TITLE: **An Afro-communal reflection on justice and rights in national health insurance scheme in Nigeria**

Review Comments:

**Reviewer 1:**

**[**For editors:

If the authors can greatly modify the paper, systematically identifying the ethical concepts, discussing them (there is a lot written in the literature on these concepts), explaining what fairness means, and how it can be operationalized in the African context (given the limited resources) and differentiating clearly the implications of these for the NHIS policy vs. the health system ethical issues that also contribute to lack of UHC in Nigeria, then perhaps it could be accepted for publication.]

This paper is on an issue that is both topical, and relevant. With the call of the SDGs for Universal Health Coverage (UHC), it is relevant to understand how health insurance schemes in low and middle income countries are gearing up to help governments deliver on the promise of UHC. However, the paper lacks some important details and references, could be written in a simpler style and more attention could have been paid to the grammar.

1. For example, the authors could avoid the use of complicated concepts such as in this paragraph – which I am still struggling to understand fully. There are a few more such examples.

“*Or should it be based on “urgency and importance” of a moral need based on reason for desire, how well-off the benefit will outlive the need, and the moral sacrifice involved in each of the needs? Or should it be based on instrumental value and harm status?*

1. The paper omits mentioning some key concepts such as SDGs, and UHC. It also does not provide a comprehensive picture of the national health financing for UHC, and other initiatives that are supporting “Health for all” in Nigeria, which will provide context to the role that NHIS could or should play on the road to UHC. In relation to the description of the NHIS itself, other than the requirement of co-payment by employees, the authors do not mention how those who are self-employed or unemployed could have access to the scheme. This already leaves out a vast majority of the population. They also do not mention how the policy was formulated. On what basis was the decision made to cover some health issues and not others? This would shed some light on procedural ethical issues.
2. The authors mention that the policy lacks a “robust ethical foundation” but do not mention what the robust ethical foundation might look like. Rightly so, they point out that the policy should focus on fairness (the term actually used by the author is fair treatment, which is confusing) rather than equality, but do not quote the seminal work on “Making fair choices on the path to Universal Health Coverage”[[1]](#footnote-1) The framework provided in this publication could have helped them to anchor the discussion in a systematic and comprehensive manner. As it stands, they now meander through the ethical concepts. They talk about justice and fairness but do not explain what fairness might look like, or what NHIS would need to do differently if it employed fairness as the ethical principle. Concepts such as ‘priority services’, ‘risk protection’, ‘fair inclusion’, ‘unacceptable trade offs’, ‘prioritisation’, ‘public accountability’, ‘monitoring and evaluation’ are missing from the discussion. Mention is made of the ‘priority given to the worse off’ but only in the context of particular diseases or health conditions. No mention is made of those who are ‘worse-off’ in a socio-economic sense or in terms of overall health status.
3. The authors rightly critique ‘equal access for equal needs’ and the difficulty of quantifying needs in a ‘fair manner’, but do not propose a solution. The WHO guidance could have been quoted as one example of a solution.
4. The authors on page 9 of 16, compare prioritization of cardiomegaly vs. a prolactin tumour (a relatively rare condition), but cardiomegaly is a condition due to several causes and a prolactin tumour is a very specific disease condition, so this appears to be a wrong example. Besides, not knowing whether either of the two conditions is treatable, what is the implication of these conditions for the patient, and other medical details, it is difficult to understand why one should or shouldn’t be prioritized over the other. Besides it would be relevant in this paragraph to bring in discussions of cost effectiveness (which all entities dealing with health financing need to do) and its role in prioritization.
5. The authors conflate the ethical principles of the NHIS with the lack of accountability of the Nigerian health system, the poor state of the Nigerian health system, lack of access due to lack of health facilities in the rural and hard to reach populations etc. These contribute to poor health of the Nigerian population, but NHIS does not have a direct responsibility for these.
6. The authors rightly point out the injustice in using age as a criterion for allocating health care resources, but use the worst possible example especially in the context of a lower middle income country like Nigeria, where a heart transplant would not make it to the top of the ‘priority services’. Perhaps treatment of more ‘mundane conditions’ such as an upper respiratory infection or meningitis may have been more relevant.
7. The authors point out the lack of dissemination of the NHIS policy as one reason why the poor or the rural population is unable to access its benefits. That maybe so, but poor dissemination cannot be conflated with the substantive ethical principles of the policy itself.
8. They rightly point out that equality does not always lead to justice, but do not explain how. An example or two would have been helpful.
9. The authors state that every health need is morally important, and that needs should be fairly treated, and that society should provide care from a sympathetic understanding of the situation of a person’s need – but these are abstract ideals. In their proposed solution for the Nigerian health insurance system, ethical principles such as solidarity, consensual decision making, fair access have been identified, but the authors fall short of explaining how these could be operationalized, especially in the face of challenges such as extremely low resources, and a huge unmet need, in addition to corruption which has not been mentioned, but which perhaps exists. It would be helpful if the authors could propose some solutions given their knowledge of the local situation and politics.

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**Reviewer 2:**

1. It is a good paper, topical, very much needed in the present context of UHC and the pushing of the health insurance model. I am sure that this kind of paper is required for India also with its massive health insurance scheme of Ayushman Bharat and could influence policy especially in countries which are taking up health insurance as a financing mechanisms.
2. They have written it very well and have made efforts, language is simple, flow is good and overall the paper is fine.
3. However, I find that the paper, at many places, makes statements relating to the core issue of ethics and equity issues without providing adequate evidence. One finds that they are generic statements, i have inserted these comments in the sheet.
4. The paper needs to be revised and to provide evidence and data to prove that the NHIS is not able to guarantee equal health care rights to all Nigerians. I also feel the the theoretical part could be reduced

The recommendation is that it may be sent to the authors for reworking and to provide evidence.

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1. https://www.who.int/choice/documents/making\_fair\_choices/en/ [↑](#footnote-ref-1)