A Comprehensive Review of the Contributory Health Insurance Legal Framework in Nigeria: Focus on the Borno State Contributory Healthcare Management Agency Law, 2018 (as amended).

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Abstract

The Borno State Contributory Healthcare Management Agency (BOSCHMA) Law (2018) established a contributory health insurance framework covering public, private, and informal sectors, with explicit provisions for vulnerable groups such as internally displaced persons (IDPs), women, children, the elderly, and persons with disabilities. However, its implementation in a post-conflict setting faced challenges of financial instability, governance risks, systemic weaknesses, and conflict-related disruptions. This article employs doctrinal legal analysis supported by policy review and comparative evidence to critically assess both the 2018 Law and the BOSCHMA Bill, 2025, within Nigeria's decentralized health insurance landscape. Drawing on legislative texts, policy documents, and international comparators, the analysis examines institutional design, financing arrangements, and service delivery provisions, evaluating their alignment with Universal Health Coverage (UHC) principles and responsiveness to Borno's conflict-affected population. Findings highlight significant progress in the 2025 Bill, including the harmonization of references with the National Health Insurance Authority (NHIA) Act 2022, legislated percentage-based contributions for public servants, and statutory provisions mandating transparent, evidence-based identification of indigent and vulnerable populations. These reforms directly address weaknesses in the 2018 Law, particularly the outdated references to the repealed NHIS Act and ambiguities in defining vulnerable groups. Nonetheless, operational challenges remain, including ensuring sustainable financing, institutional capacity-building, public trust, and delivery of guaranteed benefit packages in fragile settings. The review recommends embedding transparent beneficiary identification systems, defining explicit benefit entitlements, strengthening governance and accountability frameworks, and institutionalizing robust monitoring mechanisms. Lessons from national reforms and global post-conflict models provide actionable pathways for implementation. The Borno case, now reinforced by the 2025 Bill, offers critical insights for advancing UHC in fragile and conflict-affected contexts worldwide.

Keywords: Universal Health Coverage, Contributory health insurance, Health insurance, Borno State, Post-conflict health funding.

1. Introduction

The quest for Universal Health Coverage (UHC) stands as a global health imperative, recognized for its profound significance in fostering national development and ensuring societal well-being.[1]

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In Nigeria, the commitment to UHC has largely manifested through the establishment of state-level health insurance schemes, reflecting a decentralized approach to healthcare financing and delivery. [2] The Borno State Contributory Healthcare Management Agency Law, 2018,[3] emerges as a pivotal legislative instrument within this national drive, particularly noteworthy given the distinctive and arduous challenges posed by Borno State's prolonged insurgency.

The enactment of a state-level contributory health insurance scheme in such a severely affected, post-conflict region represents a critical policy evolution, signaling a strategic shift towards resilience and recovery through social protection. [4] This initiative transcends conventional emergency humanitarian aid, aiming instead for the establishment of sustainable, long-term health systems.[5] The law implicitly acknowledges the broader role of robust health systems in rebuilding the societal fabric and ensuring enduring stability in a challenging environment.

Nigeria's health performance has been among the poorest globally over the last two decades.[6] [7] The way a country finances its healthcare system is a critical determinant for reaching UHC, as it dictates the affordability of available health services.[8] Unfortunately, achieving the optimal mix of financing sources remains a significant challenge in Nigeria.[9] The Alma-Ata Declaration of 1978, to which Nigeria is a signatory, affirms that health is "a fundamental human right" and that its attainment is "a most important world-wide social goal" requiring multi-sectoral action, with primary health care as the key and governments bearing ultimate responsibility.[10] Despite this,

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[1] The World Health Report: Health Systems Financing: The Path to Universal Coverage' <https://iris.who.int/handle/10665/44371> accessed 20 August 2025.
[2] Nigeria Gets New National Health Insurance Act – PLAC Legist' <https://placng.org/Legist/nigeria-gets-new-national-health-insurance-act/> accessed 20 August 2025.
[3] Borno State Contributory Healthcare Management Agency Law, 2018 2018 (Borno State Printer).
[4] 'Global Monitoring Report on Financial Protection in Health 2021' <https://www.who.int/publications/i/item/9789240040953> accessed 20 August 2025.
[5] 'Universal Health Coverage Overview' <https://www.worldbank.org/en/topic/universalhealthcoverage> accessed 20 August 2025.
[6] Adam Wagstaff and Sven Neelsen, 'A Comprehensive Assessment of Universal Health Coverage in 111 Countries: A Retrospective Observational Study' (2020) 8 The Lancet Global Health e39 <https://www.thelancet.com/action/showFullText?pii=S2214109X19304632> accessed 16 August 2025.
[7] 'World Bank: Number of Poor Nigerians Increased by 24m between 2018' <https://www.thecable.ng/world-bank-number-of-poor-nigerians-increased-by-24m-between-2018-and-2023/> accessed 20 August 2025.
[8] Diane McIntyre and others, 'Challenges in Financing Universal Health Coverage in Sub-Saharan Africa' [2018] Oxford Research Encyclopedia of Economics and Finance <https://oxfordre.com/economics/display/10.1093/acrefore/9780190625979.001.0001/acrefore-9780190625979-e-28> accessed 16 August 2025.
[9] Adeyinka Adeniran and others, 'Determinants of Health Insurance Adoption among Residents of Lagos, Nigeria: A Cross-Sectional Survey' (2024) 5 Open Health <https://www.degruyterbrill.com/document/doi/10.1515/ohe-2023-0043/html> accessed 16 August 2025.
[10] Fortune Benjamin Effiong and others, 'Coverage and Predictors of Enrollment in the State-Supported Health Insurance Schemes in Nigeria: A Quantitative Multi-Site Study' (2025) 25 BMC Public Health 1

many Nigerians die yearly from preventable diseases due to lack of access to quality healthcare and financial barriers, with the majority living below the poverty line.[11]

Borno State's diverse demographic profile and history of vibrant economic activities in agriculture and trade have been severely undermined by prolonged insurgency, leading to widespread displacement, destruction of infrastructure, and disruption of livelihoods (United Nations Office for the Coordination of Humanitarian Affairs.[12] This has exacerbated existing public health challenges, including high burdens of communicable diseases, weakened health infrastructure, and restricted access to quality healthcare services. The BOSCHMA Law (2018) explicitly defines "vulnerable groups" to include pregnant women, children under five years, the aged, the disabled, the poor, and internally displaced persons (IDPs.[13] This targeted definition demonstrates legislative intent to address conflict-aggravated vulnerabilities, moving beyond generic poverty classifications to address specific health needs. Enacted "to provide for the establishment of the BOSCHMA, and other matters related therewith," the bill received gubernatorial assent from Engr. Prof. Babagana Umara Zulum in 2019.[14] The relatively swift legislative process indicates high political will, reinforced by reports confirming state government financial contributions to facilitate the scheme's commencement. Political commitment is crucial for the scheme's execution, especially in Borno's resource-constrained and conflict-affected environment. The Borno State Contributory Healthcare Scheme (BSCHS) adopts a tripartite structure: the Borno State Equity Health Programme (BSEHP) for vulnerable groups, the Formal Health Programme for students and formal-sector workers, and the Informal Health Programme (IHP) for self-employed and informal-sector participants. The scheme's objectives include ensuring access to affordable quality healthcare, protecting households from catastrophic medical expenditure, mitigating healthcare cost inflation, and equitably distributing healthcare costs.

This article critically reviews the BOSCHMA Law, 2018, evaluating its institutional, financial, and service delivery frameworks, and highlighting strengths, weaknesses, and implementation challenges. While innovative in scope, the law's long-term sustainability will depend on addressing legal gaps, operational ambiguities, and the realities of implementing UHC in a post-conflict context.[15] [16]

<https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-025-23329-4> accessed 16 August 2025.

[11] 'World Bank: Number of Poor Nigerians Increased by 24m between 2018' <https://www.thecable.ng/world-bank-number-of-poor-nigerians-increased-by-24m-between-2018-and-2023/> accessed 16 August 2025.

[12] 'Nigeria Humanitarian Needs Overview 2024 | OCHA' <https://www.unocha.org/publications/report/nigeria/nigeria-humanitarian-needs-overview-2024> accessed 20 August 2025.

[13] Borno State Contributory Healthcare Management Agency Law, 2018 2018 (Borno State Printer).

[14] 'BOSCHMA Set To Roll Out Formal Health Sector In Borno - Voice of Nigeria Broadcasting Service' <https://von.gov.ng/boschma-set-to-roll-out-formal-health-sector-in-borno/> accessed 16 August 2025.

[15] 'Global Monitoring Report on Financial Protection in Health 2021' <https://www.who.int/publications/i/item/9789240040953> accessed 20 August 2025.

[16] 'Universal Health Coverage Overview' <https://www.worldbank.org/en/topic/universalhealthcoverage> accessed 20 August 2025.

2. Conceptual and Legal Foundations of Contributory Health Schemes in Nigeria

2.1. Principles of Social Health Insurance and Risk Pooling

Social health insurance schemes are built on fundamental principles designed to ensure equitable access to healthcare and financial protection.[17] [18] Central to these is the concept of risk pooling, where the financial risk of illness is spread across a large group of people rather than being borne by individuals.[19] This solidarity principle ensures that healthy individuals contribute to cover the costs of the sick, and higher-income individuals cross-subsidize care for lower-income groups.[20]

Cross-subsidization is particularly vital for achieving Universal Health Coverage (UHC), as it enables the inclusion of vulnerable populations who may not be able to afford contributions[21]. Effective risk equalization mechanisms are crucial for the long-term viability of such schemes, preventing adverse selection and ensuring that the fund remains solvent.[22]

2.2. The Nigerian Legal Framework for Health Insurance: Evolution and Current Status

Nigeria's approach to health insurance began with the National Health Insurance Scheme (NHIS) Decree No. 35 of 1999, promulgated under General Abdulsalami Abubakar to provide insured persons and their dependents with access to quality, cost-effective health services Operational from 2005, the scheme offered programs for public and organized private sector workers and voluntary contributors. [23] However, the Voluntary Contribution Social Health Insurance Programme (VCSHIP) excluded dependents, limited coverage to routine illnesses, and omitted high-cost conditions such as cancer, HIV/AIDS, hepatitis, and cardiovascular diseases.[24] Contributions of 15% of basic salary for the insured and four children under 18 were criticized for ignoring extended dependency realities,[25] with further barriers including a 60-day waiting period and 10% co-

[17] Guy Carrin and Chris James, 'Social Health Insurance: Key Factors Affecting the Transition towards Universal Coverage' (2005) 58 Int Soc Secur Rev 45.
[18] Di McIntyre and others, 'Promoting Universal Financial Protection: Evidence from Seven Low- and Middle-Income Countries on Factors Facilitating or Hindering Progress' (2013) 11 Health Research Policy and Systems.
[19] 'The World Health Report: Health Systems Financing: The Path to Universal Coverage' <https://iris.who.int/handle/10665/44371> accessed 20 August 2025.
[20] 'Scaling Up Affordable Health Insurance : Staying the Course' [2013] Scaling Up Affordable Health Insurance <https://hdl.handle.net/10986/13836> accessed 20 August 2025.
[21] 'Global Monitoring Report on Financial Protection in Health 2021' <https://www.who.int/publications/i/item/9789240040953> accessed 20 August 2025.
[22] Adam Wagstaff and Sven Neelsen, 'A Comprehensive Assessment of Universal Health Coverage in 111 Countries: A Retrospective Observational Study' (2020) 8 The Lancet Global Health e39 <https://www.thelancet.com/action/showFullText?pii=S2214109X19304632> accessed 16 August 2025.
[23] National Health Insurance Scheme Decree, Laws of the Federation of Nigeria 1999.
[24] Bolaji S Aregbeshola, 'A Tax-Based, Noncontributory, Health-Financing System Can Accelerate Progress toward Universal Health Coverage in Nigeria' (2018) 20 MEDICC Review 40 <https://pubmed.ncbi.nlm.nih.gov/31242171/> accessed 16 August 2025.
[25] Eric Obikeze and others, 'BENEFIT INCIDENCE OF NATIONAL HEALTH INSURANCE SCHEME IN ENUGU STATE, SOUTHEAST NIGERIA' (2013) Volume 2 Issue 1 African Journal of Health Economics 13 <http://www.ajhe.org.in/abstract.php?article_id=2591> accessed 16 August 2025.

payments.[26]

Although founded on fairness and risk sharing, the NHIS primarily served formal sector workers, leaving most of the informal economy without protection.[27][28] Legal reviews found the Act narrow in scope and weak in enforcement.[29] The National Health Insurance Authority (NHIA) Act 2022 replaced earlier laws, made health insurance compulsory, expanded informal sector coverage, and introduced multiple funding streams including the Vulnerable Group Fund.[30] [31] Analysts see this as potentially transformative but stress that political will, sustainable financing, and robust governance are essential.[32] The NHIA Act's success will also depend on addressing vulnerable population needs, such as tailored benefits, geriatric services, and subsidies for older informal-sector workers.[33] Comparative perspectives show Ghana's publicly funded, uniform benefits and reduced out-of-pocket spending,[34] while Nigeria's community-based health insurance (CBHI) schemes struggle with low enrolment, trust deficits, and affordability barrier. [35][36] Recommendations include a phased approach, strengthening infrastructure and workforce before

[26] Bolaji S Aregbeshola, 'A Tax-Based, Noncontributory, Health-Financing System Can Accelerate Progress toward Universal Health Coverage in Nigeria' (2018) 20 MEDICC Review 40 <https://pubmed.ncbi.nlm.nih.gov/31242171/> accessed 16 August 2025.
[27] OE Onwujekwe and others, 'Health Insurance: Principles, Models and the Nigerian National Health Insurance Scheme' (2011) 16 International Journal of Medicine and Health Development 45 <https://journals.lww.com/ijmh/fulltext/2011/16010/health_insurance__principles,_models_and_the.8.aspx> accessed 16 August 2025.
[28] Christiana Ogben and Olayinka Stephen Ilesanmi, 'Community Based Health Insurance Scheme: Preferences of Rural Dwellers of the Federal Capital Territory Abuja, Nigeria' (2018) 9 Journal of Public Health in Africa 540 <https://pmc.ncbi.nlm.nih.gov/articles/PMC6057720/> accessed 20 August 2025.
[29] Oluwakemi Amudat AYANLEYE, 'A LEGAL APPRAISAL OF THE NATIONAL HEALTH INSURANCE SCHEME IN NIGERIA' (2013) 5 106 <http://www.photius.com/countries/nigeria/society/nigeria_society_primary_health_care_~10006.html> accessed 8 November 2021.
[30] Tope Michael Ipinnimo and others, 'The Nigeria National Health Insurance Authority Act and Its Implications towards Achieving Universal Health Coverage' (2022) 29 Nigerian Postgraduate Medical Journal 281.
[31] Daniel Chidike NWUZOR, 'THE NATIONAL HEALTH INSURANCE AUTHORITY ACT 2022: ANALYSIS, CHALLENGES AND PROSPECTS' (2022) 6 African Journal Of Law And Human Rights <https://ezenwaohaetorc.org/journals/index.php/AJLHR/article/view/2160> accessed 20 August 2025.
[32] Abiodun Awosusi, 'Nigeria's Mandatory Health Insurance and the March towards Universal Health Coverage' (2022) 10 The Lancet Global Health e1555 <https://www.thelancet.com/action/showFullText?pii=S2214109X22003692> accessed 16 August 2025.
[33] Fareedah Muhammad, Yunusa Abdulrahman and Mohammed Phd, 'AN ANALYSIS OF THE NATIONAL HEALTH INSURANCE AUTHORITY ACT 2022: IMPLICATIONS FOR THE AGEING POPULATION IN NIGERIA' (2025) 4 Journal of Social Theory and Research.
[34] Isaac A Odeyemi and John Nixon, 'Assessing Equity in Health Care through the National Health Insurance Schemes of Nigeria and Ghana: A Review-Based Comparative Analysis' (2013) 12 International Journal for Equity in Health 1 <https://link.springer.com/articles/10.1186/1475-9276-12-9> accessed 18 November 2021.
[35] Isaac A Odeyemi and John Nixon, 'Assessing Equity in Health Care through the National Health Insurance Schemes of Nigeria and Ghana: A Review-Based Comparative Analysis' (2013) 12 International Journal for Equity in Health 1 <https://link.springer.com/articles/10.1186/1475-9276-12-9> accessed 18 November 2021.
[36] Okechukwu Ignatius Eze and Ifeoma Felicia Chukwuma, 'Does Expanding Health Insurance in Rural Nigeria Result in Improved Health Outcomes and Poverty Reduction?' (2024) 4 Journal of Global Health Economics and Policy e2024007 <https://doi.org/10.52872/001c.125491> accessed 16 August 2025.

expanding coverage,[37] with rural evidence pointing to affordable premiums, coverage for common illnesses, and transparent management as critical for uptake.[38]

The NHIA Act's success will depend on addressing vulnerable population needs. Muhammad identifies the ageing population as a test case, warning that without tailored benefits, geriatric services, and subsidies for older informal-sector workers, many will remain excluded. Comparative perspectives show Ghana's publicly funded, uniform benefits and reduced out-of-pocket spending[39], while Nigeria's community-based health insurance (CBHI) schemes struggle with low enrolment, trust deficits, and affordability barriers.[40] [41] Recommendations include a phased approach, strengthening infrastructure and workforce before expanding coverage.[42] Rural evidence points to affordable premiums, coverage for common illnesses, and transparent management as critical for uptake.[43]

For Borno State, the 2018 Contributory Healthcare Management Agency Law still references the repealed NHIS Act, replaced by the NHIA Act 2022.[44] [45] Alignment is essential for legal coherence and intergovernmental financing collaboration. State-supported schemes continue to face low enrolment, especially among informal workers, students, and the less educated, with lack of awareness and distrust as major barriers.[46] As PwC (2019) notes, state health insurance can improve outcomes and direct public spending efficiently, but its long-term impact depends on

[37] Okechukwu Ignatius Eze and Ifeoma Felicia Chukwuma, 'Does Expanding Health Insurance in Rural Nigeria Result in Improved Health Outcomes and Poverty Reduction?' (2024) 4 Journal of Global Health Economics and Policy e2024007 <https://doi.org/10.52872/001c.125491> accessed 16 August 2025.
[38] Christiana Ogben and Olayinka Stephen Ilesanmi, 'Community Based Health Insurance Scheme: Preferences of Rural Dwellers of the Federal Capital Territory Abuja, Nigeria' (2018) 9 Journal of Public Health in Africa 540 <https://pmc.ncbi.nlm.nih.gov/articles/PMC6057720/> accessed 20 August 2025.
[39] Isaac A Odeyemi and John Nixon, 'Assessing Equity in Health Care through the National Health Insurance Schemes of Nigeria and Ghana: A Review-Based Comparative Analysis' (2013) 12 International Journal for Equity in Health 1 <https://link.springer.com/articles/10.1186/1475-9276-12-9> accessed 18 November 2021.
[40] Isaac A Odeyemi and John Nixon, 'Assessing Equity in Health Care through the National Health Insurance Schemes of Nigeria and Ghana: A Review-Based Comparative Analysis' (2013) 12 International Journal for Equity in Health 1 <https://link.springer.com/articles/10.1186/1475-9276-12-9> accessed 18 November 2021.
[41] Okechukwu Ignatius Eze and Ifeoma Felicia Chukwuma, 'Does Expanding Health Insurance in Rural Nigeria Result in Improved Health Outcomes and Poverty Reduction?' (2024) 4 Journal of Global Health Economics and Policy e2024007 <https://doi.org/10.52872/001c.125491> accessed 16 August 2025.
[42] Okechukwu Ignatius Eze and Ifeoma Felicia Chukwuma, 'Does Expanding Health Insurance in Rural Nigeria Result in Improved Health Outcomes and Poverty Reduction?' (2024) 4 Journal of Global Health Economics and Policy e2024007 <https://doi.org/10.52872/001c.125491> accessed 16 August 2025.
[43] Christiana Ogben and Olayinka Stephen Ilesanmi, 'Community Based Health Insurance Scheme: Preferences of Rural Dwellers of the Federal Capital Territory Abuja, Nigeria' (2018) 9 Journal of Public Health in Africa 540 <https://pmc.ncbi.nlm.nih.gov/articles/PMC6057720/> accessed 20 August 2025.
[44] National Assembly, National Health Insurance Authority Act, 2022 2022 A625.
[45] 'Nigeria Gets New National Health Insurance Act – PLAC Legist' <https://placng.org/Legist/nigeria-gets-new-national-health-insurance-act/> accessed 20 August 2025.
[46] Fortune Benjamin Effiong and others, 'Coverage and Predictors of Enrollment in the State-Supported Health Insurance Schemes in Nigeria: A Quantitative Multi-Site Study' (2025) 25 BMC Public Health 1 <https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-025-23329-4> accessed 16 August 2025.

operational effectiveness and financial sustainability.[47]

3. Analysis of the Provisions in the Borno State Contributory Healthcare Management Agency (BOSCHMA) Law, 2018

3.1. Institutional Design and Governance

The Borno State Contributory Healthcare Management Agency (BOSCHMA) is formally established under Section 3 of the Law as a body corporate with perpetual succession and a common seal, granting it legal autonomy to sue, be sued, and manage property for its functions.[48] Its internal structure includes departments for Administration and General Services, Planning Research and Statistics, Standard and Quality Assurance Programmes, Legal Unit, and Information and Communication Technology (ICT).

While BOCHMA operates with legal independence, it remains "under the supervision of the Ministry" of Health, introducing potential tensions between operational autonomy and ministerial oversight.[49] The Law also establishes a Governing Board with general control over the Agency, with members appointed by the Governor and approved by the State House of Assembly. The Board's composition is diverse, including representatives from government ministries, organized labor, employers, professional bodies, and the National Health Insurance Scheme (NHIA). This broad stakeholder representation is a strength for inclusivity and legitimacy.[50]However, despite the scheme's focus on vulnerable groups, there is no explicit provision for their direct representation, which may limit responsiveness to grassroots needs. The Board's strategic authority includes approving health plans, determining policies, and regulating the scheme, while the Agency executes operational tasks such as registering third-party administrators, conducting public awareness, and coordinating research.

Although framed as part-time oversight roles, in practice Board appointments in Nigerian schemes are often treated as political patronage. Members receive regular allowances that resemble compensation for political loyalty rather than reimbursement for oversight work. This undermines institutional independence and diverts resources away from service provision.

Governance safeguards include removal provisions for misconduct, financial accountability through annual audits, and mandatory public reporting, aligning with global transparency principles in health governance.[51] Confidentiality clauses protect sensitive health data, reflecting

[47] 'Nigeria Gets New National Health Insurance Act – PLAC Legist' <https://placng.org/Legist/nigeria-gets-new-national-health-insurance-act/> accessed 20 August 2025.
[48] ibid.
[49] Richard B Saltman and Antonio Duran, 'Governance, Government, and the Search for New Provider Models' (2016) 5 International Journal of Health Policy and Management 33 <https://www.ijhpm.com/article_3125.html> accessed 16 August 2025.
[50] Anne Mills, 'Health Care Systems in Low- and Middle-Income Countries' (2014) 370 New England Journal of Medicine 552 <https://www.nejm.org/doi/pdf/10.1056/NEJMra1110897> accessed 16 August 2025.
[51] WHO, 'Community Engagement: A Health Promotion Guide for Universal Health Coverage in the Hands of the

international data protection norms (National Health Insurance Authority.[52]

3.2. Scheme Design and Coverage

The scheme is designed to be inclusive, applying to all residents of Borno State, including formal and informal sector workers, the unemployed, and the self-employed, while excluding those already covered under the NHIA. It operates through three main components:

- Borno State Equity Health Programme (BSEHP), for vulnerable groups;
- Formal Health Programme, for formal sector workers and students;
- Informal Health Programme (IHP), offering affordable care from public and private facilities.

The Law[53] defines "vulnerable" to include pregnant women, children under five years, the aged, the disabled, the poor, and internally displaced persons (IDPs), and establishes the Borno State Health Equity Fund (BSHEF) to subsidize care for these groups. This aligns with pro-equity health financing principles.[54]

The Agency can define benefit packages subject to Board approval, which allows adaptability but could also risk narrowing coverage if fiscal constraints arise. Given Borno's post-conflict context, benefit packages should prioritize maternal-child health, communicable disease control, and mental health services.[55] The right of enrollees to choose healthcare providers is legislated, but real-world choice may be limited by damaged infrastructure, particularly in rural areas.[56]

3.3. Financial Architecture and Sustainability

The Borno State Contributory Health Fund (BSHCF) serves as the sole risk-pooling account for the scheme, with funding from state government grants, formal and informal sector contributions, NHIA transfers, donor funds, investment income, and fines.

The Law allows differential contribution rates for different population groups, but its Schedule specifies flat rates for formal sector salaries. However, labor unions have reported a policy shift to

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People.Geneva: World Health Organization; 2020. Licence: CC BY-NC-SA 3.0 IGO. Cataloguing-in-Publication' [2020] Geneva: World Health Organization 5 <https://www.who.int/publications/i/item/9789240010529> accessed 20 August 2025.

[52] National Assembly, National Health Insurance Authority Act, 2022 2022 A625.

[53] ibid.

[54] Diane McIntyre and others, 'Challenges in Financing Universal Health Coverage in Sub-Saharan Africa' [2018] Oxford Research Encyclopedia of Economics and Finance <https://oxfordre.com/economics/display/10.1093/acrefore/9780190625979.001.0001/acrefore-9780190625979-e-28> accessed 16 August 2025.

[55] 'Nigeria Humanitarian Needs Overview 2024 | OCHA' <https://www.unocha.org/publications/report/nigeria/nigeria-humanitarian-needs-overview-2024> accessed 20 August 2025.

[56] 'Universal Health Coverage Overview' <https://www.worldbank.org/en/topic/universalhealthcoverage> accessed 20 August 2025.

percentage-based contributions (3.5% employee, 6.5% employer), arguing this is more equitable.[57] This discrepancy between the legislative text and operational practice poses a legal ambiguity that could result in jurisdictional disputes or regulatory inconsistencies if not promptly amended. [58] Percentage-based contributions are widely considered more sustainable and equitable in contributory health financing. [5960] Without legislative clarity, contribution collection and compliance could be undermined.

The Borno State Health Equity Fund (BSHEF) is a dedicated risk-pooling account for vulnerable groups, with administrative charges permissible for scheme objectives, subject to Board approval. Unused funds must be invested in Central Bank of Nigeria Treasury instruments, ensuring financial prudence, while the Law prohibits the use of these funds for any purpose not expressly stated, safeguarding against misuse. Fund management must conform with "international best practice" and aim to "pool and equalize risk," aligning with World Health Organization (2010) recommendations for sustainable health financing.[61]

The Law defines "Provider Payment Mechanism" as direct payments from the Agency to Third-Party Administrators (TPAs) and healthcare providers for services. The Agency is authorized to regulate capitation, fee-for-service, per-diem, or other payment models, subject to Board approval. This flexibility allows for adaptation to various service delivery contexts and for incentivizing quality and efficiency in care provision.[62] Long-term financial viability will depend on consistent state government allocations, the economic capacity of the informal sector to contribute, and sustained federal funding flows from mechanisms such as the Basic Healthcare Provision Fund (National Health Insurance Authority, 2022). Given the high prevalence of vulnerable groups and overall low-income environment, the scheme's risk pooling and equalization capacity will face considerable stress. [63] Needless to add that, practical experience in Nigeria shows that contributory health funds are at risk of political capture. Politicians have, at times, redirected pooled funds towards personal or patronage purposes, while administrative overheads, including generous board

[57] 'Borno Putting Final Touches on 3.5% Deductions for Health Insurance Scheme - The Nation Newspaper' <https://thenationonlineng.net/borno-putting-final-touches-on-3-5-deductions-for-health-insurance-scheme/> accessed 20 August 2025.
[58] Adeyinka Adeniran and others, 'Determinants of Health Insurance Adoption among Residents of Lagos, Nigeria: A Cross-Sectional Survey' (2024) 5 Open Health <https://www.degruyterbrill.com/document/doi/10.1515/ohe-2023-0043/html> accessed 16 August 2025.
[59] Guy Carrin and Chris James, 'Social Health Insurance: Key Factors Affecting the Transition towards Universal Coverage' (2005) 58 Int Soc Secur Rev 45.
[60] 'The World Health Report: Health Systems Financing: The Path to Universal Coverage' <https://iris.who.int/handle/10665/44371> accessed 20 August 2025.
[61] 'The World Health Report: Health Systems Financing: The Path to Universal Coverage' <https://iris.who.int/handle/10665/44371> accessed 16 August 2025.
[62] 'Aligning Public Financial Management and Health Financing: A Process Guide for Identifying Issues and Fostering Dialogue' <https://www.who.int/publications/i/item/9789241513074> accessed 20 August 2025.
[63] Diane McIntyre and others, 'Challenges in Financing Universal Health Coverage in Sub-Saharan Africa' [2018] Oxford Research Encyclopedia of Economics and Finance <https://oxfordre.com/economics/display/10.1093/acrefore/9780190625979.001.0001/acrefore-9780190625979-e-28> accessed 16 August 2025.

allowances, consume disproportionate resources. This distorts the principle of risk pooling, whereby contributions intended for collective healthcare protection are diverted to serve narrow stakeholder interests.

To address these risks, statutory safeguards are essential. Administrative costs should be capped by law, with transparent audits and mandatory public disclosure. Board compensation must be limited to sitting allowances rather than regular stipends, while independent oversight bodies and civil society should monitor fund disbursement. By ring-fencing the Health Equity Fund and linking board incentives to measurable performance indicators, contributory health schemes can reduce political capture, restore the integrity of risk pooling, and rebuild public trust

3.4. Regulatory Oversight and Quality Assurance

The Agency is mandated to regulate and issue guidelines for registering employers, employees, and their dependents who are liable to contribute under the Law.[64] All employers, public and private, must obtain a Corporate Identification Number (CIN). This mandatory registration is vital for formalizing the scheme and ensuring compliance, though enforcement in small private enterprises and among mobile populations presents significant challenges.

A robust regulatory framework governs the accreditation and monitoring of healthcare providers and TPAs. Providers must be either public or private facilities registered with the Agency. Contributory health organizations must demonstrate financial viability, strong provider relationships, and sound accounting practices. TPA registration is time-limited and renewable, with the Agency empowered to refuse or withdraw registration for non-compliance, insolvency, or false declarations. Notably, TPAs are prohibited from delivering healthcare services directly or collecting funds, except in private or voluntary plans, a measure that promotes transparency and prevents conflicts of interest.[65]

On quality assurance, the Law requires providers to adhere to the approved Benefit Package and Treatment Guidelines, and mandates that practitioners be accredited by their respective professional regulatory bodies. While this establishes a baseline framework, specific metrics and operational mechanisms are not detailed. In Borno's post-conflict context, effective quality assurance will require the development of measurable performance indicators, patient satisfaction tracking, and regular audits.[66]

The Law also emphasizes health data governance. The Agency must collect, analyze, and report TPA data, and exchange information with the NHIA, State Health Management Information

[64] ibid.
[65] National Assembly, National Health Insurance Authority Act, 2022 2022 A625.
[66] WHO, 'Community Engagement: A Health Promotion Guide for Universal Health Coverage in the Hands of the People.Geneva: World Health Organization; 2020. Licence: CC BY-NC-SA 3.0 IGO. Cataloguing-in-Publication' [2020] Geneva: World Health Organization 5 <https://www.who.int/publications/i/item/9789240010529> accessed 20 August 2025.

System, and other bodies. The establishment of a State Data Bank is particularly significant, though success will depend on clear guidelines for data sharing, anonymization, and security to maintain public trust.[67] Table 1 highlights the key provisions and objectives of the Law (2018), while Table 2 shows the roles and responsibilities of key stakeholders under the BOSCHMA Law, 2018.

Table 1: Key Provisions and Objectives of the BOSCHMA Law, 2018

Section No.	Provision/Topic	Brief Description	Key Objective/Function
3	Establishment of the Agency (BOCHMA)	Establishes BOCHMA as a body corporate with perpetual succession and a common seal, under Ministry supervision.	Promote, regulate, supervise, and ensure effective administration of the scheme.
4	Establishment of the Board	Establishes the Governing Board with general control over the Agency.	Strategic oversight and policy determination for the scheme.
5	Appointment of Chairman and Members of the Board	Governor appoints Chairman and members (representatives from ministries, labor, employers, professional bodies).	Ensure broad stakeholder representation and expertise in governance.
7	Components of the Scheme	Defines the Borno State Contributory Healthcare Scheme (BSCHS) components: Equity, Formal, and Informal Health Programmes.	Achieve broad UHC coverage for all residents, including vulnerable groups.
7(2)	Objectives of the Scheme	Ensures access to quality, affordable healthcare; protects families from financial hardship; limits cost inflation; ensures equitable cost	Provide comprehensive health coverage and financial protection.

[67] Daniel R Hogan and others, 'Monitoring Universal Health Coverage within the Sustainable Development Goals: Development and Baseline Data for an Index of Essential Health Services' (2018) 6 The Lancet Global Health e152 <https://www.thelancet.com/action/showFullText?pii=S2214109X17304722> accessed 16 August 2025.

		distribution.	
13	Powers of the Board	Determines organizational structure, approves health plans, sets policies, regulates scheme, approves TPAs, issues fund guidelines.	Strategic control and policy-making for the scheme.
14	Functions of the Agency	Ensures policy implementation, issues regulations, manages scheme, registers TPAs, conducts public awareness, coordinates research, establishes quality assurance, defines benefit packages.	Operational management and day-to-day administration of the scheme.
15	Powers of the Agency	Regulates and issues guidelines for registration, compulsory contributions, record maintenance, fee negotiation, payment options, and assessment.	Operational regulation and enforcement of scheme rules.
16	Applicability of NHIS Act	States that provisions of the NHIS Act (1999) are applicable to this Law.	Legal alignment with federal health insurance framework (now outdated).
22	Establishment and Management of Borno State Healthcare Fund	Establishes BSHCF as the sole risk-pooling account for all funds.	Centralize and manage funds for the contributory scheme.
23	Disbursement of the Fund	Agency applies proceeds for scheme objectives, administration, remuneration, and property maintenance; invests unrequired money in CBN Treasury Laws.	Ensure prudent financial management and proper fund utilization.
24	Annual estimate	Board prepares annual estimates	Ensure financial

	Account and Audit	and ensures proper accounts, audited by State Auditor-General's appointees.	transparency and accountability.
25	Annual Report	Agency submits annual report with audited accounts to Governor, publicly presented and published on state website.	Ensure public accountability and transparency of operations.
28	Registration of Borno State residents Employers and Employees	All employers (public and private) must register and obtain Corporate Identification Number (CIN). Enrollees choose healthcare facilities.	Formalize participation and ensure patient choice.
29	Registration and services of healthcare providers	Providers participate per Agency guidelines; provide services per approved Benefit Package and Treatment guidelines.	Regulate provider participation and ensure quality of services.
30	Registration of TPAS	Recognizes existing TPAs, mandates their registration and monitoring by Agency; sets stringent registration requirements.	Regulate and monitor Third Party Administrators.
33	Functions of TPAS	TPAs render returns, engage approved providers, collect contributions, establish quality assurance, and are prohibited from direct service delivery/fund collection (except private plans).	Define TPA roles and prevent conflicts of interest.
37	Functions of the Borno State Contributory Healthcare Agency Arbitration Panel	Establishes a tiered dispute resolution mechanism (mediation, then arbitration).	Provide a framework for resolving disputes efficiently.

41	Limitations of Suits Against the Agency	Sets time limits for commencing suits against the Agency and its officers, and requires prior written notice.	Protect the Agency and its officers from frivolous lawsuits.
45	Indemnity of Officers	Officers acting lawfully are indemnified from Agency assets against civil proceedings.	Protect officers from personal liability in the course of duty.
46	Confidentiality and Non-disclosure	Officers must not use information for personal gain, treat it as confidential, and not disclose it except as required.	Protect sensitive information and maintain privacy.
50	Professional indemnity for healthcare providers	Provides for professional indemnity for healthcare providers.	Incentivize provider participation and mitigate professional risks.
53	Offences and penalties	Outlines various offenses and corresponding penalties (fines, imprisonment, delisting).	Enforce compliance and deter fraudulent activities.
Schedule	Contribution Table	Lists flat rates for contributions across different salary grades and positions.	Specifies contribution amounts for formal sector employees. [1]

Stake-holder	Agency (BOCHMA)	Governing Board	Executive Secretary	Commissioner (of Health)	Third Party Administrators (TPAs)	Healthcare Providers	Employers (Public & Private)	Employees	Local Government Focal Persons
Key Res	Ensure effective	General control	- Head of the	Recommends	Render returns to	- Participa	- Register with the	Pay compul	- Coordin

	implementation of policies and procedures [1, Sec 14(1)(a)] Manage the healthcare scheme [1, Sec 14(1)(c)] Register TPAs and approve contracts [1, Sec 14(1)(d), (e)] Conduct public awareness and education [1, Sec 14(1)(f)] Establish	of the Agency Determine organizational structure of the Agency [1, Sec 13(1)(a)] Approve all paid programs and health plans of HMOs [1, Sec 13(1)(b)] Determine overall policies, financial and operative procedures [1, Sec 13(1)(c)] - Regulate and	Board [1, Sec 5(3)(xii)] Accounting officer of the Agency, responsible to the Board [1, Sec 18(2)(b)] - Responsible for day-to-day administration and general control of employees [1, Sec 18(3)]	Board members for Governor's approval [1, Sec 5(3)]	the Agency [1, Sec 33(1)(a)] Engage only approved healthcare providers [1, Sec 33(1)(b)] Collect contributions from prepaid health plans and remit 1% to Agency [1, Sec 33(1)(c)] Establish a quality assurance system [1, Sec 33(1)(d)] Prohibited from direct healthcare service delivery or fund collection (except private/voluntary plans)	te under scheme guidelines [1, Sec 29(1)] Provide services in accordance with approved Benefit Package and Treatment guidelines [1, Sec 29(2)] - Must be accredited and registered with relevant professional regulatory body 1	Agency and obtain Corporate Identification Number (CIN) [1, Sec 28(2)] - Deduct approved contributions from employee wages and remit to concerned organization/association [1, Sec 27(3)]	sory contributions [1,Sec 15(1)(c), (d)]	ate and collaborate with the Agency

	quality assurance for all stakeholders [1, Sec 14(2)(a)] Collect, analyze, and report TPA returns [1, Sec 14(2)(b)] Maintain a State Data Bank [1, Sec 14(2)(g)] Define benefit packages (with Board approval) [1, Sec 14(2)(h)] Determine cross-	supervise the scheme [1, Sec 13(1)(e)] Establish standards, rules, and guidelines [1, Sec 13(1)(f)] Approve TPAs and their terms of engagement [1, Sec 13(1)(g)] Approve annual report and statement of accounts [1, Sec 13(2)(e)] Develop policy to identify the poor			[1, Sec 33(3)]				

	subsidy percentage for vulnerable groups [1, Sec 14(2)(i)] Regulate registration of employers, employees, contributions, records, fees, payment options	and vulnerable [1, Sec 13(2)(c)]							

Table 2: Roles and Responsibilities of Key Stakeholders under the BSCHMA Law, 2018

3.5. Legal Provisions, Enforcement, and Dispute Resolution

Section 16 of the BOSCHMA Law, 2018 explicitly states: "The provisions of this NHIS Act (and issues that are not covered by this Law) are applicable to this Law and all the regulations made hereunder". This clause refers to the "NHIS Act 1999" as defined in Section 2 of the Borno Law.[68] However, a critical legal lacuna arises because the National Health Insurance Authority Act, 2022.[69] [70]

The Law establishes a tiered dispute resolution mechanism in which disputes must first be referred to a Mediation Committee and, if unresolved, to an Arbitration Panel. The parties mutually appoint a "three-man panel of arbitrators," governed by the Arbitration and Conciliation Law, Laws of Borno State. This embedded alternative dispute resolution (ADR) framework is consistent with

[68] ibid.
[69] National Assembly, National Health Insurance Authority Act, 2022 2022 A625.

best practices in health sector governance, offering a faster and less adversarial process than traditional litigation (Omale, 2020).

As shown in Table 3 (Summary of Offenses and Penalties under Section 53 of the Law), State Law outlines a wide range of offenses, including fraud, misappropriation of funds, and unauthorized disclosure of health information, together with corresponding penalties. The inclusion of clear sanctions reflects strong legislative intent to enforce compliance, protect scheme integrity, and deter abuse.[71]

The detailed and significant penalties embedded in the Law[72] underscore a strong legislative commitment to enforcing compliance and deterring fraudulent activities. Notably, the provision for delisting Third-Party Administrators (TPAs) for repeated withholding of payments serves as a powerful deterrent against financial impropriety, directly protecting healthcare providers and reinforcing trust in the scheme.

The Law provides legal protection for the BOSCHMA and its officers, including limits on the timeframe for initiating suits, three months from the act in question, or six months for continuing damage, and a requirement for one month's prior written notice. While such provisions guard against frivolous litigation, incorporating Alternative Dispute Resolution (ADR) methods like mediation and arbitration could further ease dispute resolution, offer faster, cost-effective, and confidential settlements while preserving stakeholder relationships.[73]

Furthermore, officers acting lawfully are indemnified from Agency assets against civil proceedings, ensuring that staff can carry out their duties without fear of personal financial liability. The Law[74] also mandates "professional indemnity for healthcare providers," a critical incentive that mitigates providers' professional risks and encourages their active participation.[75]Robust confidentiality and non-disclosure provisions prohibit officers from using privileged information for personal gain, require them to treat such information as confidential, and restrict disclosure except under specific, legally defined circumstances. These safeguards are consistent with international best practices for protecting patient data and maintaining trust in publicly funded health insurance schemes.[76] Table 3 shows a summary of offenses and penalties (BOSCHMA Law, 2018 vs. BOSCHMA Bill, 2025)

[71] 'The World Health Report: Health Systems Financing: The Path to Universal Coverage' <https://iris.who.int/handle/10665/44371> accessed 20 August 2025.
[72] ibid.
[73] Ayomikun Akinola-Fowotade, '<p>Application of Alternative Dispute Resolution Mechanisms</P>' [2024] SSRN Electronic Journal <https://papers.ssrn.com/abstract=5366180> accessed 20 August 2025.
[74] ibid.
[75] 'The World Health Report: Health Systems Financing: The Path to Universal Coverage' <https://iris.who.int/handle/10665/44371> accessed 16 August 2025.
[76] Abba Elgujja and Augustine Arimoro, 'A Review of the Patients' Right of Confidentiality under the Saudi Arabian Laws' <https://www.preprints.org/manuscript/201908.0231/v1> accessed 24 August 2019.

Table 3: Summary of Offenses and Penalties (BOSCHMA Law, 2018 vs. BOSCHMA Bill, 2025)

Offense Description	BOSCHMA Law, 2018 (Section 53 Penalty) [1]	BOSCHMA Bill, 2025 (Section 60 Penalty) [1]	Analysis of Change
Producing false registration certificate	Max 12 months imprisonment or N250,000 fine + cost of treatment [[1], Section 53(1)]	Max 12 months imprisonment or N250,000 fine + cost of treatment [[1], Section 60(1)]	Consistent. Maintains severity of penalty.
Conniving to receive/give cash (person/org)	Max 12 months imprisonment and N500,000 fine (person/org) [[1], Section 53(2)(a)]	Max 12 months imprisonment and N500,000 fine (person/org) [[1], Section 60(2)(a)]	Consistent. Maintains severity of penalty.
Conniving to give cash (healthcare practitioner)	Max 12 months imprisonment and/or N500,000 fine [[1], Section 53(2)(b)]	Max 12 months imprisonment and/or N500,000 fine [[1], Section 60(2)(b)]	Consistent. Maintains severity of penalty.
Conniving to give cash (healthcare organization)	N2,000,000 fine [[1], Section 53(2)(c)]	N2,000,000 fine [[1], Section 60(2)(c)]	Consistent. Maintains severity of penalty.
Failure to comply with auditor's requirement	Fine not exceeding N100,000 or max 3 months imprisonment or both [[1], Section 53(3)]	Fine not exceeding N100,000 or max 3 months imprisonment or both [[1], Section 60(3)]	Consistent. Maintains severity of penalty.
Failure to pay/remit contributions	First offender: Fine not less than N2,000,000 or max 2 years imprisonment or both [[1], Section	First offender: Fine not less than N2,000,000 or max 2 years imprisonment or both [[1], Section	Consistent. Maintains severity of penalty.

	53(4)]	60(4)]	
Failure to comply with TPA functions (healthcare practitioner)	Disengagement from scheme without claim/entitlement [1, Section 53(5)]	Disengagement from scheme without claim/entitlement [1, Section 60(5)]	Consistent. Maintains severity of penalty.
Confidentiality contravention (Section 45(1))	Fine not less than N150,000 or max 2 years imprisonment or both [1, Section 53(6)]	Fine not less than N150,000 or max 2 years imprisonment or both [1, Section 60(6)]	Consistent. Maintains severity of penalty.
TPA failure to pay facility	Pay sum; fine not less than twice amount withheld; delist for repeated offense [1, Section 53(7)]	Pay sum; fine not less than twice amount withheld; delist for repeated offense [1, Section 60(7)]	Consistent. Maintains severity of penalty.

4. Strengths and Innovations of the BOSCHMA Law, 2018

The BOSCHMA Law, 2018 demonstrates several significant strengths that position it as a potentially transformative health policy intervention. Its ambitious scope, aiming for Universal Health Coverage (UHC) for "all residents," including the self-employed and unemployed, is highly commendable and aligns with global UHC aspirations.[77] A particularly innovative aspect is the explicit recognition and establishment of a dedicated fund, the Borno State Health Equity Fund (BSHEF), for vulnerable groups, including "pregnant women, children under five years, the aged, the disabled, the poor and Internally Displaced Persons (IDPs)."

This proactive stance on UHC in a post-conflict setting, combined with its explicit focus on vulnerable populations, positions Borno State as a potential model for other fragile and conflict-affected contexts.[78] [79] [80] It demonstrates a profound commitment to rebuilding and social

[77] 'The World Health Report: Health Systems Financing: The Path to Universal Coverage' <https://iris.who.int/handle/10665/44371> accessed 16 August 2025.
[78] Olga Bornemisza and others, 'Promoting Health Equity in Conflict-Affected Fragile States' (2010) 70 Social Science & Medicine 80 <https://www.sciencedirect.com/science/article/abs/pii/S0277953609006236?via%3Dihub> accessed 16 August 2025.
[79] Olga Bornemisza and others, 'Promoting Health Equity in Conflict-Affected Fragile States' (2010) 70 Social Science & Medicine 80 <https://www.sciencedirect.com/science/article/abs/pii/S0277953609006236?via%3Dihub> accessed 16 August 2025.
[80] Zlatko Nikoloski, Mubarik M Mohamoud and Elias Mossialos, 'Universal Health Coverage in Fragile and

protection that extends beyond immediate humanitarian relief, aiming instead for sustainable health equity.[81]

The Law also establishes a strong legal framework, clearly delineating institutional structures for the BOSCHMA and its Governing Board, outlining their respective powers and functions, and detailing robust enforcement mechanisms. The inclusion of diverse stakeholders on the Board, including labor unions, employers, and professional bodies, promotes inclusivity and broad-based buy-in, which is essential for the scheme's legitimacy.[82]

Furthermore, the provisions for financial transparency and accountability, through requirements for annual expenditure estimates, audited accounts, and publicly accessible reports, are crucial for building and maintaining public trust in the management of public funds. The adaptability in provider payment mechanisms and the prohibition on TPAs from direct service delivery are also notable strengths, promoting efficiency and preventing conflicts of interest.[83]

The scheme's inclusion of private healthcare providers expands patient choice and enhances service accessibility, potentially driving improvements in healthcare quality as providers upgrade facilities to meet accreditation standards.[84] The engagement of Health Maintenance Organizations (HMOs) for service monitoring can reinforce ethical conduct and accountability. Additionally, the government's commitment to funding coverage for vulnerable groups exemplifies social responsibility and equity-oriented governance.[85]

5. Challenges, Gaps, and Recommendations for Policy Refinement

Despite its strengths, the BOSCHMA Law, 2018 exhibits certain weaknesses and gaps that could impede optimal implementation.

5.1 Legal Alignment

The most critical legal challenge is the outdated reference to the NHIS Act 1999 in Section 16.

Conflict-Affected States: Insights from Somalia' (2025) 24 International Journal for Equity in Health 1 <https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-025-02486-3> accessed 20 August 2025.

[81] Olga Bornemisza and others, 'Promoting Health Equity in Conflict-Affected Fragile States' (2010) 70 Social Science & Medicine 80 <https://www.sciencedirect.com/science/article/abs/pii/S0277953609006236?via%3Dihub> accessed 16 August 2025.

[82] Christian Ngozi Okolo and others, 'The Challenges of Establishing Universal Health Coverage in Enugu State, South East Nigeria' (2019) 9 Developing Country Studies 49 <https://www.iiste.org/Journals/index.php/DCS/article/view/47579> accessed 4 December 2021.

[83] Bolaji S Aregbeshola, 'A Tax-Based, Noncontributory, Health-Financing System Can Accelerate Progress toward Universal Health Coverage in Nigeria' (2018) 20 MEDICC Review 40 <https://pubmed.ncbi.nlm.nih.gov/31242171/> accessed 16 August 2025.

[84] Christian Ngozi Okolo and others, 'The Challenges of Establishing Universal Health Coverage in Enugu State, South East Nigeria' (2019) 9 Developing Country Studies 49 <https://www.iiste.org/Journals/index.php/DCS/article/view/47579> accessed 4 December 2021.

[85] 'The World Health Report: Health Systems Financing: The Path to Universal Coverage' <https://iris.who.int/handle/10665/44371> accessed 20 August 2025.

This federal law has been superseded by the National Health Insurance Authority Act, 2022.[86]

5.2 Operational Clarity

The ambiguity surrounding the definition of "vulnerable… as defined by the Board" could result in inconsistent or non-transparent identification of eligible beneficiaries for the Health Equity Fund.[87] Similarly, the lack of legislatively guaranteed benefit packages leaves service scope entirely at the discretion of the Agency and Board, potentially resulting in minimal coverage that may not meet comprehensive health needs.[88] The frequent requirement for "Board approval" for operational functions could also create bureaucratic delays. [89]

5.3 Enforcement Capacity

While the Law contains comprehensive offenses and penalties, its effectiveness will depend on the judicial system's ability to enforce provisions efficiently and fairly, particularly in a post-conflict environment with weakened rule of law and judicial infrastructure.[90]

5.4 Public Engagement and Trust

In a conflict-affected region with weakened trust in institutions, public skepticism is a major challenge. Studies indicate that informal sector workers often distrust health insurance administration and government, doubting the security of pooled funds[91] This highlights the need for transparent communication, consistent service delivery, and robust public awareness campaigns.[92]

5.5 Financial Sustainability

Securing consistent funding, particularly from the informal sector, remains a significant hurdle.[93]

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[86] National Assembly, National Health Insurance Authority Act, 2022 2022 A625.
[87] Olga Bornemisza and others, 'Promoting Health Equity in Conflict-Affected Fragile States' (2010) 70 Social Science & Medicine 80 <https://www.sciencedirect.com/science/article/abs/pii/S0277953609006236?via%3Dihub> accessed 16 August 2025.
[88] Christian Ngozi Okolo and others, 'The Challenges of Establishing Universal Health Coverage in Enugu State, South East Nigeria' (2019) 9 Developing Country Studies 49 <https://www.iiste.org/Journals/index.php/DCS/article/view/47579> accessed 4 December 2021.
[89] Diane McIntyre and others, 'Challenges in Financing Universal Health Coverage in Sub-Saharan Africa' [2018] Oxford Research Encyclopedia of Economics and Finance <https://oxfordre.com/economics/display/10.1093/acrefore/9780190625979.001.0001/acrefore-9780190625979-e-28> accessed 16 August 2025.
[90] 'Universal Health Coverage Overview' <https://www.worldbank.org/en/topic/universalhealthcoverage> accessed 20 August 2025.
[91] Fortune Benjamin Effiong and others, 'Coverage and Predictors of Enrollment in the State-Supported Health Insurance Schemes in Nigeria: A Quantitative Multi-Site Study' (2025) 25 BMC Public Health 1 <https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-025-23329-4> accessed 16 August 2025.
[92] 'Global Monitoring Report on Financial Protection in Health 2021' <https://www.who.int/publications/i/item/9789240040953> accessed 20 August 2025.
[93] Diane McIntyre and others, 'Challenges in Financing Universal Health Coverage in Sub-Saharan Africa' [2018]

The inconsistency between the Law's flat-rate contributions and the reported operational shift to percentage-based contributions for civil servants[94] requires formal legal correction to ensure fairness and certainty. Covering non-contributing vulnerable groups depends heavily on a well-functioning cross-subsidy mechanism for the BSHEF.[95] [96]

Beyond the legal ambiguities, financial sustainability is undermined by governance realities: excessive administrative costs, politically inflated allowances, and leakage of funds intended for service delivery. These dynamics weaken public trust and reduce enrolment, since contributors perceive that their pooled resources benefit elites rather than protecting households against health shocks.

A viable solution is to strengthen governance and accountability mechanisms by legislating a strict ceiling on administrative costs, ensuring that the majority of pooled funds are dedicated to service delivery. Independent audits, with findings publicly disclosed, should be mandated to curb fund leakage and enhance transparency. Furthermore, adopting digital financial tracking systems and citizen-led oversight platforms can reduce opportunities for diversion while rebuilding confidence. By linking administrative expenditure and board allowances to performance indicators, such as enrolment growth, service quality, and equity outcomes, the scheme can realign incentives, restore public trust, and encourage broader participation in contributory health insurance.

5.6 Infrastructure and Human Resources

Borno's prolonged insurgency has damaged health infrastructure, worsened healthcare workforce shortages, and created access gaps in rural and insecure areas.[97] Strategic investments in rebuilding facilities, training and retaining healthcare personnel, and incentivizing rural postings are essential.

5.7. Broader Challenges in Nigerian Health Insurance

The NHIS was designed to expand access to quality healthcare but has faced adoption barriers due to the concurrent legislative list, unclear state roles, lack of cooperation between professional

Oxford Research Encyclopedia of Economics and Finance <https://oxfordre.com/economics/display/10.1093/acrefore/9780190625979.001.0001/acrefore-9780190625979-e-28> accessed 16 August 2025.

[94] 'Borno Putting Final Touches on 3.5% Deductions for Health Insurance Scheme - The Nation Newspaper' <https://thenationonlineng.net/borno-putting-final-touches-on-3-5-deductions-for-health-insurance-scheme/> accessed 20 August 2025.

[95] Di McIntyre and others, 'Promoting Universal Financial Protection: Evidence from Seven Low- and Middle-Income Countries on Factors Facilitating or Hindering Progress' (2013) 11 Health Research Policy and Systems.

[96] James Akazili, John Gyapong and Diane McIntyre, 'Who Pays for Health Care in Ghana?' (2011) 10 International Journal of Equity in Health 26.

[97] Christian Ngozi Okolo and others, 'The Challenges of Establishing Universal Health Coverage in Enugu State, South East Nigeria' (2019) 9 Developing Country Studies 49 <https://www.iiste.org/Journals/index.php/DCS/article/view/47579> accessed 4 December 2021.

bodies such as the NMA and PSN, low awareness, and high poverty levels. [98] [99] It has been criticized as elitist, largely benefiting federal workers while excluding many others, and fraud remains a challenge across the healthcare system.[100]

The NHIS, as conceived, was meant to bridge an existing gap and widen opportunities for access to qualitative healthcare, but it has faced numerous challenges. Healthcare is on the concurrent legislative list, meaning states are not compelled to embrace the NHIS, leading to only a few states adopting the scheme due to concerns about unclear state roles. Past government antecedents have also militated against the program, leading to a lack of acceptability among Nigerians and widespread lack of awareness.

Lack of cooperation between various professional bodies of health providers, such as the Nigerian Medical Association (NMA) and the Pharmaceutical Society of Nigeria (PSN), has also been a challenge. Perhaps the greatest challenge of all is the level of poverty among the majority of the populace. The NHIS, as currently established, has been criticized as elitist, primarily benefiting federal government workers, while state, local government, and private sector workers (both formal and informal) are not benefiting. Fraud is also prevalent in all tiers of the healthcare delivery system, requiring strong corporate governance.

6. Comparative & Research Insights

Nigeria's health insurance penetration remains low despite over two decades of NHIS/NHIA operations. As of 2024, NHIA coverage is under 10% nationally, with stark inter-state disparities, Lagos, Delta, and the Federal Capital Territory report higher coverage due to stronger fiscal capacity and private-sector participation, while poorer and conflict-affected states such as Borno, Yobe, and Zamfara record coverage below 3%.[101] These disparities reflect fiscal constraints, governance variations, infrastructure gaps, and differences in enrollee trust.[102]

The informal sector, comprising more than 65% of Nigeria's workforce, remains the most significant coverage gap. Evidence from low- and middle-income countries (LMICs) shows that voluntary contributions from informal workers rarely sustain schemes without substantial

[98] Christian Ngozi Okolo and others, 'The Challenges of Establishing Universal Health Coverage in Enugu State, South East Nigeria' (2019) 9 Developing Country Studies 49 <https://www.iiste.org/Journals/index.php/DCS/article/view/47579> accessed 4 December 2021.

[99] 'Universal Health Coverage Overview' <https://www.worldbank.org/en/topic/universalhealthcoverage> accessed 20 August 2025.

[100] Isaac A Odeyemi and John Nixon, 'Assessing Equity in Health Care through the National Health Insurance Schemes of Nigeria and Ghana: A Review-Based Comparative Analysis' (2013) 12 International Journal for Equity in Health 1 <https://equityhealthj.biomedcentral.com/articles/10.1186/1475-9276-12-9> accessed 20 August 2025.

[101] Federal Ministry of Health & Social Welfare, 'State of the Health of the Nation Report' <https://fmohconnect.gov.ng/wp-content/uploads/2025/05/The-State-of-Health-of-the-Nation-Report-2024.pdf> accessed 20 August 2025.

[102] Oshokha Ilegogie, 'Mandatory Health Insurance and Its Impact on Access to Healthcare in Nigeria: A Review of the National Health Insurance Act (NHIA)' (21 July 2024) <https://papers.ssrn.com/abstract=4910491> accessed 20 August 2025.

subsidies or mandatory enrolment.[103] [104] In Nigeria, voluntary uptake is hindered by irregular incomes, low awareness, mistrust of government programmes, and lack of perceived value in benefit packages.[105]

6.1. International Reference: Rwanda's *Mutuelles de Santé*

Rwanda's community-based health insurance model, *Mutuelles de Santé*, is often cited as a sub-Saharan African success story. By implementing sliding-scale premiums based on income categories, integrating donor and government subsidies for the poorest, and embedding compulsory enrolment at community level, Rwanda achieved coverage rates exceeding 90% by 2010.[106] [107]

However, sustainability challenges remain, and an example is the heavy dependence on external donor funding, up to 50% in some years.[108] Another challenges is service quality pressures as utilization grows faster than capacity.[109]

.Similarly, delays in provider reimbursements can reduce provider trust.[110]

These issues highlight the need for balanced expansion, growing enrolment while protecting funding stability and service quality.

6.2. Lessons for Borno State

- Subsidy Mechanisms: Like Rwanda, Borno could adopt graduated contribution rates supplemented by targeted subsidies from its Health Equity Fund for internally displaced persons (IDPs), subsistence farmers, and the urban poor. [111]

  Community Gatekeeping: Leveraging traditional leaders, ward development committees,

[103] Adam Wagstaff and Sven Neelsen, 'A Comprehensive Assessment of Universal Health Coverage in 111 Countries: A Retrospective Observational Study' (2020) 8 The Lancet Global Health e39 <https://www.thelancet.com/action/showFullText?pii=S2214109X19304632> accessed 16 August 2025.
[104] 'Global Monitoring Report on Financial Protection in Health 2021' <https://www.who.int/publications/i/item/9789240040953> accessed 20 August 2025.
[105] Adeyinka Adeniran and others, 'Determinants of Health Insurance Adoption among Residents of Lagos, Nigeria: A Cross-Sectional Survey' (2024) 5 Open Health <https://www.degruyterbrill.com/document/doi/10.1515/ohe-2023-0043/html> accessed 16 August 2025.
[106] Médard Nyandekwe, Manassé Nzayirambaho and Jean Baptiste Kakoma, 'Universal Health Coverage in Rwanda: Dream or Reality' (2014) 17 PAMJ. 2014; 17:232 <https://www.panafrican-med-journal.com//content/article/17/232/full> accessed 16 August 2025.
[107] Benjamin Chemouni, 'The Political Path to Universal Health Coverage: Power, Ideas and Community-Based Health Insurance in Rwanda' (2018) 106 World Development 87 <https://www.sciencedirect.com/science/article/pii/S0305750X18300330?via%3Dihub> accessed 16 August 2025.
[108] Benjamin Chemouni, 'The Political Path to Universal Health Coverage: Power, Ideas and Community-Based Health Insurance in Rwanda' (2018) 106 World Development 87 <https://www.sciencedirect.com/science/article/pii/S0305750X18300330?via%3Dihub> accessed 16 August 2025.
[109] Médard Nyandekwe, Manassé Nzayirambaho and Jean Baptiste Kakoma, 'Universal Health Coverage in Rwanda: Dream or Reality' (2014) 17 PAMJ. 2014; 17:232 <https://www.panafrican-med-journal.com//content/article/17/232/full> accessed 16 August 2025.
[110] 'Global Monitoring Report on Financial Protection in Health 2021' <https://www.who.int/publications/i/item/9789240040953> accessed 20 August 2025.
[111] 'Global Monitoring Report on Financial Protection in Health 2021' <https://www.who.int/publications/i/item/9789240040953> accessed 20 August 2025.

and local NGOs for enrolment drives can improve uptake and compliance.[112]

- Donor Integration: Harmonizing humanitarian health financing with the contributory scheme can extend coverage to displaced populations without duplicating costs.[113]

In summary, Borno's contributory scheme could draw on Rwanda's success in mass enrolment, Nigeria's own inter-state fiscal lessons, and digital integration trends across African health systems, while building a sustainable, conflict-sensitive financing model that recognizes the limits of voluntary informal sector contributions.

7. BOSCHMA Law 2018 Amendments:

7.1. BOSCHMA Amendment Law (2022)[114]

The 2022 amendment to the Borno State Contributory Healthcare Management Agency (BOSCHMA) Law marks an important step forward by resolving the inconsistency between flat-rate and percentage-based contributions for public service employees, aligning the scheme more closely with contributory financing practices. This technical correction strengthens the scheme's financial framework and demonstrates a willingness to reform.

Yet, critical legal and operational gaps remain unaddressed. The law continues to reference an outdated federal health act and lacks explicit criteria for defining "the poor" and "Internally Displaced Persons." These omissions create ambiguity in targeting subsidies and undermine the equity goals at the heart of contributory health insurance. My earlier review concluded that these weaknesses were significant, and the amendment leaves those concerns unchanged.

New national evidence underscores why these gaps cannot be ignored.[115] show that state-supported health insurance schemes across Nigeria suffer from persistently low enrolment, particularly among informal workers, students, and those with lower education. Barriers such as limited awareness, financial constraints, and dissatisfaction with scheme performance mirror the challenges likely to arise if BOSCHMA fails to clearly define and protect its most vulnerable groups. Without legal clarity and targeted safeguards, Borno risks replicating the same shortcomings seen in other states.

Taken together, these findings suggest that while the BOSCHMA amendment provides needed technical improvements, deeper reforms are required. Clear legal definitions, stronger equity

[112] Médard Nyandekwe, Manassé Nzayirambaho and Jean Baptiste Kakoma, 'Universal Health Coverage in Rwanda: Dream or Reality' (2014) 17 PAMJ. 2014; 17:232 <https://www.panafrican-med-journal.com//content/article/17/232/full> accessed 16 August 2025.
[113] 'Universal Health Coverage Overview' <https://www.worldbank.org/en/topic/universalhealthcoverage> accessed 20 August 2025.
[114] Borno State Contributory Healthcare Management Agency(Amendment) Law, 2022 2022 (Borno State Printer).
[115] Fortune Benjamin Effiong and others, 'Coverage and Predictors of Enrollment in the State-Supported Health Insurance Schemes in Nigeria: A Quantitative Multi-Site Study' (2025) 25 BMC Public Health 1 <https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-025-23329-4> accessed 16 August 2025.

safeguards, and deliberate strategies to raise awareness and build trust among vulnerable groups are essential. Only by addressing these unresolved gaps can Borno's contributory health insurance scheme avoid the pitfalls identified nationwide and move closer to delivering on the promise of universal health coverage.

7.2. BOSCHMA Law Amendment Bill (2025)[116]

The BOSCHMA Bill, 2025 represents a bold and commendable legislative effort to correct the shortcomings of the 2018 Law and advance the State's journey toward Universal Health Coverage (UHC). By explicitly aligning with the National Health Insurance Authority Act, 2022, the Bill resolves a long-standing legal inconsistency, thereby strengthening intergovernmental coherence and creating opportunities for enhanced federal support. Equally important is the formal adoption of percentage-based contributions for public service employees, which introduces a fairer and more financially sustainable funding model. The decision to repeal earlier laws and re-establish the framework in a more coherent form reflects a clear political commitment to building an integrated and future-oriented health insurance system.

Despite these important advances, the Bill's effectiveness will ultimately depend on how it addresses remaining ambiguities. Chief among these are the lack of precise legislative definitions for vulnerable groups and the absence of clarity on the guaranteed scope of benefit packages. While the Bill introduces new procedures for identifying indigent populations, stronger statutory language is needed to enhance transparency and guard against arbitrary exclusions. Beyond the text itself, operational realities in Borno's post-conflict setting, including mobilizing consistent funding, strengthening institutional capacity, rebuilding damaged health infrastructure, and fostering public trust, will remain formidable challenges. Meeting these demands will require sustained political will, adaptive strategies, and practical implementation mechanisms that translate legislative ambition into real access.

By adopting the recommended refinements, Borno State can ensure that its contributory health insurance scheme is not only legally sound and financially resilient, but also equitable, transparent, and responsive to the unique needs of its population, particularly the most vulnerable. In doing so, the State positions itself as a valuable case study for how UHC can be advanced in fragile and humanitarian contexts, offering lessons of both legal innovation and practical resilience. *Table 4 highlights the key changes introduced in the BOSCHMA framework through the 2022 Amendment Law and the 2025 Bill.*

[116] Borno State Government, Borno State Contributory Healthcare Management Agency (Amendment) Bill, 2025 2025.

Table 4. Changes Made in the Amendments to the BOSCHMA Law, 2018 vs Bill, 2025

Provision/Topic	BOSCHMA Law, 2018 (Relevant Section & Description)	BOSCHMA Law, 2018 (2022 Amendment Impact)	BOSCHMA Bill, 2025 (Relevant Section & Description)	Analysis of Change/Impact
NHIS/NHIA Act Applicability	Section 16: Refers to "NHIS Act 1999" as applicable.[1]	No direct amendment to Section 16 in 2022 Gazette.[1]	Section 13: Refers to "NHIA Act 2022" as applicable.[1]	Resolved. Direct legal harmonization, eliminating critical legal lacuna and facilitating federal collaboration.
Vulnerable Group Definition	Section 2: "Vulnerable... as defined by the Board".[1] Board develops policy (Section 13(2)(c)).[1]	No direct amendment to definition in 2022 Gazette.[1]	Section 2: "Vulnerable... as defined by the Board".[1] Board prescribes methods for indigence (Section 24(2)).[1]	Partially Resolved. Procedural clarity added via "prescribe methods," but core discretion remains.
Board Composition	Section 5(3): Includes specific professional bodies (e.g., NMA, PSN, MHWUN).[1]	Section 5(3)(b) amended to add NANNM, removed NECA.[1]	Section 6: Includes representatives from 3 senatorial zones, 2 organized labour, Ministries (Health, Finance,	Improved. Broader representation (geographical, CSO, NHIA). Potential for diluted specific professional expertise.

			Justice), CSO, NHIA, NECA.[1]	
TPA Functions/Oversight	Section 33: TPAs render returns, engage approved providers, collect 1% contribution, quality assurance. Prohibited from direct service/fund collection (except private plans).[1]	Section 14(2)(b,d,g) repealed, removing Agency's functions to collect/report TPA returns and investigate complaints.[1]	Sections 35, 36: Detailed functions for HMOs/TPAs. Explicit NHIA accreditation (Section 4(1)(d), 37(1)). Maintains prohibition on direct service/fund collection.[1]	Strengthened. Re-establishes and clarifies oversight, linking to NHIA accreditation, mitigating conflicts of interest.
Overall Legislative Approach	"A LAW TO PROVIDE FOR THE ESTABLISHMENT of the... Agency Law, 2018".[1]	Amendment Law, 2022.[1]	"A BILL FOR A LAW TO PROVIDE FOR THE RE-ESTABLISHMENT of the... Agency Bill, 2025".[1] Repeals 2019 and 2022 laws (Section 70).[1]	Comprehensive Overhaul. Indicates a deliberate fresh start to integrate changes and address previous shortcomings.

Policy Recommendations

To enhance the BOSCHMA Law, 2022 and ensure its effective implementation and sustainability, the following measures are recommended:

1. Legal and Regulatory Alignment

- Clarify vulnerable group definitions: Establish legislated, transparent, evidence-based criteria for identifying "the poor" and internally displaced persons (IDPs) to ensure equitable access to the Health Equity Fund.[117]

Appendix 1 proposes a draft legislation to cover this issue. The insertion of these provisions ensures that the identification of indigent persons and Internally Displaced Persons under the Borno State Contributory Healthcare Management Agency Bill, 2025, is guided by transparent, objective, and verifiable standards. By legislating clear criteria, mandating stakeholder consultation, and requiring periodic review, the amendment strengthens accountability, minimizes discretion, and safeguards equity in access to healthcare benefits. This framework not only aligns with constitutional principles of fairness and social justice but also provides a sustainable legal foundation for protecting the most vulnerable populations in Borno State.

2. **Governance, Operational Clarity, and Transparency**

Guarantee benefit packages: Define comprehensive benefit packages addressing Borno's specific health burdens, maternal, child health, communicable diseases, and mental health.[118][119]

- Reduce bureaucratic bottlenecks: Minimize routine "Board approvals" for operational tasks to prevent delays.
- Set clear TPA contracts: Specify performance indicators, quality assurance standards, and patient outcome metrics. [120]
- Strengthen institutional capacity: Enhance BOCHMA through targeted staff training, ICT upgrades, and robust data systems.[121]
- Create inclusive oversight structures: Form multi-stakeholder boards and public accountability platforms.[122]

[117] Fortune Benjamin Effiong and others, 'Coverage and Predictors of Enrollment in the State-Supported Health Insurance Schemes in Nigeria: A Quantitative Multi-Site Study' (2025) 25 BMC Public Health 1 <https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-025-23329-4> accessed 16 August 2025.
[118]
[119] Obinna Onwujekwe and others, 'Constraints to Universal Coverage: Inequities in Health Service Use and Expenditures for Different Health Conditions and Providers' (2011) 10 International Journal for Equity in Health 50.
[120] Adam Wagstaff and Sven Neelsen, 'A Comprehensive Assessment of Universal Health Coverage in 111 Countries: A Retrospective Observational Study' (2020) 8 The Lancet Global Health e39 <https://www.thelancet.com/action/showFullText?pii=S2214109X19304632> accessed 16 August 2025.
[121] Diane McIntyre and others, 'Challenges in Financing Universal Health Coverage in Sub-Saharan Africa' [2018] Oxford Research Encyclopedia of Economics and Finance <https://oxfordre.com/economics/display/10.1093/acrefore/9780190625979.001.0001/acrefore-9780190625979-e-28> accessed 16 August 2025.
[122] Christian Ngozi Okolo and others, 'The Challenges of Establishing Universal Health Coverage in Enugu State, South East Nigeria' (2019) 9 Developing Country Studies 49 <https://www.iiste.org/Journals/index.php/DCS/article/view/47579> accessed 4 December 2021.

3. **Financial Sustainability and Public Trust**

- Secure consistent funding: Maintain government appropriations, develop robust financial models, and manage the Health Equity Fund transparently. [123]
- Expand revenue sources: Introduce a corporate health tax for high-cost cases[124] and index contributions to inflation.[125]
- Promote public engagement: Launch culturally relevant awareness campaigns to boost enrolment and trust, especially among informal sector workers. [126] [127]
- Foster cross-sector collaboration: Partner with ministries, NGOs, and development agencies to address social determinants of health. [128]
- Address service gaps: Develop healthcare delivery models for insecure or infrastructure-deficient areas.[129]
- Establish a clear remuneration framework limiting Board compensation to sitting allowances and documented expenses, with statutory caps, annual audits, and public disclosure. Appointments should be merit-based and inclusive, reducing political patronage and ensuring resources prioritize service delivery over administrative overhead.

4. **Monitoring, Evaluation, and Technology**

- Robust M&E systems: Track coverage, financial protection, service use, and quality outcomes.[130]

[123] Nkaiso Lawrence Essien, 'Financial Risk Protection and Nigeria's Journey towards Universal Health Coverage' (2025) 2 npj Health Systems 2025 2:1 1 <https://www.nature.com/articles/s44401-025-00021-8> accessed 16 August 2025.
[124] 'Global Monitoring Report on Financial Protection in Health 2021' <https://www.who.int/publications/i/item/9789240040953> accessed 20 August 2025.
[125] Diane McIntyre and others, 'Challenges in Financing Universal Health Coverage in Sub-Saharan Africa' [2018] Oxford Research Encyclopedia of Economics and Finance <https://oxfordre.com/economics/display/10.1093/acrefore/9780190625979.001.0001/acrefore-9780190625979-e-28> accessed 16 August 2025.
[126] Simeon Lauterbach, 'Political Trust, Political Participation and Conflict A Case Study of the Boko Haram Conflict in Nigeria'.
[127] WHO, 'Community Engagement: A Health Promotion Guide for Universal Health Coverage in the Hands of the People.Geneva: World Health Organization; 2020. Licence: CC BY-NC-SA 3.0 IGO. Cataloguing-in-Publication' [2020] Geneva: World Health Organization 5 <https://www.who.int/publications/i/item/9789240010529> accessed 20 August 2025.
[128] Diane McIntyre and others, 'Challenges in Financing Universal Health Coverage in Sub-Saharan Africa' [2018] Oxford Research Encyclopedia of Economics and Finance <https://oxfordre.com/economics/display/10.1093/acrefore/9780190625979.001.0001/acrefore-9780190625979-e-28> accessed 16 August 2025.
[129] Di McIntyre, Filip Meheus and John Arne Rottingen, 'What Level of Domestic Government Health Expenditure Should We Aspire to for Universal Health Coverage?' (2017) 12 Health Economics, Policy and Law 125 <https://pubmed.ncbi.nlm.nih.gov/28332456/> accessed 16 August 2025.
[130] 'Global Monitoring Report on Financial Protection in Health 2021' <https://www.who.int/publications/i/item/9789240040953> accessed 20 August 2025.

- Strengthen accountability: Establish strict dispute resolution timelines and require independent audits.[131]
- Leverage digital solutions: Implement biometric/mobile enrolment and partner with humanitarian agencies for outreach.[132]

5. Research-Based Implementation Models

- Tax-based financing: Use general taxation or earmarked levies (telecom, alcohol, sugary drinks) to fund informal sector coverage.[133] [134]
- Provider payment reform: Apply blended payment models, capitation for primary care and case-based payments for hospitals.[135]

Collectively, these measures aim to align the BOSCHMA Law with national reforms, strengthen governance and financial resilience, and ensure equitable, context-responsive health coverage for all residents, particularly in post-conflict and underserved communities.

8. Conclusion:

The Borno State Contributory Healthcare Management Agency Law, 2018, and its subsequent amendments were foundational steps towards Universal Health Coverage in a post-conflict environment. However, a re-evaluation in light of the proposed Borno State Contributory Healthcare Management Agency Bill, 2025, reveals a new and much more comprehensive legislative approach to addressing the scheme's challenges.

The 2025 Bill represents a significant victory for policy refinement, explicitly titled as a "re-establishment" and a repeal of the previous laws. This new legislation successfully resolves two of the most critical flaws that plagued its predecessor. Firstly, it rectifies the outdated legal reference by explicitly linking the state scheme to the National Health Insurance Authority Act, 2022 (NHIA Act 2022), thereby providing a stable legal foundation, ensuring inter-governmental coherence, and securing access to federal funding streams. Secondly, the Bill formalizes the shift to an equitable, percentage-based contribution model for public service employees, setting a key

[131] Adam Wagstaff and Sven Neelsen, 'A Comprehensive Assessment of Universal Health Coverage in 111 Countries: A Retrospective Observational Study' (2020) 8 The Lancet Global Health e39 <https://www.thelancet.com/action/showFullText?pii=S2214109X19304632> accessed 16 August 2025.
[132] 'Global Monitoring Report on Financial Protection in Health 2021' <https://www.who.int/publications/i/item/9789240040953> accessed 20 August 2025.
[133] Adam Wagstaff and Sven Neelsen, 'A Comprehensive Assessment of Universal Health Coverage in 111 Countries: A Retrospective Observational Study' (2020) 8 The Lancet Global Health e39 <https://www.thelancet.com/action/showFullText?pii=S2214109X19304632> accessed 16 August 2025.
[134] 'Universal Health Coverage Overview' <https://www.worldbank.org/en/topic/universalhealthcoverage> accessed 20 August 2025.
[135] Adam Wagstaff and Sven Neelsen, 'A Comprehensive Assessment of Universal Health Coverage in 111 Countries: A Retrospective Observational Study' (2020) 8 The Lancet Global Health e39 <https://www.thelancet.com/action/showFullText?pii=S2214109X19304632> accessed 16 August 2025.

inconsistency between previous legislative text and operational practice. This demonstrates a strong and decisive political commitment to both legal clarity and financial sustainability.

However, while the 2025 Bill introduces new procedures for identifying indigent populations, a significant ambiguity persists. The definition of "vulnerable" still grants the Board broad discretion, potentially hindering transparent and equitable access to the Health Equity Fund for the poor and displaced. This highlights that while the Bill makes substantial progress, its core equity objective remains unanchored by stronger, legislated criteria. Similarly, the formidable operational challenges inherent in a post-conflict environment, including inconsistent funding from the informal sector, building institutional capacity, and rebuilding damaged healthcare infrastructure, are issues that the law can only frame, not fully resolve.

In essence, the 2025 Bill transforms the Borno State health insurance scheme from a flawed but promising framework into a legally coherent and financially sound policy. Its effectiveness and long-term sustainability will now hinge on robust implementation and addressing the remaining gaps. The highest priorities for policymakers are to: (1) legislate more transparent and objective criteria for defining vulnerable groups; and (2) ensure that the Bill's strong legal framework is matched by equally strong operational strategies to build public trust and deliver on its promise of equitable and accessible healthcare for all of Borno State's residents. This comprehensive approach will be essential to realizing the scheme's full potential in a complex humanitarian context.

Author Declarations

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Ethical Considerations: This article is based solely on analysis of publicly available legal texts, statutes, and policy documents. No human participants or confidential data were involved.
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Appendix 1

*Proposed Amendment to the Borno State Contributory Healthcare Management Agency Bill, 2025 (*Suggested Draft Legislation to Define 'Vulnerable Populations')

The following new sections are proposed to be inserted into the Bill to strengthen statutory language and enhance transparency in the identification of vulnerable populations. These sections are intended to replace or supplement existing provisions that grant broad discretion to the Board, ensuring that the process is objective and verifiable.

PART V – VULNERABLE GROUP FUND AND IDENTIFICATION

Legislative Mandate for Indigence Verification Policy

24A. (1) Notwithstanding any other provision in this Bill, the Agency and its Governing Board shall, by regulation, establish and implement a transparent, evidence-based, and verifiable policy for the identification and enrollment of indigent and other vulnerable persons in Borno State.

(2) The policy shall be developed and made publicly available no later than six (6) months after the commencement of this Bill.

(3) The policy shall be subject to a resolution of the State House of Assembly before its final adoption and implementation.

Criteria for Identification of Indigent Persons

24B. (1) The policy for identifying indigent persons shall not be arbitrary and shall be based on a multi-dimensional assessment that includes, but is not limited to, the following criteria:

(a) Household income and consumption levels, bench-marked against a state-specific poverty line or a proxy-means testing model.
(b) Lack of access to basic social amenities and services.
(c) Household size and dependency ratio.
(d) Ownership of assets or property.
(2) The Agency shall, in developing the criteria under subsection (1), collaborate with relevant Ministries, Departments, and Agencies (MDAs), such as the Ministry of Economic Planning and other social development partners, to ensure the use of objective and verifiable data.

(3) The criteria for identifying indigent persons shall be reviewed and, where necessary, updated no less frequently than once every three (3) years to ensure their continued relevance and accuracy.

Identification of Internally Displaced Persons (IDPs)

24C. (1) For the purpose of this Bill, an Internally Displaced Person (IDP) shall be identified in collaboration with the Borno State Emergency Management Agency (SEMA), the National Emergency Management Agency (NEMA), and other officially recognized humanitarian organizations.

(2) The identification and enrollment of IDPs shall be based on official registration and verification data maintained by the agencies listed under subsection (1).

(3) The Agency shall establish a mechanism for the continuous verification of the status of IDPs to ensure that scheme benefits are equitably distributed and not subject to fraud.

Stakeholder Consultation and Public Dissemination

24D. (1) The Agency, in collaboration with the Board, shall conduct a public consultation process with civil society organizations, community leaders, and representatives of vulnerable communities before the finalization of the policy and criteria for identifying indigent persons and IDPs.

(2) The finalized policy and criteria shall be published on the Agency's official website and through other widely accessible media, including in major local languages, to ensure transparency and public awareness.

(3) The Agency shall establish a clear and accessible grievance redressal mechanism for any person who believes they have been unfairly excluded from the scheme.