



IMPROVING FINANCIAL ACCESS TO HEALTH SERVICES FOR THE POOR IN NIGERIA

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More Money for Health

Brief: Nigeria



► Priority Actions

- Advocate for increased government funds for primary healthcare
- Expand national health insurance coverage
- Mobilise community resources
- Engage the private sector

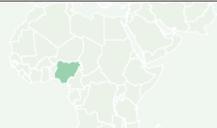
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Overview

There are various ways that health programmes can raise additional funds to provide primary healthcare to the poor, rural residents, and other vulnerable groups such as women and children. Despite the Nigerian government's commitment to achieving the Millennium Development Goals (MDGs) by 2015, the country is not on track to achieve the MDGs for maternal and child health before 2040 (Lozano et al., 2011). According to the United Nations Children's Fund (UNICEF), one in seven Nigerian children die before their fifth birthday—double the average rate for least developed countries (UNICEF, 2012). An estimated one in 23 Nigerian women are projected to die from maternal causes during their lifetime; this risk is much lower in other countries with a similar gross domestic product per capita, such as Ghana (1 in 68) and Mauritania (1 in 44) (WHO, 2012).

Nigeria spends approximately 6 percent of its total government budget on health—far below the 15 percent benchmark pledged by African Union countries in the 2001 Abuja Declaration (Ichoku, 2011; WHO, 2011). Many other African countries spend a higher proportion of their budgets on health, including Chad (14% of total budget), Ghana (13%), and Niger (15%) (Ichoku, 2011).





Key Lessons

To convince policymakers to spend more money on health programs, advocates must justify the additional funds.

- Provide specific information on system weaknesses and improvements needed
- Provide evidence on cost-effectiveness and benefits of health investments

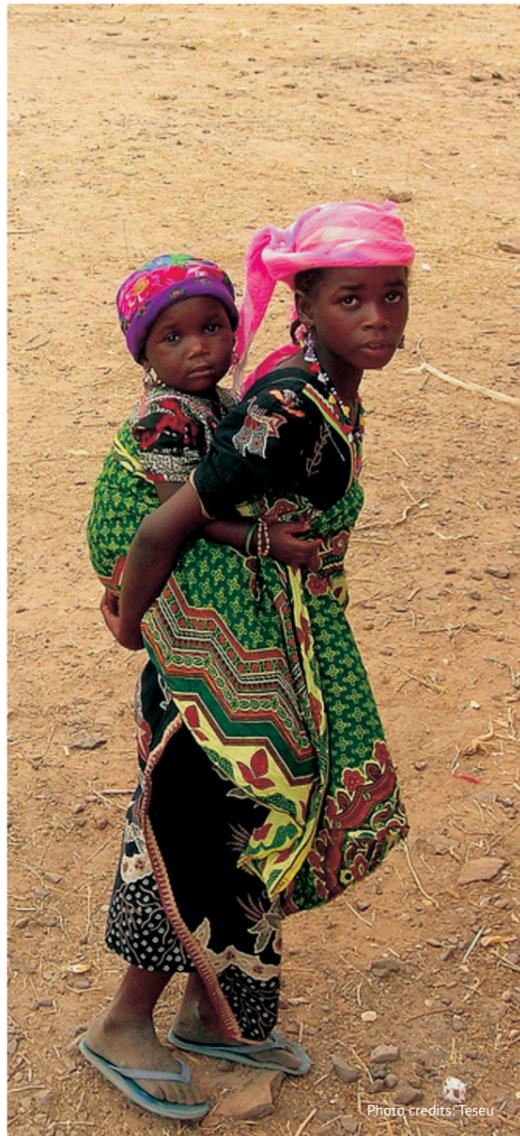


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Additional funds for health services in Nigeria could come from the following sources:

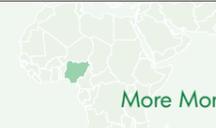
- Increased budgetary allocations by federal, state, and local governments
- Passage of the National Health Bill, which would increase federal and state funding for primary healthcare
- Allocation of a proportion of revenues from a value added tax and/or other earmarked taxes
- Funds and contributory schemes such as social health insurance, equity funds, and conditional cash transfers
- Funds, in-kind contributions, and donations from the private sector, civil society organisations, and development partners

Advocating for Increased Government Funds for Primary Healthcare

Health professionals are keenly aware of the weaknesses of many aspects of Nigeria's health system and of the need to provide free or subsidised health services to vulnerable groups. Their concern needs to be directed towards providing concrete information about the need for improvements to policymakers (at all government levels), political leaders, media representatives, and the general public. Health advocates need to make a strong case for investing in health services, stressing the benefits of good health to individuals, families, communities, and the economy. Many health interventions—such as maternal, neonatal, child health (MNCH) and reproductive health—have proven to be highly cost-effective, saving money in the long run.

The National Health Bill, passed by Nigeria's National Assembly in May 2011 and currently awaiting the President's signature, offers the promise of improvements in the health system and additional investments in primary healthcare (PHC). The bill supports provision of a basic package of services for all Nigerians and sets up a PHC fund with 2 percent of the consolidated federal revenue—estimated at 64 billion Naira (US\$413 million) in 2011. The bill also calls for states to provide adequate funding of State Primary Health Care Development Agencies (SPHCDA). If adopted, the bill would accelerate Nigeria's progress towards universal health coverage and lead to improved health indicators.

Additional public funds for health could also come from the government's allocation of a proportion of the revenues from a value-added tax, taxes on mobile telephone recharge cards, and/or other earmarked taxes. A small surcharge could add up to a large pool of funds when collected nationwide.



Expanding National Health Insurance Coverage

Health insurance plans are designed to cover large numbers of people at a reasonable cost by spreading the risk of catastrophic illness or injury. Expanding health insurance plans beyond formal sector employees requires strong political commitment and careful planning to ensure financial viability. Many health insurance plans benefit from public-private partnerships that take advantage of existing healthcare capacity and involve community members in planning and monitoring services provided to plan members.

Nigeria's National Health Insurance Scheme

The National Health Insurance Scheme (NHIS) has been a major source of funding for MNCH care. Set up in 2008 with funds allocated from the debt relief gains, the NHIS initiated programmes in six states during 2008–2009 and then worked in six additional states in 2009–2010. During the first two years, the NHIS provided a total of 9.25 billion Naira (US\$58.6 million). States were encouraged to match the NHIS grants in order to expand coverage. Using a public-private partnership model, accredited service providers and health maintenance organisations receive a monthly payment per enrollee for primary and secondary care as well as an administrative payment. The scheme has provided subsidised health services to more than 1.5 million pregnant women and children under 5 in the 12 states. More than 1,200 health facilities have been rehabilitated and equipped. A 2009 assessment reported a highly favorable cost-benefit ratio, with the value of the lives saved in the first year of operation worth six times more than the scheme's investment in health services.

The NHIS has demonstrated that using new funds to strengthen existing health facilities and leverage additional funds yields tangible benefits and enables synergies across various health initiatives. Some of the lessons learned are that enrollee registration has to be carefully monitored to prevent fraud; it takes time to establish a functional referral system; and community participation is essential to achieving success.

Ghana's Social Health Insurance Scheme

Ghana is one of the few countries that have made serious progress towards universal coverage by emphasising the informal sector (people who are self-employed such as market traders and farmers) from the onset. The 2003 National Health Insurance Act in Ghana authorised three types of health insurance schemes: (1) district mutual health organisations

Key Lessons

While expanding health insurance coverage has helped to optimise funding and equity, challenges remain.

- Monitor enrollee registration to prevent fraud
- Allocate adequate time to establish an efficient referral system
- Engage community participation to ensure success of programme
- Employ use of cross-subsidies to recoup losses in other parts of the system
- Pool registrants from the informal and formal sectors to increase equity in incurred cost
- Through performance-based financing, provide incentives to health workers to improve service quality and to the community to increase use of services

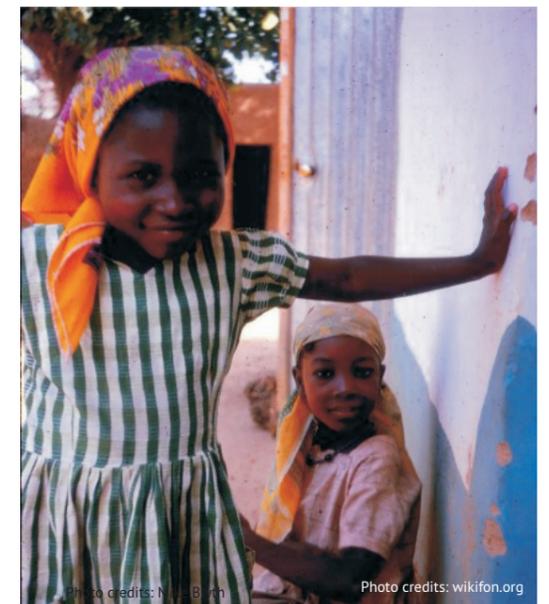


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(DMOs), which operate in every district and are subsidised by the national government; (2) private commercial insurance sold by companies; and (3) private mutual insurance, or cooperatives in which members pay into a fund for healthcare. These schemes are regulated by the National Health Insurance Authority. The DMOs are funded through a 2.5 percent value-added tax and 2.5 percent of contributions to social security from the employees or employers in the formal sector, coupled with premiums between US\$5 and US\$33 per person from adults working in the informal sector. The DMOs' benefit package covers ambulatory care, hospital admission, surgery, diagnostics, consultation, and specialised care. The scheme exempts children under age 18, the poor, pregnant women, people age 70 and older, and pensioners from payments. As of June 2010, 15.6 million people were registered under the DMOs. About 30 percent of these registrants were from the informal sector (Atim, 2011).

While challenges remain, especially in terms of long-term sustainability and equity, Ghana's scheme offers potential lessons for Nigeria's NHIS as it expands to cover more people in the rural and informal sectors. Specifically, Nigeria could replicate aspects of Ghana's experiences designing benefit packages and determining exemptions. Two key features that enhance equity are cross-subsidies, which entail using profits from one part of the scheme to meet losses from another part, and pooling registrants from the informal and formal sectors, which ensures that the risk related to financing health interventions is borne by all individuals regardless of employment (Atim, 2011).

Rwanda's Coverage of the Informal Sector

Rwanda has also made impressive progress towards universal health coverage. With high-level political support, the government has made health insurance compulsory for everyone. To meet the needs of people in the informal sector and the poor, the government set up a community-based health insurance (CBHI) plan, which was pilot-tested during 2001–2005. The results of the pilot test showed that the scheme had improved some health indicators, but service quality and antenatal care uptake were very low. Accordingly, in 2005, the government supplemented the CBHI plan by introducing performance-based financing (PBF) in facilities to provide an incentive to health workers to improve service quality. It is also testing community PBF to encourage pregnant women to use antenatal services. While the coexistence of CBHI and PBF has not eliminated health challenges, about 90–95 percent of Rwandans in the informal sector are enrolled and are accessing healthcare. During 2005–2011, deliveries at health facilities increased by 78

percent, new curative consultations by 51 percent, and family planning users by 209 percent. The long-term sustainability of these schemes is not yet assured; donors and the Rwandan government pay about 30 percent of CBHI contributions (Humuza, 2011).

Mobilising Community Resources

Communities have untapped potential to not only raise funds but also plan, manage, monitor, and build public support for community-level health programmes. Two health financing mechanisms—equity funds and community-based health insurance—have successfully involved communities in running local health programmes. Community involvement also helps to attract funds from federal, state, and local government area (LGA) agencies, as well as international partners.

Equity Funds

Health equity funds can address challenges of low access to and use of health services and can improve health indicators at the community level. One example of an equity fund that has enabled poor and vulnerable groups to access MNCH services is the one in the Ambursa community in Kebbi State. Beginning in 2000, a local association collected donations from individuals, mosques, and town associations. The association formed a management committee and set eligibility standards and health services to be supported. To date, the fund has raised 5 million Naira (US\$31,700), which has been used to add MNCH services to 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. Immunisation rates and use of antenatal care have risen, although few women opt to use family planning or give birth at the health center. 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).

In Ondo State, the Abiye Equity Fund was established to improve access to primary healthcare. Combining World Bank, state, and local 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 LGA. The fund has provided drugs and supplies, water and electricity, and staff training; and it has purchased ambulances and mobile phones for pregnant women. Between 2009 and 2011,

deliveries in health facilities have tripled, and the number of pregnant women making antenatal care visits has increased nearly five-fold (Adinlewa, 2011).

Community-based Health Insurance

Lagos State initiated a pilot study to mobilise private funding to provide health services to people in the informal sector. In 2008, the state MOH, one LGA, and three communities set up the Ikosi-Isherei Mutual Health Plan, a CBHI scheme. Each household participating in the scheme makes a monthly payment. Enrollees are covered for antenatal care and basic healthcare services; referrals and higher level care are paid directly by the enrollee. The LGA provides a subsidy to pay for premiums for the very poor. More than half of the active families were fully subsidised by the local government, raising concerns that some of the 500 subsidised families might not be in need.

A 2010 assessment found that the quality of services was good in terms of lower maternal and neonatal mortality rates, drug availability, and patient satisfaction. Some of the challenges were high turnover among the health providers, who are civil servants and therefore can be reassigned by the local government; high attrition rates among enrollees; lack of a profit and loss statement and data on the actual costs to provide services; and a concentration of enrollees from one community. The evaluators recommended that the programme managers evaluate alternative financing sources; expand outreach to bring in new enrollees (e.g., government employees, association members, and small employers); and set up a community fund that accepts donations (Zamba, 2011).

Engaging the Private Sector

With all levels of government in Nigeria facing tight budgets, partnerships with the private sector can help expand the pool of human and financial resources and improve access to services. Private sector services and products require little support from donors and governments and are therefore sustainable despite limited resources. Partnering with the private sector would help the public sector concentrate its resources on services for those most in need.

Harnessing the potential of the private sector requires strong government leadership and a supportive policy environment. Key to the success of such partnership is the adoption of a single framework of action for all partners, creation of a single national coordinating body, and establishment of a single national monitoring and evaluation mechanism to ensure adherence to accepted standards.

Public-Private Providers Network

Given the large number of private health facilities throughout the country, it makes sense to involve them in planning service delivery

Key Lessons

Equity funds and community-based health insurance help to mobilise private funding, but sustainability and quality are ongoing concerns.

- Establish a management committee to ensure transparency, accountability and adherence to eligibility criteria
- Build a cadre of skilled staff
- Ensure that a fund is set up to accept donations
- Identify alternative resources to supplement voluntary contributions and ensure drug supplies
- Ensure government subsidies reach those most in need
- Expand outreach for new enrollees

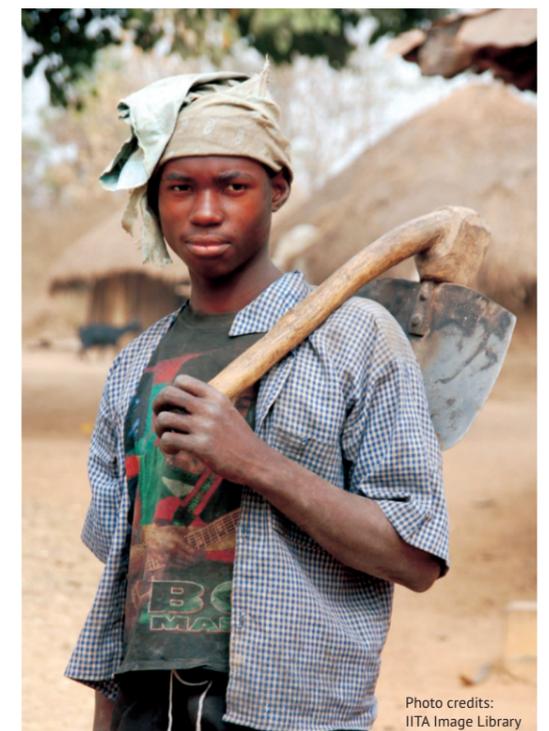


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Key Lessons

Successful public-private partnerships should be carefully structured to ensure consistency and efficiency.

- Adopt a single framework of action
- Establish a single national coordinating body
- Institute a single monitoring and evaluation mechanism
- Involve health facilities in planning and systems development

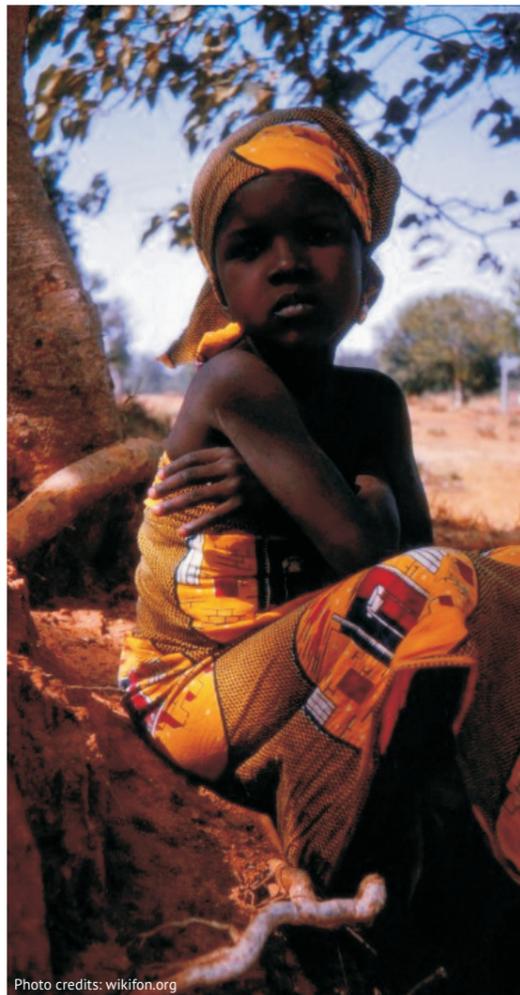


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systems and referral networks. In Kwara State, a CBHI scheme has set up a network of public and private health facilities to provide comprehensive health services. Since 2007, a health maintenance organisation has been providing community-based health insurance. The 55,807 enrollees pay a premium of 300 Naira (US\$1.90) per year; the programme is heavily subsidised by donors. The benefit package covers inpatient and outpatient visits, hospital care, consultation with specialists, provision of prescribed drugs, laboratory and diagnostic tests, radiology, and treatment of HIV/AIDS, malaria, and tuberculosis. Enrolment is below target, and many enrollees have dropped out due to migration. Some challenges include enrollees' inability to pay premiums, an inadequate number of providers, and suboptimal quality of services (Adenusi, 2011).

Actions Needed

Participants of the conference, "Improving Financial Access to Maternal, Newborn and Child Health Services for the Poor in Nigeria," generated an extensive list of actions to increase resources for MNCH services, including the following:

Federal

- Build broad coalitions to advocate for signing the National Health Bill into law and increasing budgetary allocations to health
- Promote various approaches for raising more money for health, including innovative methods such as taxes and surcharges
- Urge national and state assembly members to use part of their constituency project funds to pay the insurance premiums for low-income constituents
- Consider amending the NHIS Act to require universal health insurance

State

- Remove impediments to state adoption of NHIS
- Support implementation of CBHI
- Allocate more resources to MNCH interventions and release funds in a timely manner
- Strengthen the decentralisation process
Improve budget implementation and strengthen transparency and accountability mechanisms

LGA

- Help to mobilise and organise communities to implement CBHI
- Raise budgetary provisions for PHC systems and facilities

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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>.