



Workable Social Health Insurance Systems in Sub-Saharan Africa: Insights from Four Countries

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Abstract

One of the major barriers to access to healthcare in most sub-Saharan African countries is financial constraints. The need therefore arises for African states to put in place workable social health insurance schemes, as is the practice in most developed countries. This article assesses the peculiar characteristics of sub-Saharan African countries that may impact on their ability to build capacity and effectively govern social health insurance schemes for their populations in a sustainable manner. In doing so, it draws from the experiences of countries that have experimented with different approaches to health insurance with varied outcomes. While Ghana has recorded some success, Nigeria and Rwanda have been able to domesticate their policies within a legal framework, yet South Africa is still to detach itself completely from health structures of the apartheid era. In sum, implementation faces a myriad of challenges in these countries and a lot remains to be done. What are these challenges and what steps are being taken to address them? How can other African countries learn from their experiences? Using four African countries as case studies, this article seeks responses to these questions. Specifically, it argues that sub-Saharan African countries need to take account of their socio-cultural, economic and political environments in fashioning their own health insurance strategies that will be pragmatic, socially acceptable and economically sustainable so as to meet the present and future needs of their populations, rather than an unwholesome adoption of the Western model. In making broad recommendations for countries on account of common challenges and experiences, This article emphasizes the importance of transparency in resource governance, unassailable accountability and greater political will by African governments for the eventual workability of their health insurance schemes.

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Résumé

L'un des principaux obstacles à l'accès aux soins de santé dans la plupart des pays d'Afrique subsaharienne, ce sont les contraintes financières. En conséquence, les États africains se trouvent devant la nécessité de mettre en place des régimes d'assurance santé sociaux réalisables, comme cela se fait dans la plupart des pays développés. Le présent article évalue les caractéristiques particulières des pays d'Afrique subsaharienne qui peuvent avoir des incidences sur leur aptitude à renforcer les capacités et à gérer de manière efficace et durable les régimes d'assurance santé sociaux pour leurs populations. Ce faisant, il s'inspire des expériences des pays qui ont essayé différentes approches de l'assurance santé avec des résultats divers. Alors que le Ghana a enregistré quelques succès, que le Nigeria et le Rwanda ont réussi à incorporer leurs politiques dans un cadre juridique, l'Afrique du Sud ne s'est toujours pas complètement détachée des structures de santé de la période de l'Apartheid. En somme, la mise en œuvre se heurte à une multitude de défis dans ces pays, et il reste encore beaucoup à faire. Quels sont ces défis, et quelles mesures sont prises pour les relever ? Comment les autres pays africains peuvent-ils tirer des leçons de leurs expériences ? En prenant quatre pays africains comme études de cas, le présent article cherche des réponses à ces questions. En particulier, il soutient que les pays d'Afrique subsaharienne doivent prendre en compte leurs environnements socioculturels, économiques et politiques en élaborant leurs propres stratégies d'assurance santé qui seront pragmatiques, socialement acceptables et économiquement viables, afin de satisfaire les besoins présents et futurs de leurs populations, au lieu d'une adoption malsaine du modèle occidental. En formulant des recommandations générales pour les pays eu égard aux défis et expériences communs, l'article souligne l'importance de la transparence dans la gouvernance des ressources, de la reddition de comptes incontestable et d'une plus grande volonté politique des gouvernements africains pour la faisabilité finale de leurs régimes d'assurance santé.

Introduction

The health systems inherited by many African states at independence were organized and financed by governments which provided facilities, personnel and other inputs. By the 1980s, however, economic downturn and the embrace of International Monetary Fund (IMF) loans with stringent conditionalities meant that many governments had to cut public spending on infrastructure and services, including healthcare and education. Consequently, many African governments stopped subsidizing public services and began implementing various cost-recovery measures in public services. The cost recovery era witnessed the introduction of out-of-pocket payments for healthcare services,

public water supply and consumables in schools. Thus, since the 1980s and 1990s, out-of-pocket payments by individuals and households have accounted for a larger share of healthcare expenditure in many countries of sub-Saharan Africa (Arhin 2013; Blanchet, Fink and Osei-Akoto 2012). These payments, popularly known as user-fees or the 'cash and carry' health system in Ghana, are known for raising the cost of healthcare, thus making it unaffordable for a large number of the population. In many sub-Saharan African countries, governments rank healthcare relatively low among development priorities (Kaseje 2006:4). For this reason, insufficient resources are allocated to healthcare, including drugs, which is often financed out-of-pocket (Carapinha, Ross-Degnan, Desta et al. 2010).

Healthcare statistics in sub-Saharan Africa are generally poor. For example, although the region makes up only 11 per cent of the world's population, it accounts for 24 per cent of the global disease burden and commands less than 1 per cent of global health expenditure (International Finance Corporation 2011). Although the World Health Organization's suggested thresholds of out-of-pocket payments for health as a guarantee of adequate financial protection is in the region of 15-20 per cent, residents of many African countries spend more (World Health Organization 2010). For example, out-of-pocket spending on health was between 27 and 37 per cent in Ghana in 2012 (Lagomarsino, Garabant, Adyas et al. 2012; Saleh 2012); about 52 per cent in Kenya (Kaseje 2006:4); between 64.5 and 70 per cent in Nigeria in the 1998-2008 period; while in South Africa, government contributes about 42 per cent of all expenditures on health. The remaining 58 per cent is paid by private sources in insurance premiums and out of pocket payments (Valrie 2004).

Whereas the United Nation's recommended minimum required budgetary allocation to health is 15 per cent, many African countries fall below this minimum in their budgetary allocations. According to Spreuwewers and Dinant (2012),

in 2007, more than half of the 53 African countries spent less than \$50 per person (as average) on health. Of the total health expenditure, 30 percent came from governments, 20 percent from donors and 50 percent from private sources of which 71 percent was paid by patients themselves, the so-called out-of-pocket payments.

The dire picture of the healthcare situation in sub-Saharan Africa described above, coupled with Africa's status as a low-income region where poverty is a major barrier or hindrance to accessing healthcare, underscores the need for social health insurance as a means of granting access to healthcare for most of the population.

Organization of the Article

This article examines how social health insurance can be made workable in spite of the challenges facing the idea by drawing on the experiences of four countries in sub-Saharan Africa in the administration of health insurance. The article is divided into sections. The first section lays an historical foundation for the adoption of social health insurance as a public health policy by countries in sub-Saharan Africa. Section two presents a conceptual map of public policy, public health and social health insurance by identifying the public whose interest government exists to serve and protect as the target and unit of analysis of public policy. The section also interrogates the role of government and the context of public health policy development. Section three presents the background to social health insurance in sub-Saharan Africa by pinpointing the reasons for the embrace of social health insurance in the sub-region. Section four links long-term system goals of health improvement, equity, financial sustainability, efficiency and avoidance of waste with the intermediate goals of greater access, effective universal coverage, quality and safety of healthcare services which, along with affordability, social health insurance is supposed to embrace.

Section five presents the concept of Universal Health Coverage and its three dimensional approach of breadth, depth and height which translates into health equity, number and quality of treatment as well as the extent of financial risk protection respectively, which are also the targets of social health insurance. Section six presents the four case studies with their individual specificities while section seven draws out the commonalities and lessons from the case studies to guide the planning and management of social health insurance in the region. Section eight concludes the article.

Public Policy, Public Health and Social Health Insurance: A Conceptual Map

Conceptually, the public sphere incorporates every aspect of human life or activity that is regarded as requiring governmental control, intervention or regulation (Parsons 1995:3). Public policy, argues Dewey (1927), deals with the public and its problems and it will likely reflect 'how, why and to what extent governments pursue particular courses of action or inaction' (Heidenheimer, Bluhm, Peterson et al. 1990:3). For Dye (1976:1), public policy deals with 'what governments do, why they do it and what difference it makes'. Therefore, public policy speaks to the nature, causes and effects of governmental action or inaction (Nagel 1990:440).

As Hogwood and Gunn (1984:24) argue, 'for a policy to be regarded as a "public policy" it must have been generated or at least processed within the framework of governmental procedures, influences and organizations'. However, in the globalized world of the twenty-first century, an issue may be regarded as 'public' prior to direct government involvement if its formulation, crystallization and how the issue is placed on the agenda of public discourse involve mass, common or popular action. That is, there must be a form of agreement among stakeholders on the need for such action. Invariably, the strength and conviction of the agreement will push the issue or problem on to the government agenda. Such issues may include biodiversity protection, banning of smoking in public places or making quality health care available and affordable for all segments of the population irrespective of socio-economic status.

Following the World Health Organization's (1948) definition of health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity', we can conceptualize public health as a wide and deep area requiring public policy interventions not just to treat illnesses but also to prevent them. The objective will also be to advance the livelihoods of populations by taking cognizance of the physical, economic and social factors of people's lifestyles as individuals, families and communities within the local, national and global contexts. As expressed by Orme, Powell, Taylor et al. (2007:7):

Improving the public's health and well-being is a high profile feature of government policy. Public health action has extended into a far wider arena, as it recognizes that factors in people's social, economic and physical environment have a profound impact on their health and can create deep inequalities.

Public health therefore deals with issues of scientific, social, economic, environmental and political importance that affect the health and livelihoods of people in general. A main linkage between public health and public policy is the concern with the population, the public whose interest government was instituted to protect and advance. This fact comes out boldly in Kelly's (2007:xix) argument that public health is much more than an interesting scientific challenge since it deals with issues that affects us all as members of the public.

It is for these reasons that public health addresses questions of health provision, health improvement, quality of health, social care, access equity, health resources and sustainability that are crucial to the success of social health insurance in Africa.

A second linkage between public policy and public health is the crucial importance of the role of government, the maker and implementer of public policy in enforcing public health regulations and laws. As the sovereign power within its territory, government has the legal monopoly of the instrumentalities of coercion to enforce rules and to punish offenders. It has been argued that:

Public health occupies the very uncomfortable territory where the rights of some clash with the rights of others. ... The problems it addresses are scientifically challenging, are practically difficult to deal with and are about some of the most hotly contested political and philosophical issues of the day. Public health ... operates in the territory ... where human psychology, sociology, economics, politics, geography and medicine intersect and overlap (Kelly 2007:xix).

Although the ascendancy of the market economy, the trend towards minimalist government, a poor economic outlook and different interpretations of the role of the African state (as outlined by Kawabata 2006, for example) have combined to gradually alter the roles of government in the developing world, and Africa in particular, the importance of government as an organizer, implementer and regulator of social life is not in doubt.

A third linkage between public policy and public health is that because public health is multidisciplinary in orientation, involving different resources and actions by many contributors (Orme, Powell, Taylor et al. 2007:7-8), it is important to understand the context of public health policy development so as to appreciate how public health actions come about and the interests, roles and contributions of the various stakeholders in partnership for public health. It is only then that researchers can be in a position to offer intellectually stimulating and practically feasible suggestions for resolving identified problems and moving public health forward.

It is within this context that one can understand and situate Kutzin's (1996:61) conception of health insurance as 'a way to pay for health care and to ensure access to services by providing a mechanism for sharing the risk of incurring medical expenditures among different individuals'. The population constitutes the unit of analysis for public policy, and governments seek to influence and direct public life through policy.

A major concern of governments is to narrow existing gaps amongst various segments of the population and this concern has often influenced the crafting of public health policies by various governments. Kutzin (2013) submits that 'all countries seek to improve equity in the use of health services, service quality and financial protection for their populations'. This desire is particularly relevant to governments in sub-Saharan Africa where poverty

is widespread among the population and where governments are finding it difficult to meet minimum health needs. It is this desire that informs the choice of social insurance by African governments as a strategy for meeting the health care needs of the population.

Background to Social Health Insurance in Sub-Saharan Africa

A review of recent literature reveals that more countries globally are embracing health insurance schemes as a means of meeting the healthcare needs of their populations (Spaan, Mathijssen, Tromp et al. 2012; Spreeuwers and Dinant 2013; Kutzin 1996; 2013; Archin 2013; Drechsler and Jutting 2007). Available literature also indicates that while national health insurance services (NHIS) are more common in the developed countries of North America and Europe (Physicians for a National Health Programme 2010), social health insurance (SHI) and community-based health insurance (CBHI) are more widespread in Asia and Africa. However, private health insurance (PHI) schemes thrive in sub-Saharan Africa (Spaan, Mathijssen, Tromp et al. 2012) because public health systems cannot meet the needs of the entire population. Therefore private employers arrange health insurance schemes for their employees.

Beyond the desire to imitate the healthcare systems of other countries, the following characteristics may pre-dispose African countries towards adopting social or community-based health insurance systems:

- i. Poor funding of the healthcare sector (Kutzin 1996:62; Kaseje 2006; Salako 2007:15). Although the World Health Organization's recommended minimum spending on health is US \$27 per person per year, most African countries spend less than US \$10 per person per year. Also, whereas heads of states and governments in Africa committed themselves to allocate 15 per cent of their annual budgets to health at the Abuja Declaration in 2001, annual spending on health in the region rarely exceeds an average of 5 per cent of GDP (Kaseje 2006:4).
- ii. Inequitable and inefficient allocation of the few resources that are allocated to the public health sector (Kutzin 1996:62). This often results in low quality health services and geographical imbalances in the distribution of healthcare infrastructure between rural and urban areas. Invariably, health problems are worst where resources are least available and those who need more care have the least access.
- iii. A scenario of deepening poverty, high disease burden and death with approximately 54 per cent of the sub-Saharan African population living in absolute poverty. Malnutrition, HIV/AIDS, and other preventable diseases like malaria (Olugbenga 2014), diarrhea and

respiratory tract infections being the major causes of death, apart from other causes of death like injuries from accidents, violence and war. A report by the European Union (2010) estimated that about 8.8 million children under the age of five (half of them in sub-Saharan Africa) still die yearly from preventable or curable illnesses.

- iv. There is human resource scarcity in the health sector, mainly the result of brain-drain, which itself is due to poor working conditions and remuneration, poor health infrastructure and inappropriate medical technologies. Other problems include inadequate medical personnel in some countries, and the concentration of medical workers in a few urban areas to the neglect of rural areas (Kaseje 2006:7).
- v. Weak, inappropriate health systems that are too old, underfunded, deficient in data reporting and which neglect traditional, faith-based and other informal services of care that can complement orthodox medical care (Kaseje 2006:7).

Besides the above-mentioned characteristics of healthcare systems in sub-Saharan Africa, the following peculiarities act as catalysts for the adoption of social health insurance by countries in the region:

- i. Africans generally value unity and appreciate communal loyalty in the spirit of being one's brother's keeper. This agrees with the philosophy of 'from each according to his ability; to each according to his need' which social health insurance symbolizes.
- ii. Even without direct government involvement, a growing proportion of the private sector in Africa is embracing joint health insurance schemes for their workers, particularly within the urban private sector.
- iii. Consequent upon rising poverty, there is a growing army in Africa of the unemployed, the under-employed and the unemployable (who received sub-standard education and want jobs whose demands they cannot cope with) and the destitute who need access to healthcare as human beings. In the face of dwindling government resources, reduced healthcare funding, rising health inequalities and other concerns of foreign donors who have been contributing to healthcare in Africa, social health insurance would be appropriate for sub-Saharan Africa.
- iv. More importantly, public or universal social welfare systems are not yet developed in many African countries. Therefore, the expanded African interpretation of the concept of 'family' (in terms of determining appropriate beneficiaries) would make whole-scale adoption of Western health financing systems problematic for Africans.

Health System Goals and Health Insurance in Sub-Saharan Africa

The World Health Organization (WHO) argues that a health system is more than a pyramid of publicly-owned personal healthcare delivery facilities or structures, but also consists of all organizations, people and actions whose primary intent is to promote, restore or maintain health (WHO 2007:1). Health system goals generally include improvement of health and health equity in ways that are responsive, financially sustainable and optimally efficient; they must also avoid wastage of resources. However, in order to attain these goals, a health system must also achieve the intermediate goals of ensuring greater access, effective coverage, quality and safety of healthcare services for the majority of the people (WHO 2007:1).

People enjoy different levels of economic, social and physical access to healthcare needs. It is reasonable, therefore, to establish systems that can allow individual members of a group to access healthcare when they need it without paying astronomical costs, which they may not be able to afford unless they sacrifice other needs that may also be pressing. Social health insurance, Kutzin (1996:61) submits, is 'a way to pay for health care and to ensure access to services by providing a mechanism for sharing the risk of incurring medical expenditures among different individuals'.

Kutzin emphasizes the strategic importance of financial protection as well as the ability, willingness and access to use health services, as prerequisites for social health insurance. He argues that since public policy objectives in the health sector include improving health status, equity, efficiency, acceptability (to providers and users) and sustainability, expanded coverage of health insurance may be a means to achieve progress towards these objectives (Kutzin 1996:61). However, he warns that the pursuit of broad coverage through health insurance is not the end of policy.

Historically, access to healthcare has been a challenge to the poor in sub-Saharan Africa for several reasons. These include, but are not limited to, poor management of healthcare institutions that encourage the waste of resources, inadequate health personnel, physical and economic denial of access where facilities are located far away from supposed beneficiaries and the bulk of healthcare cost being borne out-of-pocket by patients. Another challenge is the received philosophy that promotes curative to preventive healthcare therapy. This situation generates problems of inequality, inequity and low quality services. Although inequities in health status are a universal problem affecting health systems, an added problem in the developing world, including Africa, is unbearably low health outcomes, which can be addressed with the strategy of universal health coverage.

Universal Health Coverage

Universal health coverage (UHC) is a strategic aspect of the post-2015 Millennium Development Goals (MDGs), aimed at reducing individual and household health spending that is a major cause of poverty in many countries. As Margaret Chan, Director-General of the WHO, explained, UHC is:

the single most powerful concept that public health has to offer ... a powerful equalizer that abolishes distinctions between the rich and the poor, the privileged and the marginalized, the young and the old, ethnic groups, and women and men (Chan 2012).

UHC, according to WHO (2013), is an idea targeted at ensuring that all people have access to promotive, preventive, curative and rehabilitative health services of sufficient quality to be effective, while also ensuring that people do not suffer financial hardship when paying for these services. Since it became a priority programme of the WHO, it has become a major focus of health reform programmes globally. It is particularly relevant to health reforms in sub-Saharan Africa where health statistics present an ugly picture, particularly in terms of economic and physical access as well as equity, two major issues that drive and sustain poverty.

UHC pays particular attention to the aforementioned issues by addressing critical questions of equity in access to health services, ensuring a good and acceptable level of quality of health services and ensuring financial risk protection for a majority of the population. Equity is a bulwark against social and economic discrimination in health, so that everyone who needs health services may get them whether or not they can pay for them. A health service is acceptable if it can improve the health of beneficiaries, and the cost of health services must not put beneficiaries at the risk of financial impoverishment or hardship.

Taken together, these objectives are in tandem with the assessment criteria of the WHO's (2008) three-dimensional approach of breadth, depth and height of coverage for assessing progress towards UHC. Breadth (or span across socio-economic classes) corresponds to equity and is the proportion of the population, notably the poor and other disadvantaged groups, that has access to healthcare. Depth of coverage corresponds to the number and quality of services and assesses the range of health services available to meet the healthcare needs of covered populations. The height of coverage corresponds to the extent of financial risk protection of the population. It asks what proportion of the total cost of healthcare is covered through pre-payment and what percentage is paid out-of-pocket by beneficiaries. The objective is to keep out-of-pocket payments to the barest minimum for the majority of the population. The extent of universal coverage is an issue

which is further examined below.

The Four Case Studies

I examined social health insurance in Ghana, South Africa, Rwanda and Nigeria, with a view to finding out how their experiences might be useful in structuring new schemes in other African countries. It will also enable the revamping of ailing social health systems or enlarging small social insurance systems so they can cover entire populations.

Ghana was chosen because of its experiences in health insurance within the past decade; it is often held up as a success story in health insurance in sub-Saharan Africa (Blanchet, Fink and Ossei-Akoto 2012; Spreeuwers and Dinant 2012; Imurana, Haruna and Kofi 2014; Arhin, 2013; Apoya 2011). The intention is to help other countries learn from Ghana's experiences in terms of coverage, funding, management, political will, etc.

Rwanda is included in the study in order to examine what roles mobilization from below can play in the organization and management of health insurance schemes. We also included it so as to learn what impact heavy reliance on donor support can have on the long-term sustainability of health insurance schemes in sub-Saharan Africa.

Both Nigeria and South Africa have comparatively large territories and populations, as well as ethnic diversity. They are included in the study to observe the dynamics and effects of voluntary health insurance schemes in countries with large populations and with wide social, economic and ethnic configurations. Together with Ghana and Rwanda, the two countries demonstrate the critical importance of political will and getting targeted beneficiaries to support the implementation of public policies that will deliver public goods but extract financial resources from large swathes of poor populations in poor countries.

Taken together, the four case studies can illuminate thinking about health insurance in sub-Saharan Africa so that we can confront new challenges and re-examine old problems from new perspectives.

Methodology

The research design adopted for this work is social survey. It employs a combination of both secondary and primary sources of data. For those countries like Ghana, South Africa and Rwanda that I could not reach easily, I relied heavily on desk review of related documents. Some of these included assessment reports of the various social health insurance programmes and academic articles. It also includes reports of interviews and other forms

of interaction with the systems, their operators and the subscribers in the different countries. In the case of Nigeria, I combined primary (i.e. interviews) with secondary data available from other sources. Primary data were from key informant interviews with stakeholders in Nigeria's National Health Insurance Scheme (NHIS). These included Mr. Ajodi, M. Nuhu, the Ekiti State manager of the NHIS; Dr. Ade Tade, the Director of a service provider organization, Ade-Tade Hospital; and some employees of the Federal Government of Nigeria who are enrollees or subscribers to the NHIS. In all, I had several interviews with these stakeholders and the issues discussed included funding, service coverage, referrals, benefits to subscribers, bringing in potential subscribers from the informal sector to boost coverage, as well as other challenges facing the scheme. Also, my interaction with the State Director gave me insight into the existence and efforts of a multi-country collaborative group by managers of health insurance schemes in the continent. I also interviewed some social health insurance service providers and federal workers who are subscribers to the NHIS scheme in Nigeria.

I employed inferential analysis of the data obtained from both primary and secondary sources described above. Through this, I was able to identify and isolate issues and themes that are common to the schemes under study and other schemes in the continent for attention and treatment.

The issues identified are discussed and broad recommendations made towards their resolution in order to assist the various social health insurance schemes in sub-Saharan Africa not just to survive, but also to thrive and attain the goals of equity, quality and financial risk protection for enrollees.

Ghana's National Health Insurance Scheme

Ghana's National Health Insurance Scheme (henceforth NHIS) was established between March 2001 when its bill was passed into law, 2003 when the scheme was introduced (Apoya 2011), March 2004 when the scheme was launched and March 2005 when actual implementation commenced by the John Kufuor-led New Patriotic Party (NPP) (Imurana, Haruna and Kofi 2004). It was in fulfillment of one of its major political campaign promises to abolish the 'cash and carry' healthcare system that forced citizens to make high out-of-pocket payments at the point of health service delivery.

Objectives and Legal Instruments

The main policy objective of the scheme at inception in 2003 was to register, within five years of implementation, every resident of Ghana to a health insurance scheme, guaranteeing equitable access to healthcare and

adequate insurance cover against, and thus protection from, astronomical healthcare expenditure (Agyepong and Adjei 2008). The legal instrument for the scheme, the National Health Insurance Act 650 of 2003 was developed with the support of international and local health development partners. It made provisions for three major schemes, namely, a public-supported District Mutual Health Insurance Scheme (DMHIS); a Private Mutual Health Insurance Scheme; and a Private Commercial Health Insurance Scheme. Reorganization in 2012 harmonized the operations of all public-supported district mutual schemes under the umbrella of the National Health Insurance Authority through another National Health Insurance Act 852. By covering about 95 per cent of common health problems in Ghana, it was believed the scheme would be a great relief, removing catastrophic out-of-pocket payments for healthcare, enabling universal coverage and addressing problems of equity of access. To boost implementation, a National Health Insurance Council (NHIC) and a National Health Insurance Authority were established. There is also the Ministry of Health which performs specific functions related to the scheme (Ghana Ministry of Health 2004a; 2004b).

Funding

Since the scheme was originally established, partly as a cost-recovery measure and to relieve government of the burden of funding healthcare alone, funding for the scheme was shared between government and the enrollees who are the beneficiaries. To ensure success, government created a National Health Insurance Fund (NHIF) to manage and ensure a steady flow of funds from a stream of tax-based sources, government grants or premium contribution by enrollees. The sources included:

- i. A National Health Insurance Levy (NHIL) of 2.5 per cent value-added tax on goods and services. The National Health Insurance Authority (2011) reported that this tax revenue always accounted for 75 per cent of the total income for the scheme (Arhin 2013; Blanchet, Fink and Ossei-Akoto 2012).
- ii A 2.5 per cent payroll tax from Social Security National Insurance Trust (SSNIT) deductible at source from formal sector workers. This accounted for 23 per cent of funding (Blanchet, Fink and Ossei-Akoto 2012).
- iii. Individual contributions and premiums paid directly by informal sector workers to District Health Insurance Schemes. In reality, this is very little because even though persons in the informal sector constitute 70 per cent of the total Ghanaian work force, only about 22 per cent of them had enrolled with Ghana NHIS as at September, 2006 (Imurana,

Haruna and Kofi 2014). At the beginning of 2011, premiums from the informal sector had accounted for only about 5 per cent of the total income of the scheme (National Health Insurance Authority, 2011; Blanchet, Fink and Ossei-Akoto 2012). Payment of premiums by informal sector workers or enrollees is graduated from a minimum of GhC47.20 (about US \$4.80) for people of lower socio-economic groups and GhC48 (about US \$32) for people who are well off (Arhin 2013:2).

- iv. Other funds are from parliamentary allocations, donors or returns on investments. This constitutes 2 per cent of the funds (Blanchet, Fink and Ossei-Akoto 2012).

Implementation Assessment

Implementation is always a challenging aspect of public policy that can put it at risk either because the policy is bad or due to poor execution or even bad luck (Hogwood and Gunn 1984:197). Beginning with Derthick (1972), Pressman and Wildavsky (1973) and Bardach (1977), studies show that implementation has always been a challenging but interesting aspect of public policy. By the same token, implementation evaluation and analysis is even more challenging. A consideration of the findings of many implementation analyses made by Olugbenga (2013) suggest that 'implementation is the graveyard of policy'. Implementation of Ghana's National Insurance Scheme (NHIS) was premised on a foundation of institutions and processes aimed at facilitating UHC that is backed up with strong political will by government from inception. It was the main political campaign issue on the basis of which the opposition John Kufour-led New Patriotic Party (NPP) wrestled power from John Atta Mills's incumbent National Democratic Congress (NDC).

Ghana NHIS consisted of a National Health Insurance Authority, a network of 145 District Level Mutual Health Insurance Schemes (DMHIS), a premium exemption that covers formal sector workers paying contributions to the Social Security National Insurance Trust (SSNIT) and their dependants, staff of the Armed Forces and the Police Service, children under eighteen years-old (formerly with at least one, but now with both parents paying contributions) and persons over eighteen, SSNIT pensioners and the core poor. These are unemployed people without visible sources of income, fixed residences and not living with someone employed and with fixed residences. The scheme covers all these categories of people.

In general, the NHIS has had the following positive effects: offering comprehensive preventive, hospital and drug benefits to an extent, with

about 95 per cent of the national disease burden covered; promotion of equity by exempting certain categories of persons (particularly the poor from premium contribution although they are required to register; a slightly positive impact of about 4 per cent (at pre-NHIS levels) in reducing out-of-pocket payment for subscribers; and provision of standard, acceptable services to enrollees (Lagomarsino, Garabant, Adyas et al. 2012).

However, the scheme has faced some challenges, namely, low enrollment of about 40 per cent after a decade of implementation instead of the projected 100 per cent within five years of implementation. Funding proved to be another challenge. With the bulk of funding coming from value-added tax, the scheme appears more of a tax-funded system than a social insurance. This raises the question of financial sustainability.

Ghana NHIS faces some administrative challenges that constitute limitations on its effectiveness. Act 650 (particularly Section 31) that established the scheme makes enrolment technically compulsory for all residents of Ghana. In reality, however, enrolment is voluntary since there is no penalty for defaulting. This perhaps explains the low coverage figures (about 40 per cent) after a decade of operation, meaning that about 60 per cent of residents still use the 'cash and carry' health system. Even for the enrolled, the mandatory annual renewal of user-cards is not automatic, causing temporary access denials for some holders of such cards. The NHIS is fragmented into different schemes in different districts, and this breeds challenges of co-ordination, efficiency and accountability.

Apoya's (2011) estimate show that 36 per cent of costs could have been saved if government had taken the right measures to tackle inefficiencies and cost escalation. Finally, only a marginal reduction has been recorded in out-of-pocket payments since the commencement of the scheme in 2003, and other problems affecting both the quality of service and height of coverage have emerged. For instance, although about 3,000 health facilities are serving the system (Seddoh, Adjei and Nazzar 2012, cited in Arhin 2013), it suffers inadequacy of staff and equipment in certain places (Witter, Arhinful, Kusi et al. 2007). Following an independent review in 2008, the Ministry of Health itself reported discrimination against NHIS insured patients, low likelihood of being seen by a qualified doctor, long queues and waiting time and less likelihood of receiving all prescribed drugs. Other observed anomalies included demand for unofficial and additional fees by frontline medical staff for out-of-stock items in various facilities, with the aim of supplementing incomes (Ministry of Health 2009).

Ghana's NHIS scheme's initial aim of universal coverage within five years of implementation has not been achieved after a decade. Also, there are

contradictory statistics on coverage from different sources, depending on the assessor. It is instructive that figures and commentaries on the scheme from government and international health development partners stand in sharp contrast to those given by independent assessors and researchers. Other assessments of the scheme are contradictory. This suggests that individuals, groups and institutions are playing politics with the figures about the programme to achieve particular ends.

On coverage, for instance, the National Health Insurance Authority (2011) calculated this to be about 1.3 million (approximately 6.5 per cent) of an estimated population of 20 million in 2005. Four years later, in 2009, the NHIA put coverage figures at an encouraging approximate figure of 10 million, which is about 50 per cent of the population (National Health Insurance Authority 2011). After much criticism over its cumulative method of assessing enrollment (National Health Insurance Authority 2011; Apoya 2011), the NHIA conceded and revised its figures, putting 'active' enrollees at 8.16 million (about 34 per cent of the population) at the beginning of 2011. By October, 2013, enrollment for private and other mutual insurance tiers were quoted to be less than 6 per cent of Ghana's population, bringing the total number of the insured to about 40 per cent after a decade of implementation.

The above situation suggests that, apart from the NHIA, foreign development partners and some researchers either had vested interests or were simply deceived by figures and reports. For instance, Spreeuwers and Dinant (2012) stated that 'Ghana is the only country in sub-Saharan Africa that successfully implemented a national health insurance scheme. In 2008, five years after implementation, 45 percent of the Ghanaian population is enrolled'. In the same report, however, they also noted that 'rumour has it that the Ghanaian health system has difficulties in raising sufficient funds to pay for all enrolled patients, and some say that the insurance scheme will shortly go bankrupt due to its own success' (Spreeuwers and Dinant 2012). It appears that the adulation for Ghana's NHIS is probably greater than its achievements, prompting caution in recommending the scheme as a model to other sub-Saharan African countries.

Health Insurance in Rwanda

Objectives and Legal Instrument

Rwanda operates a community-based health insurance system called the '*Mutuelle de santé*' scheme which provides insurance for curative care for over 50 per cent of the population who are employed outside the formal

sector and, therefore, vulnerable to astronomical healthcare costs. Its objectives, derived from the Bamako Initiative of 1988 was 'to revitalize health care strategy and strengthen equity in access to health care' through the strategy of decentralization. In the post-1994 genocide period, the government started to rebuild the healthcare delivery system through the health insurance law no. 62 of 30 December 2007. It is a community-based system that incorporates primary, secondary and tertiary care with three key elements, namely:

- i. investment in strong and free preventive care against major diseases;
- ii. emphasis on subsidized, curative care by means of voluntary, prepaid health insurance; and
- iii. performance based health financing as basis for continued funding in order to improve the quality of care (Kayonga 2007:2).

The central government has decentralized the implementation of health policies to the sector and district levels, leaving (at the national level) the functions of policy development, capacity building, monitoring, evaluation and resource mobilization (Kayonga 2007: 3). Like other health insurance programmes, it shifts fees from the point of service to a pre-payment system that includes registration fees, insurance premiums payable at regular intervals regardless of whether or not the health insurance holder uses the services and a co-payment at the point-of-use.

Funding

Funding for the *Mutuelle* comes from two main sources, namely members' annual premiums (comprising 50 per cent) and transfers from the government, other insurance funds, development partners, charity organizations and non-governmental organizations which make up the remaining 50 per cent. Each member's annual premium was us \$2 per person up until 2011 when it was increased to US \$6 per family member (Asaba 2015:2). According to Kayonga (2007:3), this 50 per cent is made up of 12 per cent from each of the civil servants' social insurance, Military Medical Insurance and the Genocide Victims' Fund; 13 per cent comes from the annual budget of the Ministry of Health while less than 1 per cent comes from development partners and local government.

Implementation Assessment

As Dhillon (2011) argues, the Rwandan healthcare delivery system and the *Mutuelle* in particular have recorded some achievements because they enjoyed great support from the government and the overall health policy

environment, especially since the government makes investment in health a priority. This includes strong local political support and international assistance, increasing strategic investments in health, strong economic performance, a uniquely effective public administration and strong popular support and buy-in to government policies and programme initiatives by the population.

Rwanda's health insurance programme has improved access to healthcare for the population in recent years. From a mere 7 per cent in 2003, insurance coverage of the population increased to 91 per cent in 2010 according to the Ministry of Health, Republic of Rwanda (2010) and utilization of health services rose from 0.31 outpatient visits per capita in 2003 to 0.95 in 2010; while under-five mortality reduced by half from 15.2 per cent in 2005 to 7.6 per cent in 2010 (National Institute of Statistics of Rwanda 2006; 2011). Kayonga (2007:4) attributes the relative success of the *Mutuelle* to its dedication to quality services, community orientation, bottom-up architecture, political will, a results-driven atmosphere, continual improvement, financial access for the poor, and the existence of a large, uninsured informal sector that provides a market for community-based health insurance.

However, there are challenges. Dhillon (2011) found confounding correlations between *Mutuelle* coverage in Rwanda and improvements in utilization and indicators, notably concurrent increases in health spending. Both the Rwandan Ministry of Health and the World Health Organization (WHO 2011) found that the country spent US \$10 per capita on health in 2002, but by 2010, this had increased to US \$48 per capita. This can be explained by the high level of government commitment to the success of the *Mutuelle* health scheme. For instance, although the scheme generated a small percentage of overall health spending and therefore could not be self-financing, government felt committed to it in order to encourage international donors to contribute their quotas, which happens to be significantly high.

Although *Mutuelle* coverage increased in enrolment over time, the same cannot be said of its resource generation capacity. For example, the *Mutuelle* accounted for only 5 per cent of all health spending in 2006 and at least 20 per cent of its funds come from donors and government subsidies (Ministry of Health, 2008). Figures from the Ministry of Health, Rwanda (2008) indicate that Rwanda's health spending is heavily dependent on foreign donors who contributed 33 per cent of its health spending in 2002, which increased to 53 per cent in 2006.

This above suggests that the *Mutuelle* is not self-financing and that without foreign donor assistance, it may be unsustainable. Like Ghana's health insurance system, it is heavily subsidized by government. Unlike

Ghana's system, however, it charges co-payments at the point of care, a barrier to access for the poor. Statistical evidences from a small pilot study on the impact of enrolment fees and point-of-use co-payments on health services utilization in the *Mutuelle* in 2007 found that visits per capita and health service utilization doubled when enrollment fees and point-of-use copayments were suspended (Dhillon 2011). A study of research reports, Ministry of Health papers and results of pilot studies on the Rwandan health system shows that the *Mutuelle* faces the following challenges:

- i. The existence of premiums and co-payments limit the attainment of universal coverage, and is a barrier to access. Increasing premiums and co-payments have worsened access and health service utilization.
- ii. The *Mutuelle* generates minimal funding on its own, relying on funding from government, which in turn looks to international donors for the bulk of its health spending. This naturally places a limit of sustainability and expansion if foreign sources of funding fail, especially given that many other challenges such as the renewed migrant crisis in Europe equally deserve donors' attention. Expanding Mutual Fund contributions is a way out, but it has to be done carefully so it will not affect access, equity and utilization.
- iii. Other challenges include numerous priorities, financial gaps, human resource constraints, insufficient institutional capacity and management ability, and increasing participation that put strains on performance and maintaining a high quality of care.

South Africa

South Africa operates a dual healthcare system that is financed through a combination of private and public sources of general tax, private insurance and out-of-pocket payments. The system is dominated by private medical schemes that pool resources to cater for a small percentage of the population while the public health system is overburdened by a larger volume of users with fewer resources.

Therefore, health equity, access and affordability are major issues in South Africa as global health sector reforms are increasingly tending towards the objectives and ideals of UHC. Health insurance in South Africa is for the minority rich who can afford the cost while the poor majority depends entirely on the public-financed health system. This fact has limited thinking, action and research on the development of the health sector. For instance, in a systematic study of the impact of health insurance in Africa and Asia, Spaan, Mathijssen, Tromp et al. (2012) could not find existing studies on the

South African and Zimbabwean health systems even though private health initiatives (PHI) exist in these countries. They reasoned that this could be symptomatic of 'a certain bias in reporting on health insurance schemes, possibly driven by national government, donor or research priorities, data availability and difficulty in publishing negative impact results' (Spaan, Mathijssen, Tromp et al. 2012).

Medical schemes that dominate private health initiatives in South Africa owe their origin to the 1956 Friendly Societies Act of the apartheid era and a strong and united social solidarity background which the regulatory framework seeks to preserve by requiring contributions to be community-rated.

Characteristics of the South African Dual Health System

- i. Like the inherited health systems of many other African states, it is weak on equity and therefore inappropriate for a post-apartheid society of the twenty-first century.
- ii. The regulatory framework seeks to protect and preserve the status quo. For instance, relevant laws continue to protect pro-rich regulations and even though health schemes are *de jure* 'not for profit', they are *de facto* run by 'for-profit' organizations. The question remains as to whether individuals should be allowed to die because they cannot afford healthcare.
- iii. There are economic differentials in the treatment given to care seekers, depending on their levels of affluence. Some schemes are even restricted to particular companies or industries.
- iv. Health insurance schemes are supposed to be voluntary, but in practice, employment requirements make them compulsory.
- v. Human resources distribution in the health sector is disproportionately skewed in favour of the private sector to the detriment and underdevelopment of the public sector.

South Africa is already considering a major health system restructure in preparation to embrace universal coverage that can promote equity and financial risk protection. It is therefore important to highlight, as we have done above, the ways in which the current system encourages inequity and exposes the poor majority to financial risk. This will be useful as a guide for the change process.

Health Insurance in Nigeria

The Nigerian National Health Insurance Scheme (NHIS) was established by Decree 35 (now Act 35) of 1999, re-acted as the National Health Insurance Scheme ACT, Cap N42, laws of the Federation of Nigeria, 2004, to operate

as a public-private partnership, directed at providing accessible, affordable and qualitative healthcare for the population. It was introduced against the background of poor health indicators, underfunding of the health sector for a long time by government and a dwindling ability of federal and other levels of government to cope with health funding. Other indicators were a rise in private expenditure to 70 per cent of total health expenditure and a steady rise in out-of-pocket expenditure on health; a high infant mortality rate of 19 per cent and annual mortalities of children under five years of over a million. These figures represented the highest in Africa and the second highest in the world, from 1990 into the first decade of the twenty-first century. The government had relied more and more on international donor funding of the health sector, even as pressures rose for the country to meet UN MDGs.

The NHIS was designed to cover preventive, promotive and curative components of healthcare delivery for various segments of the population. This is reflected in its elaborate schemes for the formal and informal sectors, the organized private sector, the army, police and other uniformed services, students of tertiary institutions, community-based social health insurance, vulnerable groups, physically challenged persons, prison inmates, children under five as well as refugees, victims of human trafficking, internally displaced persons and immigrants. However, there are no official figures of how many of these groups are actually covered.

Funding is basically by pooling contributions from government, enrollees and donations by way of formal launch and fund-raising events targeting individuals, governmental and civil society organizations to boost the financial base of the scheme. Beside government contributions to the NHIS management, enrollees pay contributions and premiums on a regular basis, either from salary sources in the case of formal public and private sector workers or monthly contributions in the case of informal sector workers, consisting of voluntary and other community-based groups. Provider payment systems include capitation and fee-for-service for referral and emergency cases. Others are co-payment (10 per cent of the total cost of drugs dispensed per prescription excluding vulnerable groups and those in tertiary institution programmes); per diem or fees paid by primary providers/HMOs to secondary/tertiary providers for bed space during hospitalization or emergencies; and co-insurance which is part-paid by enrollees for treatments/investigations that are covered under a partial exclusion list. HMOs pay the balance of co-payments.

Implementation Assessment

The Nigerian NHIS programme has been operational for about fifteen years (1999-2015). Although updated coverage figures are not readily available, the scheme was able to achieve only about 3 per cent coverage, that is, five million out of a hundred and sixty million Nigerians, as of 2010, eleven years after inception. The reasons for the poor coverage are multiple, including the following:

- i. The enabling law makes enrollment voluntary rather than compulsory, at least for formal sector workers. The government gave managers of the scheme the mandate to cover only 30 per cent of the population, but using its discretion, management increased the target to 40 per cent, so as to place it in a position to meet government's minimum requirement. An effort to make enrollment compulsory for all by passing the NHIS bill into law in the National Assembly has met with opposition from groups that have not been reigned in to the NHIS and who think their interests would be affected by such legislation.¹
- ii. Lack of political will by government to fund the health sector appropriately. For instance, Nigerian government's spending on health is often below 5 per cent of GDP and in the 2010 budget was a paltry 3.98 per cent. Out-of-pocket payments for health averaged 64.5 per cent of total expenditure between 1998 and 2002, increasing to 70 per cent in the 2011 financial year. Expectedly, total household spending on health has been rising in Nigeria. The lack of commitment by government could be responsible for its failure to make enrollment compulsory, an action that would have boosted the resource base of the scheme, given Nigeria's large population.
- iii. There are operational challenges. For example, some service providers force enrollees to make out-of-pocket payments at the point-of-use in the form of co-payments for unavailable drugs and high co-insurance costs for medical and laboratory investigations for items on the exemption list. Also, while NHIS pays health maintenance organizations on a quarterly basis, some HMOs pay providers on monthly basis while others default in payment. This has prompted the NHIS authority to deregister some HMOs.²
- iv. Premium coverage through private sector employer-based systems is functioning but small. This is because, like many other countries in sub-Saharan Africa, government is the largest employer of labour in Nigeria. And not all private sector organizations in Nigeria that have embraced the idea of health insurance. With proper planning and

implementation of health insurance in the public sector, the saying 'the more the merrier' can be fulfilled.

- v. Finally, incessant changes in leadership of the scheme is a problem that may deprive it of the benefits of continuity. Government must avoid frequent changes of leadership, for whatever reasons, so that the scheme can reap the advantages of strategic planning in pursuit of its vision.

Health Insurance in Sub-Saharan Africa: Commonalities and Lessons

Commonalities

First, experiences of the countries surveyed point to the importance of strong political leadership to the conception, adoption and implementation of social health insurance systems that people will accept, own, utilize and help to develop to an acceptable level. This was present in the case studies, and was very strong in the cases of Ghana and Rwanda. Strong political leadership also featured in the cases of South Africa and Nigeria, although for the former, the apartheid root of the health insurance system deprived the scheme of equity as a key UHC objective, which has not been redressed in the post-apartheid period. The need to address poor health statistics was one reason why the Nigerian government adopted health insurance. But its voluntary nature has resulted in extremely low acceptance and buy-in to the health insurance scheme by the people.

Second, funding proved to be a critical factor in all countries and programmes surveyed. With the exception of the private schemes in South Africa, which fuel inequity, the bulk of funding for most programmes in the studies was from government and foreign donor organizations; user contributions were minimal. Rwanda's system is heavily dependent on foreign assistance, raising the question of long-term sustainability of foreign donor-propelled health insurance and other schemes that are mostly government rather than beneficiary driven.

Third, even with the critical funding situation, there was evidence of low transparency in resource governance and accountability in some of the systems examined. In Ghana and Nigeria, for example, there were reports of beneficiaries being told to go and make out-of-pocket purchases of critical drugs and other supplies because these were not available in hospitals. So, mechanisms must be strengthened to reduce resource leakages, promote accountability and maintain standards in order to consolidate the gains already made by the various countries, while forging ahead.

Fourth, evidence-based research on Community Based Health Insurance (CBHI) in Africa establishes a weak correlation between CBHI and

improvements in health statistics. This is true of Rwanda (Criel 1998) and Uganda (McCord and Osinde 2003) while statistics from Ghana are conflicting and confusing. Thus, there is the need for more evidence-based research on the modalities and challenges of social health insurance in sub-Saharan Africa. What appears clear, as of now, is that large swathes of Africa's populations are so poor they can contribute little towards sustaining social health insurance. They also believe they have alternatives in traditional therapies. The rich, however, would prefer exclusive health treatment, which is why they love seeking treatment in the Americas, Europe and Asia thus boosting medical tourism in destination countries. However, these practices will slow down the development of health insurance in sub-Saharan Africa.

Lessons

First, the case studies suggest that the success or failure of health insurance planning and implementation was, in large measure, a function of the size and nature of the political support it received. Therefore, political leadership in sub-Saharan Africa must see health as a major determinant of human productivity and national prosperity, rather than as an avoidable drain on national resources. All health policies already acknowledge this. After all, it is said that health is wealth. African governments must learn to think and plan with the people to achieve common goals and engage in bottom-up planning to involve groups whose support and contributions are crucial for effective plan implementation.

Second, the administrative challenges facing each scheme instruct African governments not to rush into health insurance schemes but to plan every aspect of the programmes carefully before commencement. Hurrying into schemes as the New Progressive Party did in Ghana is not the best strategy; neither is planning big schemes without sufficient commitment to the solution, as the Nigerian example shows. Rather, making schemes work by experimenting first and generating sufficient goodwill and financial resources will be decisive. In Ghana and Nigeria, for instance, the informal sector has not been properly mobilized, yet it constitutes a large chunk of the workforce in many African countries. Strategies must therefore be worked out to get the populace to consent to, and buy into, health insurance schemes. Care must also be taken to avoid health policy somersaults that are common in other policy areas in Africa as governments change. The vision of schemes must be stabilized in law to institutionalize them.

Third, in many African countries, there is a rising demand for high-end private health services in urban areas, a development that leads to the concentration of health facilities and personnel in the political, economic

and industrial capitals to the neglect of rural areas. This contrasts with the overall picture as the majority of Africa's populations live in rural and semi-urban areas with lower income. The distribution of health facilities in many sub-Saharan African countries is therefore inequitable and needs to be corrected in favour of the rural areas. Extending universal coverage to the majority is still a challenge for many.

Fourth, many African states have not leveraged opportunities provided by vertical health programmes to enrich (horizontal) public health pursuits, even when management of some such programmes already see the need for this. Both vertical and diagonal approaches should be used to improve overall health goals in Africa. For example, it is possible to make women's reproductive health needs major aspects of social health insurance programmes.

Fifth, the economic situation in the continent suggests that African countries cannot shoulder the responsibility for public health alone; neither should they abandon it to the private sector or the citizens alone. What is indicated are workable arrangements in co-operation with other stakeholders while government remains in the driving seat particularly in terms of policy making, legislation, regulatory oversight functions and funding, the extent of government involvement depending on the particular local circumstances.

Sixth is the need to stop the brain drain, develop and retain human resources in Africa's public health sector for successful implementation of health insurance schemes. The European Union (2010) suggests granting medical personnel multi-entry visa arrangements to enable work in Africa even while undergoing further training outside the continent.

Finally, African governments should consider increasing tariffs on imports of ostentatious goods while higher taxes should be charged on consumption of health-decimating items to increase resource flows to healthcare insurance.

Conclusion

To move forward, governments in sub-Saharan Africa must learn to share experiences and learn from other countries with similar characteristics. Therefore, it is recommended that countries become members of the existing Joint Learning Network that comprises countries implementing health insurance. However, there is need for flexibility, since environments differ from one to another.

By the instrumentality of the African Union, governments in the region should declare 2016-2025 'Africa's decade of health insurance' to commit African governments to develop health insurance as a viable means of funding

healthcare for their populations. They should remember that considerable government funding will be necessary at the beginning, but this should ease gradually as more people enroll into the programmes. Western countries that now have close to universal coverage took decades to get there.

Ministries of education in the various countries should include health insurance in the curricula of health-related subjects like health education and compulsory subjects like economics in schools as a way of driving awareness about health insurance in young Africans early. This will make it easier for coming generations of Africans to embrace health insurance, internalize it, contribute to it and own it rather than see healthcare as an exclusive duty of government.

Although healthcare should not be commoditized, orientation will be needed in the immediate period to get citizens and other residents who are able to pay to do so. This is because although many are so poor they can only pay little amounts, they will not want to do so, assuming they have alternatives in traditional medicine and self-medication, itinerant drug sellers and hassle-free over-the-counter medicines that are available in many countries. Also, many of the rich believe in medical tourism abroad rather than assisting government to invest in healthcare at home. Therefore, orientations must change to emphasize the need for solidarity, autonomy, flexibility and adaptation, equality, participation and social dynamism to make social health insurance work. Happily, these virtues are part of Africa's traditions that can be exploited to boost healthcare through social insurance.

Notes

1. Interview with Ekiti State NHIS Coordinator, 16 September 2015.
2. Interview with Ekiti State NHIS Co-ordinator, 16 September 2015.

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