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More Health for the Money

Brief: Nigeria

Priority Actions

- Allocate resources for optimal impact
- Improve programme efficiency and effectiveness
- Explore new financing mechanisms appropriate for the country context
- Build public-private partnerships
- Sustain investments in health

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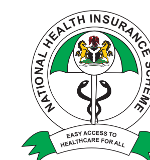
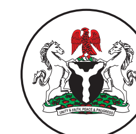
Overview

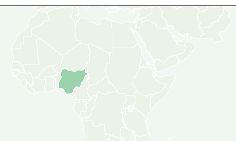
Much can be done to use existing health resources more effectively to improve overall health status and make health services more accessible to people in need, including the poor, rural residents, women, and children. Nigeria's National Health Policy recognises that access to high-quality and affordable healthcare is a fundamental human right. However, the reality is that many Nigerians cannot afford to pay for healthcare and thus suffer poor health. According to the National Health Accounts, 69 percent of health expenditures are out-of-pocket (paid by individuals); public funds account for 24 percent of health spending, with funds from the Federal Ministry of Health (MOH) and other federal agencies (12%), state MOHs (5%), and local government areas (LGAs) (7%) (Fakeye, 2011; Soyibo et al., 2009).

Allocating Resources for Optimal Impact on Health

Ideally, health funds should be allocated according to the major causes of death and ill health. However, much of Nigeria's health funds are skewed towards hospitals and other higher levels of the







Steps to Address Imbalances in Resource Allocation

- Analyse health problems among the poor and vulnerable groups and invest in their needs, such as MNCH, FP/RH, and endemic disease control
- Improve programme planning by making detailed cost estimates, identifying funding sources before implementation, and setting up systems to monitor expenditures, as required in the Medium Term Sector Strategy process
- Improve the processes for budgeting, appropriating, and releasing public funds
- Ensure that all budgeted funds are spent on priority interventions
- Strengthen the capacity of managers at the federal, state, and LGA levels to plan and implement cost-effective health services

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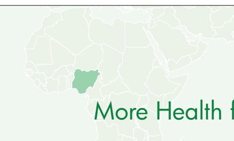
healthcare system and to facilities in urban areas. Nearly three-fourths (74%) of the federal health budget is spent on curative care—treating existing diseases or medical conditions. In contrast, one-eighth (13%) of the health budget is spent on preventive care—preventing disease, chronic conditions, or injuries through actions such as immunisation, behavior change, and improved sanitation (Fakeye, 2011).

The Kaduna State MOH used the Medium Term Sector Strategy to plan and budget for health programmes. The process was to determine the overall goals and objectives; identify and prioritise the key programmes to achieve these objectives; estimate the funds needed to implement the programmes; align the costed, prioritised programmes with available resources; define the expected outcomes of the programmes; and phase in the new initiatives over a three-year period. The plan was developed by a Health Sector Planning team, thus ensuring political commitment to focus resources on pro-poor healthcare delivery and to link results to objectives and cost. This process ensured that funds were allocated for priority programmes and enabled programme planners to track progress (Gyas, 2011).

A study conducted by the Lagos State MOH and several donor agencies is a useful model for examining programme needs in relation to funding allocations. To understand bottlenecks affecting access to antenatal care, the study team analysed available data and interviewed policymakers, programme implementers, and community members. The team identified several steps to increase use of health services: (1) fund outreach to the community; (2) address financial and other barriers that impede women's use of services; and (3) improve the quality of services to encourage return visits (Beysolow-Nyanti, 2011).

Field research can help programme planners and managers determine pricing, cost recovery, and subsidies to support disadvantaged groups. The Nigerian Federal MOH commissioned three studies on the prices, costs, and expenditures for various contraceptive methods. An ability-to-pay study conducted in six states found that people in the lowest three wealth quintiles could not afford the fees for family planning services at public facilities. This finding led the federal government to remove user charges for contraceptive services in April 2011. The National Health Insurance Scheme is considering adding family planning to its benefit package for community-based health schemes. A willingness-to-pay study found that more than half of those surveyed said that they were willing to make higher contributions to pay for contraceptives for the poor. On average, they were willing to contribute 695 Naira per year (US$4.32). This level of altruism suggests that community financing mechanisms such as community-based health insurance would be feasible for family planning services. The third study estimated the total costs of providing contraceptive supplies, including the commodity costs, storage, transport, and supply chain management. This analysis found that transportation costs for commodities were not included in state and local budgets and were paid for through cost recovery at service delivery points (Adeniran, 2011).



Improving Efficiency

Nearly all health programmes, services, and facilities could become more efficient—to provide services to more people without increasing overall costs and while maintaining high-quality services. Optimal efficiency is attained when a facility's outputs (e.g., number of patients, laboratory tests, and x-rays) match inputs (e.g., the number and type of health providers, drugs, equipment, beds, and other costs). In other words, the number of patients served should be in scale with the facility's staffing and other resources. Efficiency is important at all levels of service delivery, but it is especially needed in hospitals, since they are expensive to set up and operate. A recent study indicates that there is considerable scope for improving the efficiency of hospitals in Nigeria. Out of a random sample of 200 public and private hospitals in southeast Nigeria, three in four (76%) hospitals were rated inefficient, mainly because they had excess unused capacity (Ichoku et al., 2011).
Greater efficiency is achieved by linking health expenditures more closely with health outcomes while upholding quality standards.

Using Financing Mechanisms to Bolster Efficiency

Results-based Financing

The traditional model of health financing assumes that health facilities will receive funds based on their actual expenses, such as staff salaries, equipment, and medicines. This model provides no incentive for health providers to increase their patient load or keep costs low, since their expenses are paid regardless of their performance. Health economists are testing alternative payment models to improve efficiency.

Results-based financing gives payments to facilities based on outputs, such as the number of patients and type of services provided. The National Primary Healthcare Development Agency, in collaboration with the Federal MOH and the World Bank, is pilot testing this model in one LGA each in three states—Adamawa, Nasarawa, and Ondo—to increase use of maternal, newborn, and child health (MNCH) services at primary healthcare facilities. The project 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. Some of the challenges associated with this model are the difficulty of verifying the quality and quantity of the services and addressing demand-side barriers to service use (e.g., social norms, lack of knowledge about the benefits of healthcare, and perceptions about the quality or cost of the services). If not

Ways to Improve Efficiency

- Allocate staff responsibilities to ensure that highly skilled health workers are used appropriately and that other staff perform routine functions that require less specialised training
- Provide training to staff to ensure that they effectively perform specific tasks and meet patients' needs
- Monitor health expenditures closely
- Eliminate wasteful practices
- Examine purchasing procedures
- Increase accountability for providing high-quality services
- Eliminate corruption and leakage of drugs and supplies
- Provide community outreach to ensure services are matched with needs

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properly designed, results-based financing could trap low-performing facilities in a vicious cycle of low performance and low funding, never allowing them the opportunity to perform better. Also, the model must be financially viable if it is to be widely used (Ekisola, 2011).

Basket Fund

To allocate existing funds for primary healthcare more efficiently, Zamfara State created a basket fund, which pools funds from three sources—14 LGAs (70% of the total), the state government (20%), and development partners (10%). Established in 2009, the fund disburses 1.5 million Naira (US$9,700) monthly to support immunisation and maternal health services. The state and the 14 LGAs maintain separate accounts in the same bank. Fund disbursements are tightly controlled, using transparent mechanisms. Service delivery data are audited regularly to ensure accuracy. In just three years, the basket fund has improved routine immunisation services. The basket fund managers would like to extend coverage to subsidised MNCH services, but this expanded mandate would require more resources (Musa, 2011).

Exemption and Insurance Schemes

Jigawa State has given high priority to health programmes: 12 percent of its 2011 budget is allocated to health, and the 2009–2011 budgets have included a line item for MNCH. In 2009, the state initiated subsidised MNCH services at 15 health facilities under an exemption scheme managed by the Gunduma Health System Board. The health facilities submit invoices to the board and are reimbursed on a fee-for-service basis. A local committee determines patients' eligibility for exemptions, based on need.

The state also provides subsidised MNCH services and some counterpart funding from the Millennium Development Goal (MDG) Maternal and Child Health Project administered by the National Health Insurance Scheme. The programme began in six LGAs in 2010 and then expanded to seven additional LGAs. Health maintenance organisations manage the programme, register pregnant women and children under age 5, and pay health facilities 550 Naira (US$3.47) per enrollee per month. For referral cases, they reimburse tertiary care facilities on a fee-for-service basis.

A 2011 assessment of both schemes reported that use of MNCH services had increased across the state, with a 40 percent increase in visits to health facilities between 2009 and 2010. During this period, deliveries at primary health centers increased by 17 percent and antenatal care visits by 51 percent. Looking to the future, programme managers need to review reimbursement rates to reflect variations in the cost of various health services and differences by facility and locality, harmonise the Drug Revolving Fund with the MDG grant, and resolve the problem of delayed payments into the drug fund (Kainuwa, 2011).

Building Public-Private Partnerships

The private sector is a major source of healthcare in Nigeria, accounting for 33 percent of primary health facilities and 72 percent of secondary health facilities (Addo-Yobo, 2011). By collaborating with the private sector, public health programmes can extend their reach, make better use of existing resources, and reduce costs.

Policymaking, too, can benefit from collaboration with private sector entities. By partnering with the private sector, the MOH can have a far-reaching effect on the quality of care. For example, private professional associations can collaborate with the MOH to set and update standards of care, private providers can establish a network that sets good standards of care, and the MOH can invite private providers to participate in training (Addo-Yobo, 2011). Such initiatives could benefit both sectors.

Voucher Schemes

In Kenya, a pilot project collaborated with public, private, and faith-based health providers to provide maternal health, family planning (FP), and other services. The project enabled poor women in five districts to purchase subsidised vouchers to obtain a defined set of services. A voucher management agency ran the system, with oversight by a steering committee and advisory board. Using an output-based approach, the agency reimbursed health facilities for specific services rendered. During the first phase in 2005, sales of vouchers for maternal health were higher than expected, but those for FP and other services were not widely used, perhaps because they covered highly specific services. This model did increase access to maternal health services, especially in urban areas. For this scheme to work, managers must give constant attention to preventing fraud and abuse and to processing claims efficiently (Owino, 2011).

In Jharkhand State, India, a public-private partnership developed a voucher scheme to provide reproductive health (RH) services to rural women. The process began with a dialogue with poor women to understand the barriers they face in accessing FP/RH services and an analysis of data to quantify inequality in healthcare use. After identifying the districts with greatest need, the programme managers set up a voucher scheme to enable poor women to obtain FP/RH services from accredited private providers. Community health volunteers and nongovernmental organisations (NGOs) distributed the vouchers to beneficiaries, and a voucher management agency reimbursed the providers for their services. In addition, the state MOH partnered with NGOs to set up mobile medical units that could provide FP/RH services in underserved areas (Mishra, 2011).

Health Sector Financing Reform

The government of Ethiopia has adopted a series of initiatives as part of health sector financing reform—defined as "an alternative arrangement for paying, allocating, organizing, and managing health resources" (Yilma and Husain, 2011, p. 3). This process entailed designing a healthcare and financing strategy and adopting proclamations, regulations, and directives. The key components are as follows:

- **Revenue retention.** Public hospitals and health centers are permitted to retain user fees in addition to their existing budget allocations. They use these funds to address budget shortages, provide quality improvements, purchase supplies, and hire additional staff.
- **Fee waiver and exemption scheme.** Prevention, health promotion, and public health services are provided to everyone free-of-charge. Poor people identified by their communities were granted fee waivers.
- **Establishment of governing boards.** These boards engage local communities and create a sense of ownership. They also improve the effectiveness and efficiency of management and help to mobilise additional resources.
- **Outsourcing of non-clinical services.** Outsourcing some services has reduced costs and improved the quality and efficiency of health services, since it allows health professionals to focus on essential healthcare.
- **Introduction of a private wing in public facilities.** Public facilities are allowed to set up private wings, thus enabling doctors to earn extra money, thereby increasing their motivation and reducing attrition. Also, the private wings have generated additional funds that have been used to improve the quality of services in the public wing.

The government is also introducing social health insurance for formal (public and private) sector employees and community-based health insurance for workers in the informal and agriculture sectors (Yilma and Husain, 2011).

Mechanisms to Improve Accessibility and Affordability of MNCH Services

- Voucher schemes that enable beneficiaries to access services at public or private facilities
- Health insurance plans in which private providers are reimbursed for a defined health package at a set rate
- Contracting out specific health services in return for a negotiated rate and standards of care or contracting specific functions such as management
- Collaboration between the public and private sectors to collect and report service delivery data, analyse costs, and evaluate various programme models and financing mechanisms

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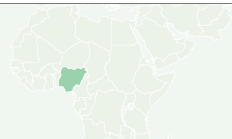


Sustaining Investments in Health

Countries can improve access to healthcare even when resources are flat, according to a 2011 study conducted by the London School of Hygiene and Tropical Medicine, titled Good Health at Low Cost. The study reviews health programmes in five countries over a 25-year period. While the proportion of their gross domestic product spent on health remained relatively constant, these countries have made major improvements in overall health status. The researchers identified six common themes that contributed to their success (Balabanova et al., 2011, p. 340):

- "Sustained investment in health systems, especially in primary care"
- Investing in building the skills of the health workforce
- "Strong political commitment to good health"
- "A high degree of community involvement"
- "Measures to ensure equity of access and use"
- "Health-promoting policies that go beyond the health system"

Nigeria and other nations can emulate these good practices, assuming there is the political will to introduce innovative approaches and promote public-private partnerships. The foundation for building effective and sustainable health systems is to base policy formulation and programme design, implementation, and evaluation on sound research. Research can help to understand individual and community health needs and ensure that funds are used efficiently and targeted to improve the health status of the poor and other disadvantaged groups.

Actions Needed

Participants of the 2011 conference, "Improving Financial Access to Maternal, Newborn and Child Health Services for the Poor in Nigeria," generated an extensive list of actions that could improve health financing at all levels, including the following:

Federal

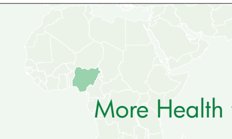
- Ensure that the National Health Bill is signed into law and implemented
- Put health on the concurrent list in the revised constitution for Nigeria
- Clarify costs of service delivery and ensure funds are appropriately allocated, based on evidence
- Conduct results-based monitoring and impact evaluation
- Increase accountability and transparency to reduce corruption
- Try new financing schemes and share results with all states
- Strengthen the capacity of universities and other training institutions to drive health financing reforms
- Improve coordination among partner agencies

State

- Provide adequate financial support to primary healthcare systems
- Develop programme and legal frameworks for social health insurance schemes as part of the National Health Insurance Scheme to decrease out-of-pocket expenditures and achieve universal coverage
- Channel some existing funds to demand-side financing mechanisms (e.g., vouchers for essential services such as FP and broad MNCH services)

LGA

- Formalise and systematise allocation processes for funds to ensure rational and equitable allocation
- Ensure that facilities at all levels have a health management information system that tracks expenditures and service use
- Scrutinise data on service use and applicable costs and discuss ways to improve services and eliminate waste with staff members, colleagues, and community members
- Strengthen the capacity of health professionals through training and supervision
- Release all funds required for health services



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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.**