CHALLENGE TRACK A — DEMAND GENERATION & AWARENESS

Background

Despite health insurance being mandatory under the NHIA Act 2022, most Nigerians remain uninsured, not because they reject the idea, but because no trusted, plain-language source tells them what it costs against what they earn, what they are entitled to, and exactly how to enrol. The gap is widest among informal workers, rural residents, and less-educated women, and it shows clearly in the numbers. In Benue State, 69.3% of informal-sector workers said they were willing to enrol, yet only 34.0% actually had, proof that willingness is not the constraint; the path from willingness to action is. Nationally, NHIA counts just over 22 million enrolees out of roughly 240 million Nigerians, and because more than nine in ten Nigerian workers hold informal jobs, the people awareness campaigns reach least are exactly the people who need reaching most. An estimated 83 million Nigerians even qualify for subsidised cover under the Vulnerable Group Fund, yet awareness climbs sharply with formal education and salaried work, and falls just as sharply without them, so the people the fund exists for are often the last to hear about it.

Four forces keep this gap open. Understanding is limited, because insurance concepts and entitlements are rarely explained in accessible, local-language formats, and awareness tracks education and formal employment rather than need. Trust is low, reinforced by chronic under-investment, health insurance has drawn under 0.11% of the federal health budget in five years and by a documented behavioural pattern in which people discount future health risk while they are healthy; Benue respondents cited both distrust and "non-belief in paying for sickness" as reasons to stay out. Pricing is unclear: the non-negotiable, NHIA-regulated annual premium for informal-sector cover is fixed at ₦38,718, roughly four times above the ~~₦~~9,020.6 a year informal workers in Benue say they can actually pay. And enrolment is difficult, because at least six parallel schemes (federal, state, Vulnerable Group Fund, tertiary-institution, community-based, and private) leave even the willing citizens unsure which door is theirs.

Challenge Question

How might we help people who are currently outside the health insurance system move from limited awareness or initial interest to informed and completed enrolment?

Priority Areas

Teams may address one or more of the following priority areas. Solutions do not need to address the entire enrolment journey, but should show how the selected intervention can move people closer to informed and completed enrolment.

1. Behaviour change and demand activation

Awareness does not automatically lead to action. Solutions should consider the beliefs, habits and social influences that shape whether people see health insurance as relevant, trustworthy and worth paying for before illness occurs.

Teams might explore approaches that:

- address the tendency to prioritise immediate needs over future health risks;
- respond to distrust or previous negative experiences;
- use trusted peers, community leaders or health workers to build confidence;
- make the value of insurance more tangible and personally relevant;
- use reminders, social proof or timely prompts to turn interest into action; or
- frame enrolment around household protection, financial security or continuity of care.

2. Eligibility, scheme matching and decision support

Nigeria's different federal, state, employer-based, private and subsidised arrangements can be difficult to navigate. People need support to determine which option applies to them, what they qualify for and what steps they should take next.

Teams might explore:

- guided eligibility or scheme-matching tools;
- simple questions that direct users to the appropriate programme;
- mechanisms for identifying possible eligibility for subsidised coverage;
- locally relevant information on available schemes and enrolment points;
- comparison of essential differences between available options; or
- clear referrals to the institution responsible for completing enrolment.

3. Trusted communication and community distribution

The source of information can be as important as the information itself. Solutions should consider how accurate insurance information can travel through the people, institutions and communication channels that intended users already trust.

Teams might explore:

- cooperatives, market associations and trade groups;
- community and religious leaders;
- frontline health workers and health facilities;
- radio, voice, USSD or other low-data channels;
- local-language and audio-visual formats;
- mechanisms for verifying legitimate agents, schemes and payment requests; or
- feedback channels through which users can ask questions and correct misinformation.

4. Enrolment conversion and assisted onboarding

Many people may begin an enrolment process but fail to complete it because the steps, documentation, payment process or responsible institution are unclear. Solutions should reduce friction between deciding to enrol and receiving confirmation that coverage is active.

Teams might explore:

- step-by-step enrolment guidance;
- document and eligibility checklists;
- assisted enrolment through community-based intermediaries;
- support for incomplete or abandoned applications;
- reminders and follow-up at key points in the process;
- visibility into application or activation status; or
- clear confirmation of coverage, benefits and where the user can seek care.

5. Affordability, payment fit and subsidy access

For people with irregular incomes, the structure and timing of payment may be as significant as the total premium. Solutions should consider how people can plan for, contribute toward or obtain support for enrolment within existing regulatory and financing arrangements.

Teams might explore:

- instalment or flexible payment pathways where permitted;
- savings or contribution mechanisms linked to existing groups or cooperatives;
- payment schedules aligned with seasonal or irregular income;
- clearer identification of available subsidies or public support;
- household-level approaches to budgeting for coverage; or
- mechanisms that connect eligible users to existing financial assistance.

Where the Enrolment Journey Breaks Down

People may first hear about health insurance through radio, health workers, employers, community leaders, cooperatives, agents or personal networks. However, hearing about insurance does not necessarily mean that they understand how it applies to them.

They may struggle to determine whether they are eligible, which scheme operates in their location, whether subsidised coverage is available, what the insurance will cost or what services it includes. Even where interest exists, unclear documentation requirements, payment arrangements, enrolment channels or confirmation processes may prevent people from completing enrolment.

Teams may choose to intervene at one or more of these points, but should clearly explain how their solution helps the intended user move closer to informed and completed enrolment.

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CHALLENGE TRACK B — TRANSPARENCY & PRICING

Nigerians who are already enrolled, or actively choosing between health insurance schemes, have no neutral way to compare cost, coverage, and real-world claims performance. Existing private comparison tools focus only on commercial HMOs, leaving the public schemes most Nigerians rely on out of view. That lack of transparency erodes trust, even among people already paying into the system. The evidence is clear. Referral delays and unsettled provider payments are among the leading complaint categories NHIA records against HMOs, and in 2024, the agency resolved 2,929 of 3,507 complaints, with 84% resolved within its own timeline, showing the friction is real, measurable, and already a regulatory priority, not just a perception problem. A private comparison market has already shown the model can work commercially. Sites like nairaCompare rank plans by network, price, and claims service, yet they exclude state, community based, and subsidised public schemes entirely. Ghana's National Health Insurance Scheme, now two decades more mature than Nigeria's, also shows that trust is not rebuilt through messaging alone. Subscription renewal still skews toward wealthier, urban subscribers because poorer households continue to face financial barriers and patchy access to information.

Four forces keep this opacity in place. First, understanding is limited. Few enrolees know what a plan actually covers or how to check a scheme's real-world track record before signing up. Second, trust remains low, reinforced by documented service failures. Referral delays and unsettled payments are among NHIA's own leading complaint categories, not rumours. Third, pricing lacks transparency because there is no standardised way to compare cost and coverage across all six of Nigeria's schemes, only across the private HMOs that a minority can access. Meanwhile, out of pocket payments still account for most of the health spending nationally, making the cost of choosing the wrong scheme even higher. Finally, access remains difficult even after enrolment. Once a claim or referral is filed, people have no visibility into its progress or any clear way to escalate cases that become stuck.

Challenge Question

How might we help people compare, understand and use health insurance coverage, and seek redress when it does not work as promised?

Priority Areas

Teams may address one or more of the following priority areas. Solutions should identify the specific decision or service problem they are addressing, whether before enrolment, while accessing care or after a problem occurs, and demonstrate how greater transparency would improve the user's experience.

1. Standardised plan information and comparison

People cannot make meaningful comparisons when schemes describe premiums, benefits, exclusions and service conditions differently. Solutions should explore how information from public and private schemes can be organised using consistent definitions and presented in ways that support informed choice.

Teams might explore:

- common categories for comparing premiums, benefits, exclusions and payment schedules;
- standardised summaries or plan information statements;
- tools that translate technical benefit packages into plain language;
- comparison across national, state-supported, employer-based and private options;
- personalised comparisons based on location, household needs or expected service use; or
- mechanisms for verifying that published plan information is accurate and current.

2. Price-to-value transparency

The premium is only one part of what insurance may cost a household. People also need to understand what they receive in return and which expenses may remain their responsibility.

Teams might explore:

- clearer presentation of co-payments, exclusions and benefit limits;
- tools that show the likely total cost of using a plan, not only the enrolment premium;
- explanations of which medicines, procedures and levels of care are covered;
- comparison of payment schedules and household or dependent coverage;
- scenario-based tools showing how different plans respond to common health needs; or
- ways to communicate the financial protection offered by a plan without making misleading guarantees.

3. Provider networks and real service availability

A benefit is only useful if the user can obtain it. Published provider lists may not show whether facilities are nearby, accepting new members or able to deliver the services included in a plan.

Teams might explore:

- searchable and regularly updated provider directories;
- information on available services, medicines, operating hours and accessibility;
- tools that help users locate an appropriate facility within their network;
- mechanisms for reporting inaccurate or outdated provider information;
- visibility into changes in provider participation; or
- approaches that show the practical geographic accessibility of a plan's network.

4. Visibility across referrals, approvals and claims

Once people begin using their coverage, they often have little visibility into what is happening behind the scenes. Solutions should reduce uncertainty during referrals, authorisations, claims or other administrative processes.

Teams might explore:

- clear explanations of the steps and documentation required;
- status tracking for referrals, approvals, claims or reimbursements;
- notifications when action is required from the user, provider or scheme;
- understandable reasons for delays, modifications or denials;
- expected timelines for each stage of the process; or
- assisted pathways for users who cannot navigate digital systems independently.

5. Accountability, redress and verified performance

Transparency should help people act when coverage does not work as promised. Solutions should strengthen the feedback loop between members, providers, schemes and regulators while avoiding unverified or easily manipulated ratings.

Teams might explore:

- clearer complaints, appeals and escalation pathways;
- case tracking and confirmation that complaints have been received and resolved;
- verified information on complaint patterns, referral delays or service performance;
- structured user feedback linked to specific facilities or schemes;
- mechanisms for schemes and providers to respond to reported problems;
- public-facing performance indicators that are fair, understandable and regularly updated; or
- ways of converting recurring user complaints into improvements in scheme administration.

Where the Coverage Journey Breaks Down

People may select a health insurance option or be enrolled through an employer, institution or public programme without fully understanding the benefits, exclusions, provider network or costs that may remain their responsibility.

The gaps often become clearer when they attempt to use the coverage. A person may encounter an unavailable provider, an unexpected payment, a delayed referral or authorisation, or a service they believed was covered. They may then struggle to understand what happened, how long resolution should take or where to raise and track a complaint.

Teams may focus on the point of selection, access to care, service navigation or redress, but should clearly identify the specific transparency or accountability problem their solution addresses.