IMPROVING FINANCIAL ACCESS TO HEALTH SERVICES FOR THE POOR IN NIGERIA

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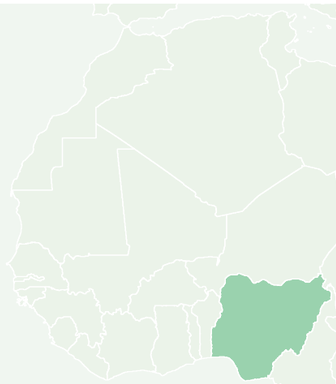
Innovative Financing Mechanisms

Brief: Nigeria



▸ Priority Actions

- Support the implementation of innovative financing mechanisms to improve equity
- Establish and strengthen state-level primary healthcare agencies
- Strengthen health systems to manage and track service provision and expenditures
- Establish robust monitoring mechanisms and conduct independent impact evaluation studies
- Engage communities in planning, implementing, and monitoring of health schemes

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Overview

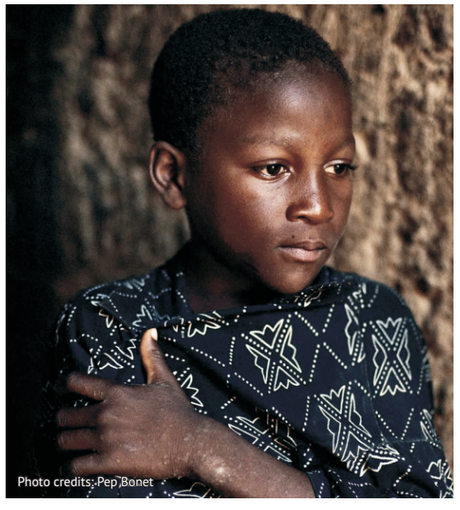
Various financing mechanisms can contribute to improved access to primary healthcare for the poor, rural residents, and other vulnerable groups such as women and children. Such mechanisms are usually introduced to address challenges related to funding shortages, poor health indicators, inefficient management of health facilities, low use of health services by the poor, and inadequate numbers of health providers. Introducing new financing mechanisms can provide an incentive to providers to offer cost-effective health services while improving the quality of care and gaining support from the local community.

The process of developing an alternative financing mechanism for health services entails the following steps:

- **Assess community needs.** Programme planners need to know what health services are important to community members, which health problems are most common, and what health needs are not being met.
- **Analyse the costs, outputs, and management systems of health programmes, services, and facilities.** Programme planners need to collect data on the patient load, staffing structure, costs to provide specific health services, payment structure, sources of funding and income, as well as quality of financial management and programme monitoring systems.

Guidelines for Effective Health Financing Mechanisms

- Conduct analytical studies and assessments to guide the planning process and serve as a baseline for measuring performance
- Generate commitment and ownership from key decision makers at the national, state, and local levels
- Engage communities in all phases of planning and implementation
- Ensure that policies support innovations, such as involvement of private entities and community groups in health programmes and retention of revenue by facilities
- Strengthen financial management by establishing accounting, auditing, and reporting systems and ensuring that managers have the requisite management skills
- Set up a rigorous monitoring and evaluation system



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- **Develop a strategy to address inequities in health services.** The strategy should identify which groups need subsidised services and what specific services or benefits will be subsidised.
- **Ensure that appropriate policies are in place to implement the new financing mechanism.** Examples include laws and regulations pertaining to use of public funds, operation of private health facilities, and financial oversight.
- **Set up a sustainable institutional structure.** Most financing mechanisms require a managing organisation that can implement the scheme, an advisory board that provides oversight, a system for reviewing invoices and making payments with measures to protect against fraud and abuse, an independent agency that monitors project outputs and has the power to determine whether indicators are being met, and a community group that can make decisions on which groups and individuals will receive subsidised services and can monitor progress. Planners should also consider outsourcing services that can be done better and/or more effectively by another source.
- **Implement the programme and use robust approaches to monitor outputs and results closely.**
- **Evaluate the programme before introducing a new phase or scaling up, including commissioning independent studies.**
- **Build in factors to promote sustainability.** Examples include broadening the insurance pool to include people whose payments can subsidise services for the poor and requiring small payments from beneficiaries or using a sliding scale for user fees.

Financing mechanisms that have proved effective in pilot studies should be adapted and scaled up to expand their reach. Most programmes benefit from using a combination of health financing mechanisms. Each approach has both advantages and disadvantages and needs to be adapted to the local context. Integrated systems perform better than fragmented ones.

Equity Funds

Health equity funds (HEFs) are demand-side financial mechanisms established to improve access to priority public health services for the poor. HEFs address challenges of limited access to and use of health services by providing specific health services for free or at a subsidised cost to the poor and vulnerable groups. Typically, the agency holding the funds sets criteria for beneficiaries, decides on services to be covered, establishes a screening process (such as review by community groups), sets up a system or contracts with a local agency to

reimburse service providers, and introduces a mechanism to monitor the programme and assess its impact. This scheme relies on the active participation of community members to provide financial management and oversight functions towards ensuring that the fund fulfils its mandate. Financial sustainability and weak financial management systems are the major challenges of equity funds.

The equity fund run by the Ambursa community in Kebbi State is supported entirely by private donations. Beginning in 2000, a local association collected donations from individuals, mosques, and town associations. To date, the fund has raised 5 million Naira (US$31,700), which has been used to cover the operational costs for maternal and child health service deliveries by the town dispensary, pay for services for 1,200 poor women and children, set up a revolving fund for drugs and consumables, and purchase an ambulance for obstetric emergencies. The fund's success owes much to its management committee, which maintains transparency and accountability and ensures adherence to eligibility criteria. Factors that affect the fund's future viability are its reliance mainly on voluntary contributions, the need to replenish donated drugs, and the lack of skilled staff (Oyeyipo, 2011).

Pooled Funding

The Abiye Equity Fund in Ondo State is supported by World Bank and state and local government funding. The Abiye Fund introduced free health services for pregnant women and children under age 5, emphasised community mobilisation, and equipped health facilities in every ward of the local government area (LGA). Between 2009 and 2011, deliveries in health facilities had tripled, and the number of pregnant women making antenatal visits had increased nearly five-fold (Adinlewa, 2011). The Millennium Development Goal (MDG) Maternal and Child Health Project administered by the National Health Insurance Scheme (NHIS) is learning from the Abiye programme in its expansion to other states, and the State Ministry of Health (MOH) is advocating for public funds to expand this initiative within the state.

Basket Funding

Zamfara State set up a basket fund to support immunisation and selected maternal health services. By pooling funds from the state's 14 LGAs, the state government, and development partners, the state mobilised 1.5 million Naira (US$9,684) and set up a state bank account with these funds in 2009. Each LGA has its own account in the same bank. Funds are disbursed directly to beneficiaries by finance officers; each invoice must be approved by representatives of the three funding agencies. The basket fund has improved coordination of financing from different sources and raised the quality of data on immunisation. Routine immunisation coverage has increased with relatively minimal cost. The basket fund could be extended to other health sectors if more resources were available (Musa, 2011).

Exemption Schemes

Governments often set criteria to provide free or subsidised healthcare services to specific groups such as the poor and vulnerable populations (e.g., women, children, and/or the elderly), as a means of promoting equity or improving overall health status. Such exemption schemes need financial support from the government as well as private sector charitable groups. Often policies to provide free or subsidised services are set without estimating the expected costs or identifying ways to compensate for the loss in revenue. Also, as service utilisation increases, programme managers often find that the number of exempt individuals escalates rapidly, thereby driving up costs. The inflated client roster may not necessarily indicate that the services are reaching people in need but rather that people who could afford to pay are enrolled due to overly broad selection criteria, inadequate monitoring, or corrupt practices.

To avoid such problems, programme planners need to set clear criteria for individuals or groups to be exempted and/or designate specific health services to be covered. They must also set up a system for screening eligible people, such as having a community group determine eligibility, if this can be done without bias. Various types of means testing have been used, including assessing housing, household assets, daily income, household features, geographic location, and the wealth index.

In Nigeria, Jigawa State implements two schemes that provide free health services to pregnant women and children under age 5 who qualify for exemptions. One scheme is based on payments for specific health services, while the other one provides a fixed monthly payment per enrollee. The plan managed by the Gunduma Health System Board uses funds from a line item in the state budget to reimburse 15 facilities for services provided to

women and children in need. A local committee determines patients' eligibility for exemptions, based on need. The second scheme, which is supported by state funds and funds from the MDG Maternal and Child Health Project, covers 13 LGAs. Health maintenance organisations manage the programme, paying health facilities 550 Naira (US$3.47) per enrollee per month. Both schemes have led to increased clinic visits. However, there are still issues related to costs and reimbursement rates that need to be resolved. For example, the costs of the Gunduma scheme exceeded the original budget allocation after just one year of operation (Kainuwa, 2011).

Results-based Financing

The traditional approach to health financing has been for the total expenses of health facilities—salaries, equipment, drugs, etc.—to be paid to provide services regardless of the quantity or quality of their outputs. An alternative approach is to set up a payment structure based on specific outputs such as patient visits and procedures or results such as improved health status in the community. With results-based financing (RBF), facilities are paid based on their achievements and performance, while in some cases, the payments serve as rewards in addition to regular costs. Such a system gives health providers an incentive to increase their client load, improve quality of care, and use funds more efficiently. The key to implementing this system is to empower communities to take a more active role in the provision of health services and overcome barriers to use of health services such as lack of information and social norms. Also, an independent agency is essential to ensure that results are measured rigorously to guard against fraud and abuse. This agency may conduct household and facility surveys to verify claims as well as operations research to assess service delivery options. RBF works best when health consumers have a choice of facilities so they can utilise the providers that provide the best quality.

Paying for quantity and quality. Nigeria's National Primary Healthcare Development Agency, in collaboration with the Federal MOH and the World Bank, is piloting an RBF project that pays participating health facilities for the quantity and quality of services they provide, provides funds to the LGAs based on specific outputs or outcomes, and disburses funds linked to specific indicators. The pilot test aims to increase use of MNCH services at primary healthcare facilities in one LGA in three states—Adamawa, Nasarawa, and Ondo (Ekisola, 2011).

Paying per output. In Kenya, a pilot project combined RBF and vouchers to provide specific maternal, reproductive health, and family planning services to poor women. The project is known as the Output-based approach (OBA). The women purchased the vouchers at a minimal cost and then obtained services from their chosen provider. The project then reimbursed each provider per service provided. The initial pilot in 2005 found that antenatal care and delivery services were popular, while there was less demand for contraceptive implants and intrauterine devices and gender-based violence services. This system encouraged the provision of high-quality services because the providers with good services attracted more clients. The programme managers concluded that the scheme worked better in urban areas than in rural areas and that it allowed better targeting of external resources (Owino, 2011).

Rewarding facilities for performance. Burundi used RBF to support the provision of free healthcare for children under 5, deliveries, and cesarean sections. One objective was to reduce the inequity in financing across provinces. To ensure that funds were not allocated only to the top performing health facilities while the less successful ones remained disadvantaged, the scheme provides bonuses to provinces and health facilities that are disadvantaged (Ekisola, 2011).

Promoting universal enrolment. Rwanda has also used RBF in conjunction with its community-based programmes. Rwanda has made health insurance compulsory, with employer-based insurance for workers in the formal sector and community-based health insurance for those in the informal sector. Nearly all (90–95%) of the people in the informal sector are now covered. Use of health services has increased, although quality of care remains a concern (Humuza, 2011). The benefit of requiring health insurance is that it produces a large risk pool so that costs can be balanced between the healthier and wealthier people and those who most need subsidised healthcare.

RBF marks a shift towards demand-side financing and thus encourages providers to invest in services that the community wants. It also helps to strengthen the capacity of the health system, since improvements in the quality of services reap benefits for the health facilities. The process of targeting resources to groups with inadequate access to health services contributes towards more equitable allocation of public resources, which are often concentrated in capital investment in facilities and hospitals. RBF empowers communities to play a more active role in decisions regarding the provision of health

services, and it complements community-based health insurance.

In Nigeria, results-based financing is best applied at the state and LGA level. States and LGAs will need to garner high-level support and supportive policies to introduce RBF. It is important to set correct prices for services and establish clear criteria for disbursement. Services need to be monitored closely to prevent fraud and abuse.

Partnering with the Private Sector

Many of the successful financing mechanisms include contributions from the private sector. Examples of such collaboration in Nigeria include the following:

- Health maintenance organisations manage many community programmes targeted at the poor.
- The service delivery network for many equity-based programmes comprises private and faith-based facilities as well as those run by the government.
- The Federal MOH has contracted with a private company for purchasing and maintaining specialised hospital equipment in selected teaching hospitals and federal medical centers.
- The Lagos State government has contracted with a private hospital to provide kidney transplant services.

The key issues involved in setting up such partnerships are regulation (licensing, accreditation, and certification) and contractual arrangements (leasing and management contracts, concessions, performance-based payments) (Addo-Yobo, 2011).

Actions Needed

Nigerian agencies can take the following key actions to apply health financing mechanisms effectively:

Federal

- Allocate and release 15 percent of state budgets to healthcare services
- Inform policymakers at all levels that investing in primary healthcare is cost-effective and contributes to socio-economic development
- Provide technical support to agencies implementing innovative financing mechanisms
- Share best practices widely among federal, state, and LGA health authorities, especially in regard to improving programme efficiency
- Track health expenditures throughout the system to understand funding allocations and their impact on health services and status
- Commission robust monitoring and impact evaluation studies on evolving innovative financing mechanisms/strategies

State

- Allocate and release 15 percent of state budgets to healthcare services
- Establish state-level primary healthcare agencies
- Adopt a strong health management information system to monitor service delivery statistics and expenditures
- Train managers of health programmes in budgeting, costing, and routine expenditure tracking
- Eliminate constraints to the provision of health services to the poor by permitting private providers to participate in health financing schemes and allowing facilities to use fees from services to upgrade facilities and improve the quality of care

LGA

- Allocate and release 15 percent of LGA budgets to healthcare services
- Engage communities in planning, implementing and monitoring health schemes
- Train managers of community-based health programmes in financial management and analysis of service delivery data

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Health financing and equity were the main themes of the landmark national conference on **Improving Financial Access to Maternal, Newborn, and Child Health Services for the Poor in Nigeria,** held in November 2011 in Tinapa, Calabar. The conference brought together 255 experts from all 36 Nigerian states and the Federal Capital Territory, including high-level government officials, political leaders, healthcare managers and planners, health economists, insurance specialists, and media representatives. These experts discussed strategies to improve financial access to integrated MNCH services, inclusive of sexual and reproductive health interventions, towards achieving universal health coverage. Among the various strategies discussed during the meeting were the need for advocacy and policy change, innovation in the design and implementation of health financing schemes, strengthening of the social health insurance scheme in the country, and the needed collaboration with private sector health providers. The conference organisers included three federal agencies, the African Health Economics and Policy Association, four United Nations agencies, three donor countries, and five health projects.

This brief is one of four in a series: "More Health for the Money," "More Money for Health," "Innovative Financing Mechanisms," and "Community-based Health Insurance." A complete list of sponsoring agencies and all conference materials and presentations are available on the conference website at **http://www.healthfinancenigeria.org**.

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