that age most children are still under the care of their parents as secondary school students, applicants seeking admission, apprentices learning trades or fresh undergraduates. In some cases, they may be unemployed graduates still under the care of their parents. Where all the children of a contributor are over 18 years, they would be precluded from benefiting though they may still be under the care of their parents. Such parents may not see the need to participate in the scheme. It is suggested that the age limit should be removed. Further a contributor who has dependants that are not biological children should also be able to take advantage of the scheme as long as they are limited to four.

3.3 How the Programme Works
An employer registers itself and its employee with the Scheme. Thereafter, the employer affiliates itself with an NHIS-approved Health Maintenance Organisation(s) (HMOs), who now provide(s) the employees with a list of NHIS-approved Health Care Providers (public and private). The employee registers himself and dependants with such Provider of his/her

\(^2\) NHIS Operational Guidelines, op cit.
choice. Upon registration, a contributor will be issued an identity card with a personal identification number (PIN). In the event of sickness, the contributor presents his/her identity card to his/her chosen Primary Health Care Provider for treatment. The contributor will be able to access care after a waiting period of sixty (60) days to enable the completion of all administrative processes.\textsuperscript{22} It is submitted that the waiting period is unnecessarily long. The contributor should be able to access healthcare after a week. In reality, contributors still have to pay 10\% of services or drugs dispensed by the health provider, thus, where the contributor does not have the required percentage of fees, he/she might be unable to access healthcare.

4. CHALLENGES

The NHIS as conceived was meant to bridge an existing gap and widen opportunities for access to qualitative healthcare with strong private sector participation, and with government defining its policy and framework.\textsuperscript{23} However, the generality of the populace are yet to benefit from the scheme. Several factors are militating against the successful implementation of the scheme. Healthcare is on the concurrent legislative list as such states are not under compulsion to embrace the NHIS. Nigeria operates a three tier healthcare system, the primary healthcare, secondary healthcare and tertiary healthcare.\textsuperscript{24} The provision of health care at the primary level is largely the responsibility of Local Governments with the support of state ministries of health and within the overall national health policy. Secondary Health Care is provided by the state governments and provides specialized services to patients referred from the primary health care level through out-patient and in-patient services of hospitals for general medical, surgical, paediatric patients and community health services. Secondary health care is available at the district, divisional and zonal levels of the states. Tertiary healthcare is provided by the federal government.

The states do not feel a compulsion to embrace the scheme as it is seen as a federal government programme hence only three states have so far adopted the scheme. Even in the states that adopted the scheme, the local government workers have not been included as that

\textsuperscript{22} Ibid.
\textsuperscript{24} Health Care (2009), http://www.motherlandnigeria.com/health.html#Policy
is left to the local government authorities to decide. In a study by Onoka et al,\textsuperscript{25} one of the reasons adduced for failure of state participation is the concern about the unclear role of states in the programme. Undefined accountability systems and the absence of financial reports of activities carried out for the FSSHIP created distrust amongst actors and constrained adoption.

Another factor militating against the program is the past antecedent of the government. Several laudable programmes launched to improve the condition of living of the populace end up in the dust bin as successive government change policies and the contributions of the workers end up in private pockets.

The scheme has failed to gain acceptability amongst Nigerian. In a study of the University of Lagos, the Health Centre incessantly called members of the community to come and register for the NHIS. The response had been persistently low.\textsuperscript{26} The question then is if it is so difficult to persuade members of this supposedly enlightened community to enrol for the scheme, how much more difficult would it be to persuade the less enlightened members of the society to participate in the scheme?

Lack of awareness by a majority of the populace is another challenge facing the scheme. Presently only workers in the federal civil service, who are contributors by compulsion as contributions are deducted from their salaries at source irrespective of whether they register with a health provider or not. Several studies have shown that a majority of the populace and even some health workers are unaware of the workings of the scheme.\textsuperscript{27} Even those who are aware of the scheme, tend to shy away from it as they view it as another avenue for the government to deprive them of their hard earned money. The apathy to the scheme might not be unconnected to the failure of several government schemes where workers salaries are deducted for projects that never materialised such as National Social Insurance Trust Fund (NSITF) and the National Housing Fund (NHF). The federal government amassed a lot of money through the NHF while its workings remain a mystery to the average Nigerian worker.

\textsuperscript{25} Onoka et al, op cit.
as they have no idea how to access the funds for their housing needs.\textsuperscript{28} The have also been unable to recover their savings.

Another challenge facing the scheme is the lack of cooperation between the various professional bodies of the health providers, the Nigerian Medical Association (NMA) and the Pharmaceutical Society of Nigeria (PSN). The grouse of the PSN is that modalities for prescribing and dispensing drug is lopsided (Uwaga)\textsuperscript{29} The health provider is empowered to prescribe and also dispense drugs to the exclusion of the pharmacist except where such provider does not have the drug in stock. Uwaga argues that the system which puts money in the hands of the physician and leaves him to determine what drugs to stock and when to refer his patients for specialist care (for which he is expected to pay) is bound to compromise the quality of health service to the insured. One tends to agree with this view. What is meant to be a cost saving devise would at the end the day turn out to be expensive. It is a fact that health provider collect 10 percent of the fees chargeable from patients at point of service. The health provider may therefore see it as an avenue to make money as dispensing drugs would then be seen as a commercial activity and the provider would prescribe only the drugs he has in stock.

One of the scheme’s greatest challenges is the implementation of the Community-Based Social Health Insurance Programme (CBSHIP) as about 80\% of Nigerians belong to that platform. This challenge has been attributed to the failure of the state governments to embrace the scheme.\textsuperscript{30} Perhaps the greatest challenge of all is the level of poverty of the majority of the populace. The minimum wage in the country is N18,000.00 which is about $112 USD per month. This comes to less that 4USD per day. It out of this amount that the worker is expected to feed, shelter and cloth his family. It is also out of this paltry sum that the worker will pay tax, NHF and also pay for health insurance. The level of unemployment in the country is also very high so that a majority of the populace would not be entitled to participate in the scheme as there is no social insurance in place for the unemployed. With


\textsuperscript{30} Rabiu, R., Community Insurance a Challenge. Remark credited to Dr. Waziri Dogo Mohammed (The Executive Secretary to the National Health Insurance Scheme) available on news.dailytrust.com viewed on 10/12/09.
widespread poverty in the land, most Nigerian are unable to spare an extra Naira on healthcare and many Nigerians patronise quacks, or they make compromises with their health with tragic consequences.\textsuperscript{31}

Further, people in the rural area even if they wanted to cannot benefit from the scheme as a result of lack of health providers. Many towns and villages do not have standard health facilities that may qualify as health providers under the scheme. To participate, people in the rural area may have to travel several kilometres to reach a health provider. Most of the private hospital in the country are ill equipped and without adequate staff. It is not uncommon to find that it is only the doctor/proprietor of a private clinic in Nigeria that has the requisite training. Most of the people who parade themselves as nurses in these hospitals do not attend the regular school of nursing or midwifery. They are often trained on the job by the doctor. Such “nurses” do not possess the requisite skills and are health hazards to the people. The public hospitals are only a little better in that they have become mere consulting rooms.

\textbf{5. HEALTH AS A HUMAN RIGHTS ISSUE}

The right to health care is implicitly linked with the right to life, and most people will agree that the right to life is fundamental. If that be the case, then human life needs to be protected and preserved. The life (that of the rich or poor) involved is immaterial. But there are no rights without limitations; hence, it then becomes relevant to know the minimum healthcare a member of a given society is entitled to, but such entitlement must not be evaluated on the basis of one’s ability to pay for basic healthcare.\textsuperscript{32} Though the right to health is fundamental and indispensable for the exercise of other human rights, there is no specific legislation on the right to health in Nigeria. Chapter IV of the 1999 Constitution which provides for the fundamental human rights makes no provisions for the right to health in spite of the fact that the right to life is only meaningful to a person who is healthy. Provisions for healthcare are contained in Chapter II of the Constitution which embodies the economic and social policies


\textsuperscript{32} Omonjezele, P., op cit.
of the country. Section 17(3)(c) provides that the State shall direct its policy towards ensuring that there are adequate medical and health facilities for all persons.

The enjoyment of other human rights is based on the right to life which would be meaningless without good health. There is a plethora of human rights treaties that treat access to health as a human rights issue. According to the International Covenant on Economic, Social and Cultural Rights everyone has “the right ... to the enjoyment of the highest attainable standard of physical and mental health.” The WHO constitution states that “The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction or race, religion, political belief, economic or social condition.”

The African Charter on Human and Peoples’ Rights imposes a duty on state parties to take measures to protect the health of their people and to ensure that they receive medical attention when they are sick. Aside from the above, the Nigerian Constitution states that Nigeria shall be a State based on principles of democracy and social justice and that the security and welfare of the people shall be the primary purpose of government. This connotes that the essence of governance is the welfare of the citizens. However, what the Constitution gives with one hand, it takes back with the other as the directive chapter II of the constitution which embodies the socio-economic rights of the people has be exclude from adjudication. Thus successive government have treated same with levity.

Be that as it may, the Committee on Economic, Social and Cultural Rights notes in relation to article 12 of ICESCR that

Health is a fundamental right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of highest attainable standard of health conducive to living a life dignity… The right to health is closely related to and dependent upon the realisation of other human rights, including the rights to food, housing, work, education, human dignity, life, non discrimination …

34 ICESCR Article 12.
35 WHO constitution.
37 1999 Constitution S. 14 (1) and (2) (b).
38 Atsenuwa et al, op cit.
Article 12.2 acknowledges that the right to health embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions and a healthy environment. This in effect encapsulates the right to health as a human right. A country that fails to invest in the healthcare of its people will be saddled with a gross reduction in production which will in turn affect its economic development.

Simply allocating greater public resources to basic health services is not enough to ensure that quality services are made available to the vast majority of poor citizens in the developing world. The impact of public spending on actual outcomes in health service delivery depends critically on existing institutions and incentives in the public sector. In recent years, public revenues in Nigeria have increased substantially due to the boom in world oil prices, and some of this windfall is being channelled into increased spending on primary health care. Yet, there remains a concern whether the institutions of public accountability in the country will effectively allow these large spending programs to translate into improved services and outcomes. A major channel through which increased public resources are expected to impact basic health and education services in Nigeria is that of spending by local governments that are largely responsible for these services. It is therefore important to delve deeper into the role of local governments and community organizations in basic health service delivery.

Health can be guaranteed only where there is access. According to the WHO about 1.3 billion people do not have access to effective and affordable health care Worldwide. Unfortunately, low and middle income countries, including Nigeria, bear 93% of the world’s disease burden, yet account for only 18% of world income and 11% of global health spending. In most developed countries and many developing countries health care is provided to everyone regardless of their ability to pay. The National Health Service, established in 1948 by Clement Atlee’s Labour government in the United Kingdom, were the world’s first universal health care system provided by government and paid for from general taxation. Alternatively,

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compulsory government funded health insurance with nominal fees can be provided, as in Italy. Other examples are Medicare in Australia, established in the 1970s by the Labor government, and by the same name Medicare was established in Canada between 1966 and 1984.\textsuperscript{41} Recently, China won an award for extending health insurance to its entire population. China is the most populous nation in the world.\textsuperscript{42}

According to the World Health Organisation, Health is “state of complete physical, mental and social well-being and not merely the absence of disease and infirmity”.\textsuperscript{43} Many external factors influence our health, such as the environment, housing and workplace conditions, and medical care. Thus, the right to health encompasses health care and those conditions essential for good health, such as safe water, adequate food, sanitation and shelter. The provision of comprehensive and adequate health care services to its citizens should be one of the central objectives of any responsible government. The sustainability and viability of a country’s economic and social growth depend largely on vibrant healthcare sector of that nation. No country can maintain a steady economic growth in the absence an adequate healthcare system.\textsuperscript{44}

The National Health System of the United Kingdom where insurance is paid for from tax is a preferred option. Government should set up a Health Tax Fund like the Education Tax Fund. Corporate Organisations should be made to pay into the fund from which individuals in need of financial assistance for huge sums of money for medical treatment would be able to draw. Health insurance for workers must be mandatory for corporate organisations. One tends to agree with Abubakar that “we must also see health as an integral part of human capital development and target it as part of any well meaning development efforts”.\textsuperscript{45}

Nigeria needs functioning institutions of health that can address people's complex health needs. The institutions should not just cure citizens but should also focus on preventative healthcare issues. These institutions must practice competitive health research that marches research in hospitals in many countries where Nigeria’s 'leaders' flock to for check ups and

\textsuperscript{42} China’s health insurance scheme wins ISSA Good Practice Award available at http://www.issa.int/News-Events/News2/China-s-health-insurance-scheme-wins-ISSA-Good-Practice-Award accessed on 13/8/2013.
\textsuperscript{44} Orabuchi, A. (2005), Poor healthcare system: Nigeria’s moral indifference, available on www.kwenu.com/publications/orabuchi/poor_healthcare.htm, accessed on 13/10/12.
\textsuperscript{45} Abubakar, op.cit.
surgery. In addition, they must cultivate and incorporate knowledge of local remedies into a general health approach. The NHIS is not the answer to Nigeria health problems. Some of these problems would be better addressed by provisions of social amenities like food security, potable waters, affordable housing, good roads, provision of electricity, security of life and property. The government should provide an enabling environment for people to live and work. Hospitals should be properly equipped. The famous Arabian proverb which “He who has health has hope, and he who has hope has everything”, underscores the importance of public health as a tool in the process of economic development.

Nigeria can afford to provide a universal health care system modelled after the United Kingdom. What Nigeria lack is good governance and the political will to improve the lot of the average Nigerian. It is on record that Nigerian legislators and executive earns the highest income worldwide. A senator in Nigeria earns more than the President of the United States of America which about the largest economy and the world’s leading democracy. A senator earns about N240 million ($1.7 million) and a member of the House of Representatives earns N204 million $1.45 million per annum while the US President earns $400, 000 per annum and British Prime Minister 190, 000 pounds. According to the Governor of the Central Bank of Nigeria, the National Assembly consumes 25 percent of the National budget yearly in salaries and allowances. While workers are clamouring for a higher minimum wage which presently stands at N18,000.00, members of the legislature are clamouring for an increase in their allowances. The House of Representative members want their quarterly constituency

allocations of N27.2 million each to increase to N42 million.\textsuperscript{51} This is in addition to their monthly salaries. Of course, the allocation for the Senators would be considerably higher. The constituency allocation is meant to enable the legislator execute projects in his constituency. However, there is little or no evidence of execution of such projects. Such money can be put to better use in providing adequate medical facility for the teeming populace. Imagine what N42 million can provide for each constituency in terms of healthcare.

CONCLUSION

The NHIS scheme as currently established is elitist as only federal government workers are benefiting under the scheme. Workers in the states, local governments, private sector both formal and informal are not benefiting under the scheme. The NHIS Act makes health insurance optional, thus workers cannot take advantage of the scheme except their employers, whether state, local government or private sector adopt the scheme. Thus a vast majority of the populace are being denied the opportunity of health insurance. Government must see access to health care as a fundamental human right and inherently linked with the right to life. Thus the provision of social amenities like potable water, good road, food security, job security and security of life and property should be of paramount importance to the government. The spirit of the Constitution which proclaims the welfare of the people as the primary purpose of governance should be enshrined in governance.

RECOMMENDATIONS

As a result of the centrality of health to national development, there must be universal coverage for all citizens. Health insurance must be compulsory for all formal sector employers of labour. This would include the state government, the local governments and the private sector. The government should set up a health tax fund like the Education tax fund to which corporate organisation must pay and from which individuals in huge sums of money for medical treatment can turn.

The provisions of social amenities like food security, potable waters, affordable housing, good roads, provision of electricity, security of life and property would go a long way in

promoting good health. The government must thus invest in basic social amenities. Good governance should not be seen as an option but as a must. The provisions of the constitution on socio economic rights must be justiciable so that the government can be made accountable for their actions to the populace.

A national identity scheme is also very essential as this would go a long way in having the necessary data to start with.