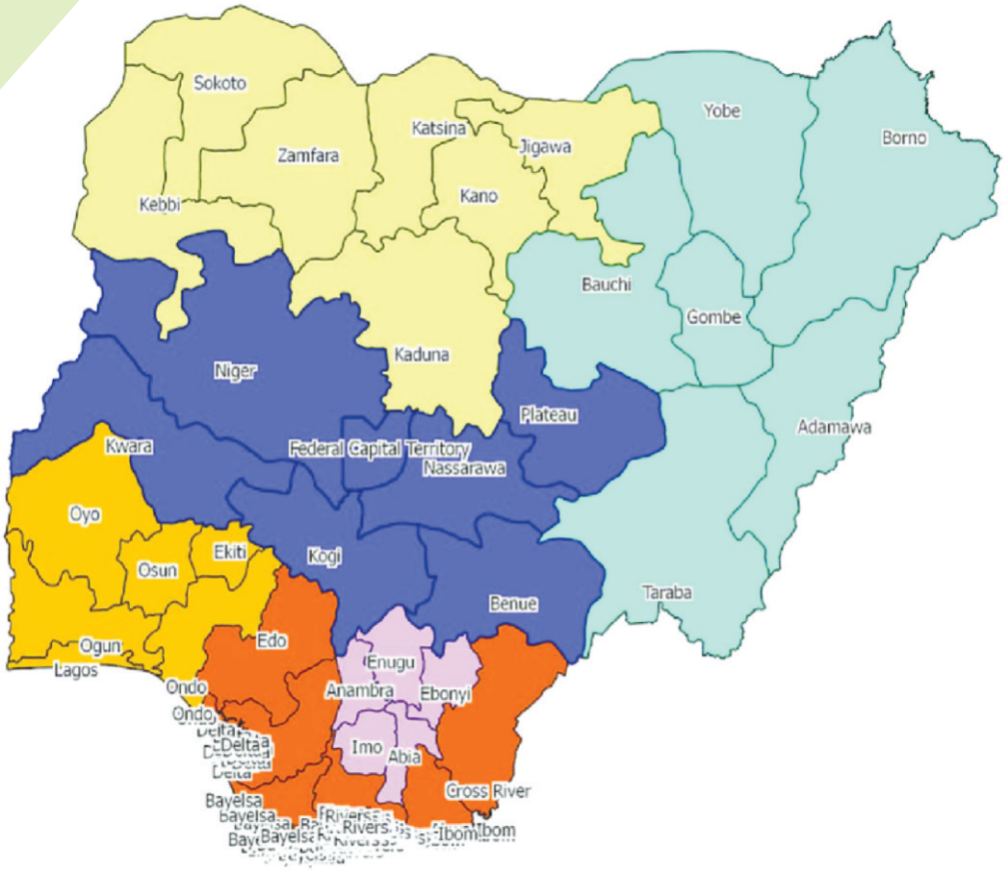
Nigeria Health Financing Policy and Strategy 2017

Achieving Universal Health Coverage and Rebuilding Nigeria's Economy through Efficient Health Investments



FEDERAL MINISTRY OF HEALTH

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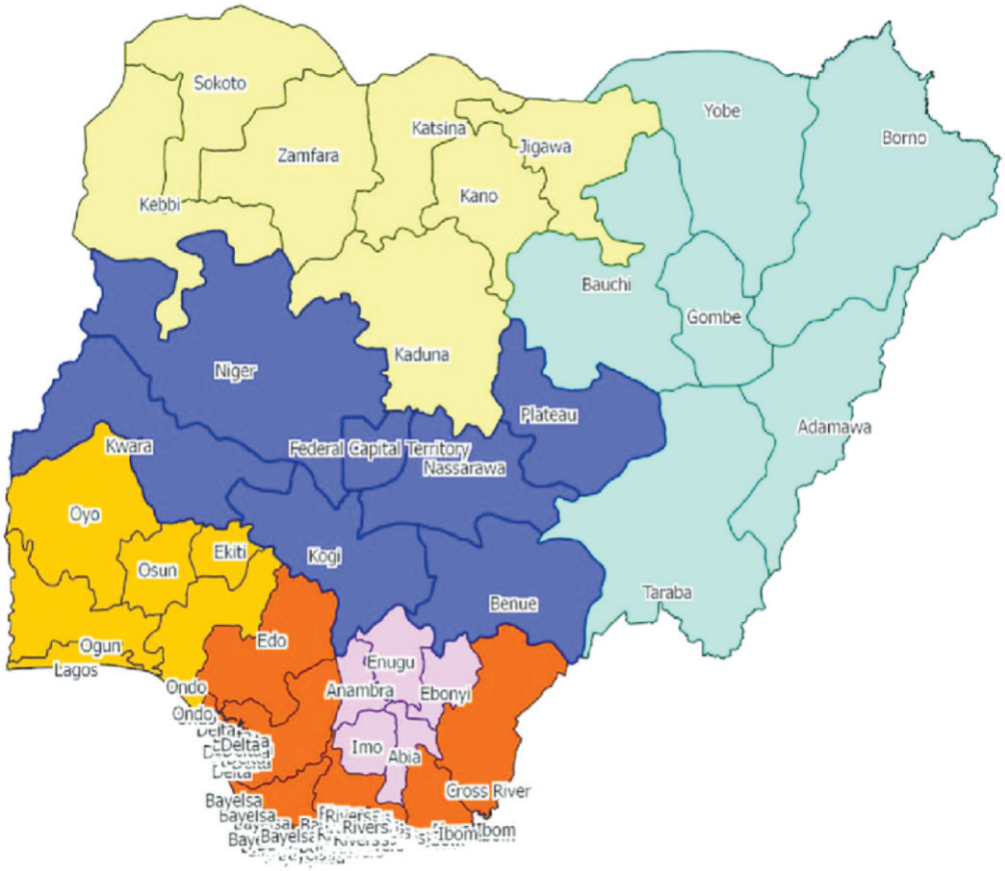

FEDERAL MINISTRY OF HEALTH

FOREWORD

Strengthening the national health financing system builds a strong foundation for the broader health system. Health financing thus serves as the pivot upon which other health system blocks revolve and rest. Achieving Universal Health Coverage (UHC) and indeed all health-related Sustainable Development Goals targets in Nigeria, therefore, will depend on how well Nigeria delivers on her ongoing health financing reforms.

The National Healthcare Financing Policy and Strategy provides evidence-based guidance to the Federal, State, and local governments as well as other actors in Nigeria's health system on how to provide an equitable and efficient health financing system that will guarantee UHC in Nigeria by 2030. It has been derived from subsisting laws and policies of government including the National Health Policy 2016, the National Health Act 2014, the Presidential Declaration on UHC and the Government's Economic Recovery and Growth Plan 2017. Its long term goal is to ensure that adequate and sustainable funds are available and allocated for accessible, affordable, efficient and equitable healthcare provision and consumption. It also provides policy directions and strategies for revenue generation, pooling, strategic purchasing and the governance system for health financing in the country.

This policy establishes the appropriate regulatory framework for health financing as part of the stewardship role of government and elaborates the roles and responsibilities of other stakeholders towards achieving UHC. It also explains the policy directions for improving efficiency and equity in the health system as improvements in health financing do not depend solely on generating additional resources, but also on the efficient utilization of available resources, and the effective and equitable deployment of resources within different population groups in the country, especially the under-served.

The strategies here proposed are expected to strengthen establishment and implementation of risk protection mechanisms including health insurance and social safety-net schemes, improving evidence generation and use for health financing policy development and implementation, as well as monitoring and evaluation.

I am confident that this national health financing policy and strategy document will provide the needed evidence-based framework for domestic resource mobilization, resource pooling, and strategic purchasing of healthcare services including results-based financing approaches, and contextual governance and institutional arrangements that will galvanize Nigeria's efforts towards achieving UHC and significantly improving the health status of all Nigerians.

I therefore, recommend this healthcare financing policy and strategy to all Nigerians, health policymakers, budget makers and custodians, development partners, academia, civil society organizations, the media, and all health system actors in Nigeria.

Prof. Isaac F. Adewole FAS, DSC (Hons)
Honourable Minister of Health
March, 2017

ACKNOWLEDGEMENT

Nigeria is in the process of accelerating achievement of Universal Health Coverage (UHC). At the core of this process is the development of the National Healthcare Financing Policy and Strategy. Considering the emerging trends in the national and international financing landscape for health especially in the wake of the Sustainable Development Goals, this policy and strategy is most appropriate in guiding the Federal, States, and Federal Capital Territory (FCT), as each of these levels engage constructively in designing their health-based programs.

Given the priority accorded health in this administration, this National Health Financing Policy and Strategy has emerged as a result of the strong leadership and commitment of the Federal Ministry of Health (FMOH) in ensuring the articulation and provision of adequate and sustainable financing for efficient provision of equitable and quality healthcare for all Nigerians. The FMOH therefore acknowledges with gratitude the collaboration and huge efforts of the National Healthcare Financing Equity and Investment Technical Working Group in drafting this policy and strategy document.

The Ministry is especially thankful to all our development partners under the auspices of the Development Partners Group, particularly World Health Organization, United Kingdom Agency for International Development, United States Agency for International Development, United Nations Population Fund, United Nations Children's Fund, World Bank, and Bill and Melinda Gates Foundation for their technical and financial support.

Let me at this point most sincerely appreciate State Ministries of Health, FCT Health and Human Services Secretariat, the National Health Insurance Scheme and National Primary Health Care Development Agency for their strong collaboration towards coordinating the task of developing this document. Special appreciation goes to the State health financing teams, other Ministries, Departments and Agencies, private sector organizations including Healthcare Federation of Nigeria and James Daniel Consulting; Civil Society Organizations led by Health Reform Foundation of Nigeria, non-governmental organizations, Centre for Health and Economic Development, and everyone who contributed to the success of this endeavour.

Finally, the Ministry is indeed grateful to our staff who facilitated the development of this first National Healthcare Financing Policy and Strategy especially the pioneer staff of the Healthcare Financing, Equity and Investment Branch under the Health System Strengthening Division of the Department of Health Planning, Research and Statistics for their dedication and determination in accomplishing this important task.

It is our hope that all Nigerians will find the National Health Financing Policy and Strategy very useful towards accelerating financing for UHC.

Dr Akin Oyemakinde
Director, Department of Health Planning, Research and Statistics
March 2017

CONTENTS

ACRONYMS

AIDS	Acquired Immune-deficiency Syndrome
BHCPF	Basic HealthCare Package Fund
BMPHS	Basic Minimum Package of Health Services
CRF	Consolidated Revenue Fund
CSOs	Civil Society Organizations
DHPR&S	Department of Health Planning, Research & Statistics
DPG	Development Partners Group
DRF	Drug Revolving Fund
ERGP	Economic Recovery and Growth Plan
FCT	Federal Capital Territory
FMOH	Federal Ministry of Health
GDP	Gross Domestic Product
HCFE&I	Health Care Financing, Equity & Investment
HIV	Human Immuno-deficiency Virus
IGR	Internally Generated Revenue
LEEDS	Local Government Economic Empowerment Development Strategy
LGA	Local Government Area
MDAs	Ministries, Departments and Agencies
MDGs	Millennium Development Goals
M&E	Monitoring and Evaluation
MTEF	Medium Term Expenditure Framework
MTSS	Medium-Term Sector Strategy
NAFDAC	National Agency for Food and Drug Administration and Control
NCDs	Non-communicable diseases
NEEDS	National Empowerment Development Strategy
NEPAD	New Economic Partnership for African Development
NGOs	Non-Governmental Organizations
NHA	National Health Accounts
NHAct	National Health Act
NHCFP&S	National Healthcare Financing Policy and Strategy
NHFIS	National Health Financing Information System
NHIS	National Health Insurance Scheme
NHMIS	National Health Management Information System
NHP	National Health Policy
NPHCDA	National Primary Healthcare Development Agency
NSHDP	National Strategic Health Development Plan
OECD	Organization for Economic Cooperation and Development
OOP	Out- of- Pocket
PETS	Public Expenditure Tracking Survey
PFM	Public Finance Management
PPM	Provider Payment Mechanism

PPP	Public Private Partnership
SEEDS	State Economic Empowerment Development Strategy
SDGs	Sustainable Development Goals
SHIS	State Health Insurance Scheme
SPHCDA	State Primary HealthCare Development Agency
TB	Tuberculosis
THE	Total Health Expenditure
TWG	Technical Working Group
UHC	Universal Health Coverage
VAT	Value Added Tax
WHO	World Health Organization

EXECUTIVE SUMMARY

In Nigeria, the total health expenditure on health has been rising but with limited financial access and risk protection from health expenditures for the majority of the population. While the population is increasing, government health expenditure on health is rather on the decline with the Total Health Expenditure (THE) only 3.8% of the GDP in 2016. Abuja Declaration is yet to be achieved as annual government budget allocation to health is also on the decline from 6% in 2012 to 4.2% in 2016 leaving critical services in the health sector heavily dependent on external funding. As a result, Out of pocket expenditure (OOPE) on health is high at about 71.5% in 2016 with almost half the population living below a dollar per day. This high expenditure on health increases the vulnerability of the poor to slip further into poverty and increasingly leads to death of predominantly poor population.

Currently, health spending is predominantly inefficient with recurrent expenditure consistently over 90% of the THE since 2010. Spending on primary health care (PHC) is only 20% in 2014, while over 80% of healthcare fund is spent on curative care. With relatively good number and mix of health workers in the country, these workers are mostly idle in public facilities as absenteeism is recorded at 29% on the average, with average patient load of three per day. Average stock-out of essential drugs is at 67%, while only 25% of PHC have basic minimum equipment. Most public health facilities lack clear accountability mechanisms making it challenging to track annual revenues accruing to the Nigerian economy from health. With the exception of tertiary hospitals, public health facilities lack management autonomy.

The above are further worsened by the challenges in the public finance management (PFM) systems of the health sector which include:

(i) General lack of strategic direction in budgeting;

(ii) Misalignment between the Ministry of Finance (MOF), Ministry of Budget and National Planning (MOBNP), National Assembly (NASS), and the Ministry of Health (MOH);

(iii) Disconnect between those who develop policies at Department of Health Planning Research and Statistics (DHPR&S) and those who manage budgeting process at Department of Finance and Accounts (DFA);

(iv) General lack of capacity across the budget process;

(v) Funding delays, which affect ability to execute budgets; (vi) perceived lack of absorptive capacity; and (vii) challenges in tracking inputs and outputs, and in connecting these to future budgeting and strategic decisions.

While the poorest households feel the heaviest impact, it is important to note that poor healthcare has negative spillover effects (externalities) on the rest of the population. Failure to curb diseases such as Tuberculosis, that affect more of the lower socio economic groups, can result in increased disease prevalence and more transmission across the country. Adopting efficient and equitable health financing strategies that will facilitate the achievement of health-

related Sustainable Development Goals (SDGs), especially Universal Health Coverage (UHC) is therefore critical in the overall strengthening of the Nigerian health system.

To demonstrate her strong commitment in fast-tracking progress towards the SDGs, especially UHC, the Nigerian government held the Presidential Summit on UHC on March 10, 2014, which prescribed actions to be taken for the country to achieve UHC. Later the same year, the National Health Act (NHAct) was enacted, and in 2016, the new National Health Policy was developed to provide clear policy directions for health in Nigeria.

A critical pathway to achieving UHC in Nigeria is the need for health financing policies and strategies that are equitable and reflect commitments to increase the proportion of all Nigerians in the bottom two quintiles that can access needed healthcare without any financial barriers. The goal of the National Health Financing Policy and Strategy therefore is to ensure that all Nigerians have access to timely, affordable, quality, efficient and equitable healthcare services they need without the risk of impoverishment.

Over the next 5 years, the six (6) objectives of this Policy and Strategy are to

i. Increase General Government Health Expenditure (GGHE) as a percentage of General Government Expenditure (GGE) by 5%
ii. Improve the coverage of Nigerians on health risk protection mechanisms by 30% by extending health insurance to 50 million Nigerians;
iii. Reduce out-of-pocket expenditure (OOPE) on health as a percentage of Total Health Expenditure (THE) by 20%
iv. Improve health expenditure on primary healthcare (PHC) and preventive health services by 20%
v. Ensure that the National Health Insurance Scheme (NHIS) and 50% of health risk protection schemes have performance-based financing (PBF) as provider payment mechanism to ensure quality and efficiency
vi. Establish and strengthen healthcare financing systems to ensure accountability, transparency and sustainability at the federal, 36 states, the FCT, and the 774 Local Government Authorities.

Achievement of the above objectives will rest on four (4) Strategic Pillars namely,

(i) Strengthened Health Financing Governance and coordination,
(ii) Adequate revenue generation,
(iii) Effective pooling and financial risk protection, and
(iv) Efficient strategic purchasing of essential health services.

A phased approach to implementation will be adopted to ensure progressive and sustained achievement over 5 years, while a monitoring and implementation framework has been developed to facilitate the roll out and operationalization of this strategy.

CHAPTER 1 | INTRODUCTION

1.1. Provision of Adequate and Sustainable Financing is Vital for Effective, Efficient and Equitable Health System Performance

The Nigerian health system has not fared well in comparison to her peers. With 63% of the population living below 1$ a day, (NDHS 2013), the high cost of healthcare to households is regressive and implies financial related barriers to accessing healthcare, unmet healthcare needs within the population along with catastrophic medical expenditure among those who access care. Achieving Universal Health Coverage within the Nigerian population requires that the current healthcare financing strategy be restructured and improved to ensure equitable, effective and efficient access to care.

The Government of Nigeria has not made considerable progress in financing the national health system in the last decade. The budget for health still falls far short of the Abuja declaration of 15% of annual budget committed to by African Countries in 2001. Adverse economic headwinds (due to falling oil revenues), poor purchasing power within the population and rising healthcare costs further complicate inadequate healthcare coverage to all of Nigeria's citizens. Hence, expanding and sustaining a robust health system in the country will depend on the availability of equitable and efficient revenue generation mechanisms; pooling and managing financial risks, strategic purchasing of basic essential health services the extent to which vulnerable groups are protected as well as the existence of efficient health care purchasing arrangements.

There is limited use and awareness of the potential impact of pre-payment financing schemes, which spreads risks, pools funds and strategically allocates resources for purchasing of services according to the health needs of the population. There is also very little action on issues of healthcare equity, financial protection, and social safety net improvements.

UHC implies that everybody, irrespective of socio-economic, political, demographic and gender differences, has equal "access to key promotive, preventive, curative and rehabilitative health services of good quality at an affordable cost"(World Health Assembly Resolution, 2005). Research has thus revealed that UHC is the way to go for societies that wish to improve the health status of its citizenry and improve economic development. It is a fact that the inequalities in income, education, social exclusion due to gender and migration status, insufficient health workers, medicines, health technologies and above all, health financing systems that do not function, have combined to make it difficult for the poor to access even the most basic health services. Improving the functioning of health systems and achieving equitable access and affordability of healthcare services to all is therefore encapsulated in current efforts to achieve universal health coverage (UHC) (Onwujekwe, 2013).

However, achieving UHC will depend on high level political commitment, appropriate legislation, enabling policies, strategic plans, adequate capacity, sustained and targeted advocacy, improved perceptions; ensuring that there is more health for money (improved efficiency); more money for health (increased funding); innovative health financing; and improvement of equity in the provision and utilization of health services with assured financial risk protection. Put together, all these will ultimately lead to better health indices and achievement of national and global health goals.

The World Health Organization (2010) proposed five key indicators for countries to track progress towards achieving universal health coverage with benchmarks namely:

i. Total health expenditure (THE) as a percentage of the gross domestic product (GDP) of the country (at least 4% - 5%);
ii. Out-of-pocket spending as a percentage of total health expenditure (not more than 30-40%);
iii. Percentage of the population covered by pre-payment and risk protection schemes (over 90%);
iv. Percentage of the population covered by social assistance and safety-net programmes (100%)
v. Percentage access to health services by the 40% poorest population (80%).

Efforts to achieve the above have led to high-level commitments by the Government of Nigeria over the years. Nigeria signed on to the global movement towards achieving UHC, which is a key thrust of the health-related Sustainable Development Goals (SDGs). The World Health Assembly in 2005 and the African Union through a conference of Ministers of Health and Finance in the African region in July 2012 passed different resolutions in support of UHC. The United Nations also passed a resolution in December 2012 in support of UHC. The first attempt to get Nigeria on the path to UHC was an international conference that was held in Tinapa Cross Rivers State in November 2011. That conference laid a foundation for the quest of the country to achieve UHC. Then, in March 2014, Nigeria held the Presidential Summit on UHC, which prescribed actions, needed for achievement of UHC in the country. The above efforts received a boost with the enactment of the National Health Act in October 2014 and the development of the National Health Policy in 2016, which further laid down foundations for achieving UHC in Nigeria.

However, UHC cannot be achieved by weak health systems, especially in Nigeria, where 71.5% of healthcare financing comes from households' out-of-pocket payments even with 63% of Nigerians living below one dollar per day. The country indeed has all the resources to achieve UHC, but it requires the right combination and optimization of the building blocks of the health system. Two related motivations for increasing access and therefore commitment to universal health coverage are (a) the fact that every individual has the right to health, and hence to some measure of healthcare, and (b) that poor health has negative spillo ver effects

(externalities), from individuals to the community1. This then pre-supposes that the larger society has a stake in ensuring that poorer individuals have access to health coverage for even basic health services. Universal health coverage therefore becomes a development issue rather than health issue as it requires broader multi-sectorial collaboration and strong political leadership and commitment to make such collaboration work. Ever since the publication of the 2000 World Health Report, there has been a growing awareness that health financing is not simply about raising money, instead, there are three (3) key functions of health financing: revenue generation, pooling and purchasing (RESYST, 2014).

The National Health Financing Policy and Strategy provides a coherent framework for achieving accessible, sustainable, affordable, equitable and efficient health care delivery that will lead to the achievement of UHC in Nigeria. This policy and strategy document benefited from extensive stakeholder consultations, wide literature search in good practice from both developed and developing countries in addition to evidence based field survey in the six geographical zones of the country.

Clear actions need to be taken to establish proper structural institutions and fiduciary systems; identify, adapt and scale up financing schemes which have proved beneficial in pilot phases; implement Social Health Insurance and contributory schemes; and explore public-private partnerships for health financing, all to ensure that there are no financial and physical barriers to accessing health care services for all who need it. There is also a need to build evidence through impact evaluations, cost-benefit analysis on which health financing schemes work and can be scaled up.

1.2. Process of Developing the National Health Financing Policy and Strategy

The process of developing the National Health Financing Policy and Strategy (NHFP&S) has been very inclusive with engagement of relevant health stakeholders and state officials. The platform for the development of the NHCFP&S was the Healthcare Financing Equity and Investment (HCFE&I) TWG, with the HCFE&I Branch of the Department of Health Planning Research and Statistics (DHPR&S) FMOH as the Secretariat. The TWG met periodically to review and consider major reports and technical contents contributed by members. A small Technical Core Team to support the Secretariat was established, made up of representatives of key ministries, departments and agencies (MDAs), civil society organizations (CSOs), and development partners namely: NHIS, National Primary Health Care Development Agency (NPHCDA), World Health Organization (WHO), United Kingdom Agency for International Development, United States Agency for International Development, United Nations Population Fund, World Bank, Bill and Melinda Gates Foundation, and Health Reform Foundation of Nigeria.

The Core Team met very often to continue technical discussions and inputs from the Consultants and TWG meetings, preparatory for the next TWG meeting. A detailed account of the steps followed in the production of this document is further detailed within the annex.

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1 The Lancet - 8 September 2012 (Vol. 380, Issue 9845, Pages 944-947)
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CHAPTER 2 | SITUATION ANALYSIS OF HEALTH FINANCING IN NIGERIA

2.1 Healthcare in Nigeria

In 1960 at the time of Nigeria's independence, the health care system predominantly provided curative care and was almost the exclusive preserve of the urban areas. This divide has continued in Nigeria till date with public and private health expenditure significantly higher in the urban than in the rural areas. Subsequent decades saw a feverish expansion in public sector provision of healthcare. A health sector strategy was introduced in the third National Development Plan and focused on primary healthcare. Then a PHC model was developed in which one (1) comprehensive health centre, four (4) health centres and twenty (20) clinics served one hundred and fifty thousand (150,000) people. By 1988, the National Health Policy provided for a decentralized system in which roles were defined for the Federal, State and Local Governments, much of which holds true today.

The National Council on Health, chaired by the Honourable Minister of Health has overall responsibility for health policy. Policy guidance and technical support are provided at the federal level and includes inputs from international relations with donors, tertiary hospital services and national health information management. The states are predominantly responsible for secondary level health service provision and some tertiary facilities including the regulation and technical support to secondary facilities while the Local Government level is concerned with the operation of publicly owned primary healthcare facilities.

Unpredictability in oil prices, the current crash in oil prices and subsequent fall in government revenues have led to a contraction in government spending affecting the healthcare sector. The fiscal transfers between the Federal and State Governments are not earmarked for health, nor are budget and expenditure reports required by States or LGAs to effect subsequent transfers leading to low levels of accountability and poor funding of social sectors such as health.

2.2 Healthcare Financing Governance Systems

The FMOH developed the NSHDP I in 2010, with UHC as its goal. This led to the acceleration of activities by various government and non-government institutions in several directions without a focal point for UHC in the FMOH.

On the one hand, the NHIS has a mandate for financial risk protection while the NPHCDA is largely responsible for ensuring physical access to quality PHC services. Other affiliated federal health agencies and parastatals such as NAFDAC and regulatory bodies have the mandate for ensuring quality of healthcare. However, many health NGOs and development partners carry out vertical programs on various fronts. There was therefore poor coordination of these programs and activities with an apparent challenge of measuring their impact.

After the Presidential Declaration on UHC in 2014, the need for a central coordination for UHC became more apparent. This then led to the creation of the Healthcare Financing Equity and Investment (HCFE&I) Branch, within the Health Systems Strengthening Division of the Department of Health Planning Research and Statistics (DHPR&S), FMOH.

The mandate of the HCFE&I Branch is to provide overall policy and strategic direction towards achieving the Presidential mandate on Universal Health Coverage (UHC) and deliver Nigeria's UHC agenda in line with the NHAct 2014 and SDGs by galvanizing and technically coordinating relevant HCF efforts in Nigeria through leveraging existing resources and building appropriate partnerships. This step by the FMOH has led to the development of the National Healthcare Financing Roadmap, the establishment of the National HCFE&I technical working group (TWG), and the development of the NHFP&S. It was agreed with States and the FCT at the first National Healthcare Financing Roundtable in Abuja, December, 1, 2014, that these efforts at the FMOH will be replicated in all the 36 States and the FCT. As at March 2017, 11 states had enacted their Health Insurance and Contributory Scheme Laws, 19 had established HCFE&I Units, 12 had constituted HCFE&I TWGs, and 3 had developed health financing Policies.

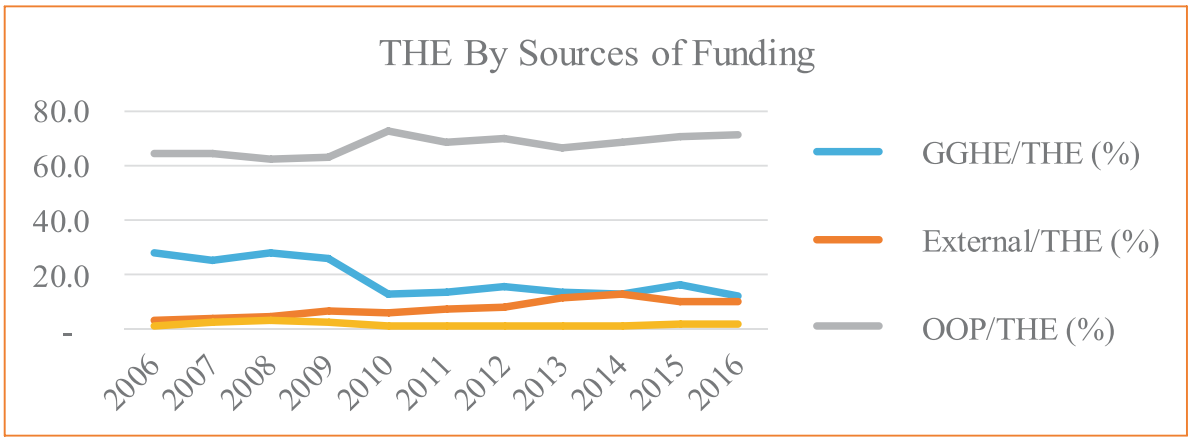
2.3 Health Financing Functions

This section of situation analysis focuses on examining the health financing systems and mechanisms of Nigeria through the three health financing functions as defined by the World Health Organization, namely: (1) Revenue mobilization; (2) Fund Pooling; and
(3) Strategic Purchasing, including provider payment mechanisms.

2.3.1 Revenue Mobilization

The Nigerian healthcare system is rather regressive with regards to revenue mobilization. Out-of-pocket spending (OOPs) by individuals and their households pre-dominate as the major financing mechanism in Nigeria accounting for 71.5% of total health expenditures (THE) in the country (NHA, 2016). This primarily discourages the poor from seeking care and leads to catastrophic medical expenditure (Xu et al, 2003, Carrin et al 2010, Mills et al, 2012).

Figure 1: Key Components of Total Health Expenditure in Nigeria:



There is generally a low level of mobilization of funding for health at all levels of government especially at the states and LGA levels. Consequently, there's low level of financial risk protection for the poor and vulnerable groups. According to Onwujekwe et al., the current malaise with health financing mechanisms within Nigeria largely depend on political factors such as the federal structure of Nigeria and its impact on the provision of public health within a political economy of constitutional bottlenecks; weak institutional and regulatory frameworks; lack of empirical evidence on the impact of existing mechanisms; lack of accountability by different levels of government, (i.e. Federal versus State versus LGA) against the background of poor macroeconomic and fiscal profile of the country, (low internally generated revenues of several States). The 4-year electoral cycle which focuses political capital on short term health projects at the expense of long term health projects has also not helped.

Per capita health expenditure of government in 2014 was 29.55$, while the total per capita health expenditure was 77.00$ in 2016. Even though increased public expenditure on health needs to be targeted to achieve the desired impact, these low levels of per capita public expenditure on health are clear stumbling blocks to achieving health coverage. They also adversely affect the stewardship role of the Government in healthcare.

Figure 2: Total Health Expenditure as a Percentage of GDP; NHA 2006-2016

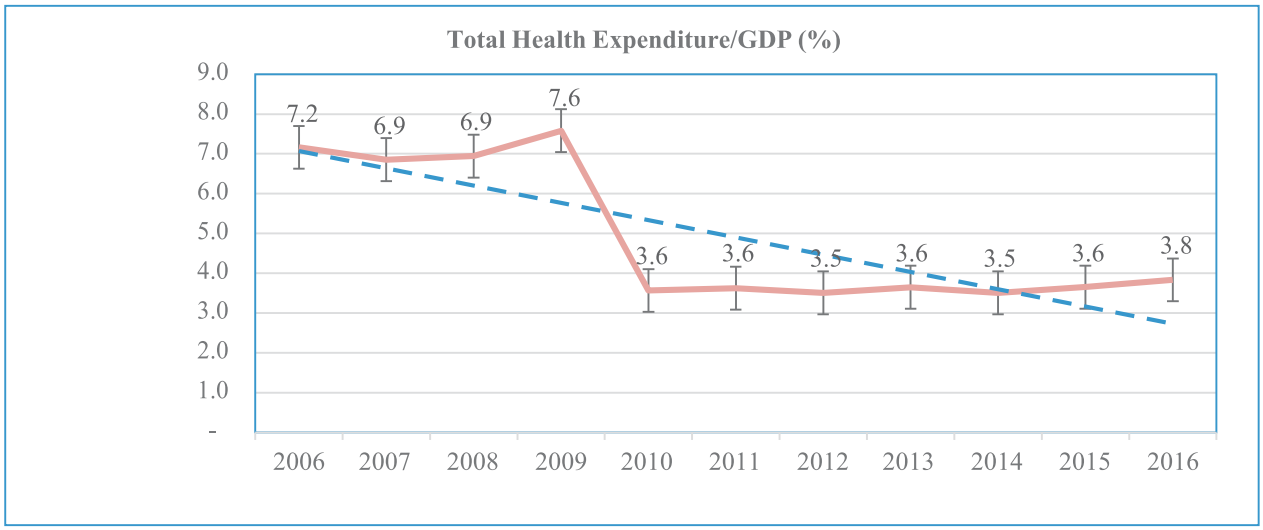
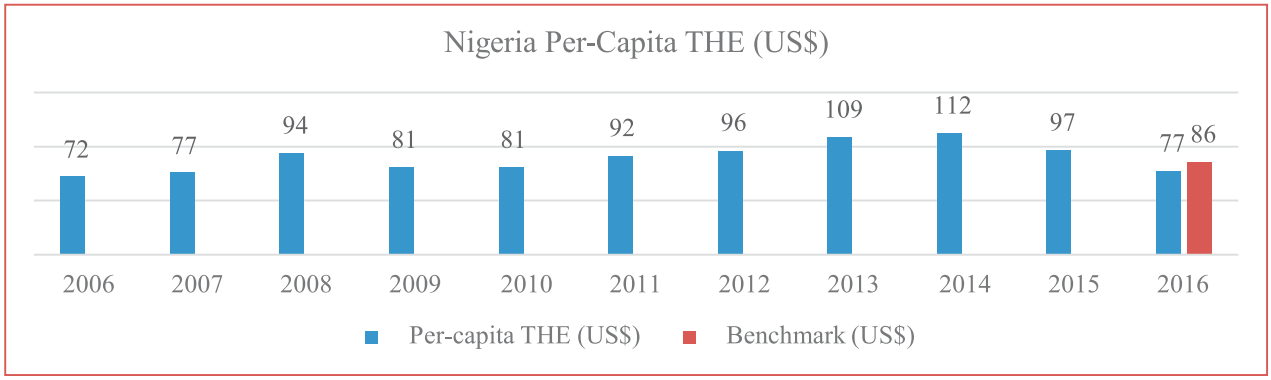
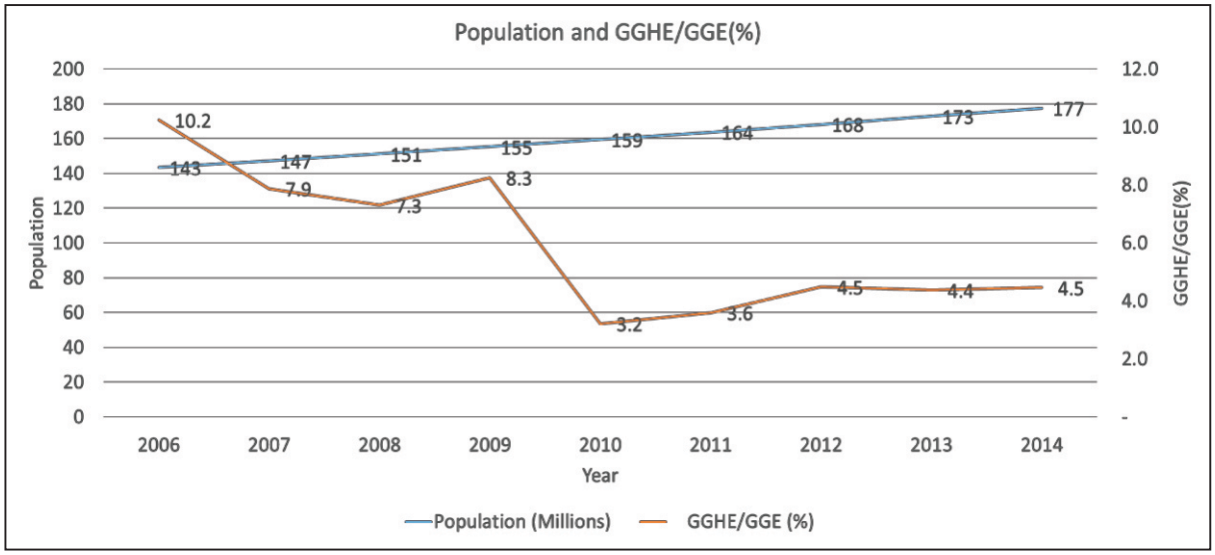


Figure 3: Nigeria Per Capita Total Health Expenditure (US$); NHA 2006 2016



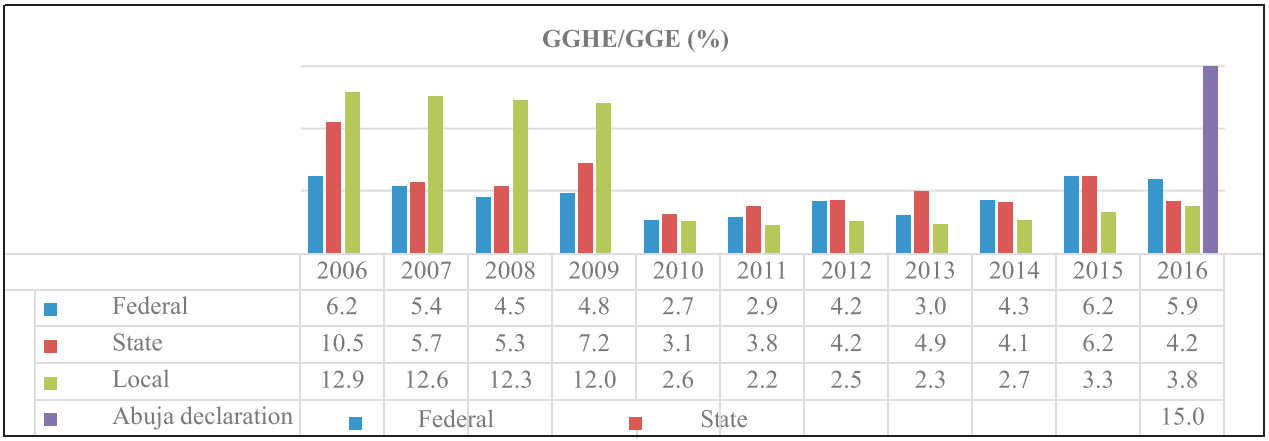
On the demand side, there are low levels of financial risk protection and coverage for the population. Health insurance schemes have less than 5% coverage of the population and are not mandatory. Currently it is more widely distributed among the formal sector with the informal sector largely left uncovered. Some of the factors that have led to its stunted growth include: lack of political will among some of the Federating units of Nigeria to roll out the health insurance schemes; lack of legal framework for mandatory health insurance; weak technical capacity to implement the health insurance schemes nationwide; and poor understanding and perceptions of health insurance by the populace.

Figure 4: While Nigeria's Population is increasing, Government Expenditure on health is rather declining; NHA 2006-2014



There is evidence that increasing public spending on health directly correlates to a fall in maternal mortality and under5 mortality rate (Wagstaff and Claeson 2004). A study on 120 countries showed that increasing government spending by a factor of **10%** led to a fall of 3.3% and 5% in U5MR and maternal mortality rates respectively Bokhari et al. (2007). Public spending also tends to be more pro-poor than private spending. It therefore follows that achieving pro-poor health outcomes requires improved resource mobilization from the different levels of government (Bidani and Ravallion 1997).

Figure 5: General Government Health Expenditure as a percentage of General Government Expenditure.



	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Federal	6.2	5.4	4.5	4.8	2.7	2.9	4.2	3.0	4.3	6.2	5.9
State	10.5	5.7	5.3	7.2	3.1	3.8	4.2	4.9	4.1	6.2	4.2
Local	12.9	12.6	12.3	12.0	2.6	2.2	2.5	2.3	2.7	3.3	3.8
Abuja declaration											15.0

Table 1: Key Health Financing Indicators in Nigeria: NHA 2010-2016							
	2010	2011	2012	2013	2014	2015	2016
Nominal GDP (Billions)	54,205	63,713	72,600	81,010	90,137	95,178	102,684
Population (Thousands)	159,425	163,771	168,240	172,817	177,476	182,202	186,988
Total Government Expenditure (Billions)	8,817.5	9,885.9	10,095.3	11,039.0	10,184.2	9,704.3	9,657.7
Federal Government Expenditure (Billions)	4,194.6	4,712.1	4,605.4	5,185.3	4,587.4	4,988.9	5,160.7
State Government Expenditure (Billions)	3,266.2	3,541.9	3,845.1	4,046.8	3,983.0	3,469.2	3,439.2
Local Government Expenditure (Billions)	1,356.7	1,631.9	1,644.8	1,806.9	1,613.8	1,246.3	1,057.8
Exchange Rate - Period Average (Naira/US$)	150.3	153.9	157.5	157.3	158.6	197.0	272.6
Total Health Expenditure (Billions)	1,933.5	2,309.7	2,546.1	2,954.7	3,161.3	3,473.5	3,935.4
Total Government Health Expenditure (Billions)	248.8	305.4	395.2	396.4	401.9	563.0	489.8
Federal Government	111.8	136.8	191.5	155.1	195.3	307.3	306.5
State Government	102.3	133.1	162.1	199.9	163.8	214.4	143.4
Local Government	34.6	35.6	41.6	41.4	42.8	41.3	39.9
Donor Health Expenditure (billions)	114.4	166.5	205.4	347.2	410.4	338.1	385.4
Households	1,405.8	1,581.0	1,776.9	1,965.5	2,168.7	2,451.1	2,813.4
Out-of-Pocket Household Expenditure	1,405.8	1,581.0	1,776.8	1,965.5	2,168.7	2,450.9	2,813.3
Private and Social Insurance						56.7	61.4
Resource Mobilization							
THE/GDP (%)	3.6	3.6	3.5	3.6	3.5	3.6	3.8
GGHE/THE (%)	12.9	13.2	15.5	13.4	12.7	16.2	12.4
GGHE/GGE (%)	2.8	3.1	3.9	3.6	3.9	5.8	5.1
Federal	2.7	2.9	4.2	3.0	4.3	6.2	5.9
State	3.1	3.8	4.2	4.9	4.1	6.2	4.2
Local	2.6	2.2	2.5	2.3	2.7	3.3	3.8
External/THE (%)	5.9	7.2	8.1	11.8	13.0	9.7	9.8
Per-capita THE (NGN)	12,128	14,104	15,134	17,097	17,812	19,064	21,046
Per-capita THE (NGN) - OOP	8,818	9,654	10,561	11,373	12,219	13,452	15,045
Per-capita THE (NGN) - Government	1,560	1,865	2,349	2,294	2,265	3,090	2,620
Per-capita THE (NGN) - Donors	718	1,017	1,221	2,009	2,312	1,855	2,061
Per-capita THE (US$)	81	92	96	109	112	97	77
Per-capita THE (US$) - OOP	59	63	67	72	77	68	55
Per-capita THE (US$) - Government	10	12	15	15	14	16	10
Per-capita THE (US$) - Donors	5	7	8	13	15	9	8
Risk pooling and Financial Equity							
OOP/THE (%)	72.7	68.4	69.8	66.5	68.6	70.6	71.5
Health Insurance/THE	-	-	-	-	-	1.6	1.6
Service Structure Efficiency							
Hospital/THE	41.2	40.3	38.5	39.9	41.5	37.9	36.7
Prevention/THE	7.0	10.5	14.1	15.2	16.5	9.0	12.8
Targeting Service Focus Efficiency							
Malaria/CHE	42.1	40.2	39.2	39.4	39.6	40.8	40.5
HIV/AIDS & Opportunistic Infections/CHE	11.5	9.1	5.3	9.1	9.5	9.7	9.9
Respiratory infections/CHE	7.1	6.7	6.9	6.3	6.3	6.3	6.5
Tuberculosis/CHE	0.4	3.6	4.0	3.6	3.6	3.4	3.6
Diarrheal diseases /CHE	1.3	1.3	1.8	1.3	1.2	1.1	1.3
Vaccine preventable diseases/CHE	1.2	2.2	2.1	2.3	2.6	3.0	3.4
Reproductive health/CHE	8.8	8.7	8.5	9.0	9.3	9.3	9.4
Contraceptive Management [Family Planning]/CHE	0.4	0.3	0.8	0.4	0.8	0.5	0.8
Non-communicable diseases/CHE	9.1	10.5	10.3	9.8	9.8	8.6	8.3
Injuries/CHE	5.2	5.1	4.1	5.0	5.0	5.2	4.8
Nutritional deficiencies/CHE	0.2	0.2	0.6	1.7	0.2	0.6	0.4
Neglected tropical diseases/CHE	0.4	0.3	0.8	0.3	0.3	0.3	0.3
Others/Non-specific/CHE	12.7	12.0	16.4	12.2	12.5	11.8	11.4
TOTAL	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

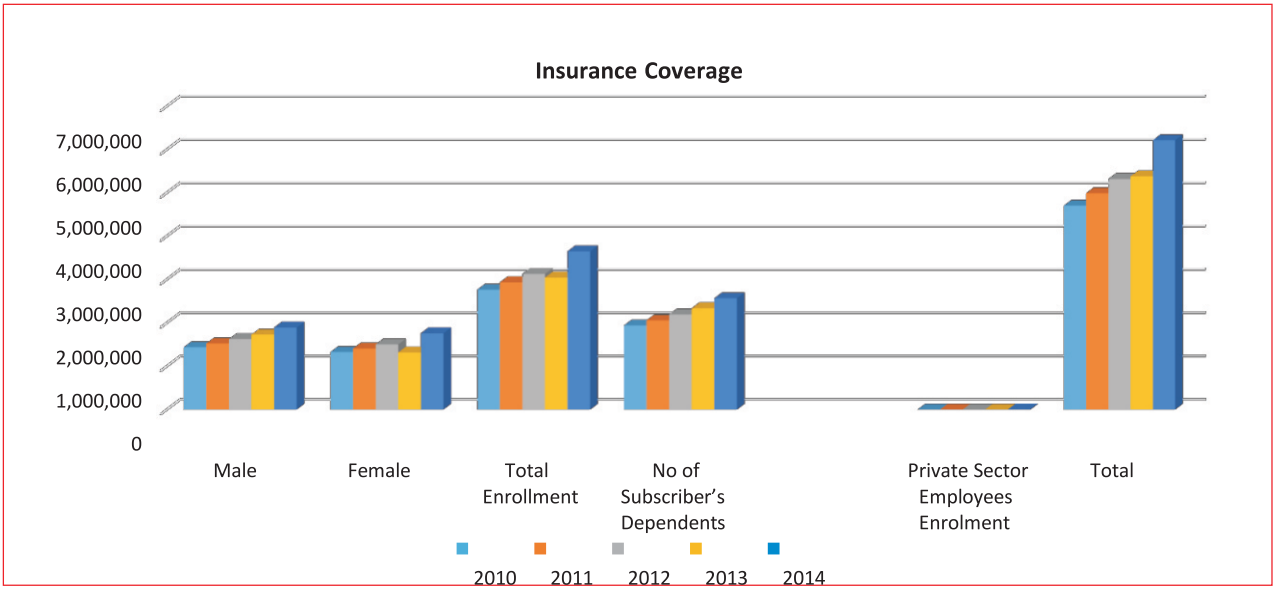
Source: Nigerian National Health Accounts 2006-2016.

2.3.2 Fund Pooling

Pooling refers to the process of accumulation and management of revenues and resources to ensure that the risk of having to pay for health care is borne by all the members of the pool and not by each contributor individually. Various forms of tax and social health insurance schemes aiming at sharing the financial risk and funds among the contributing members are the main focus of this function. The progressivity or regressively of the pooling system is a measure of how equitable these funds are generated. In progressive health financing systems, the rich pay a higher proportion of their income towards healthcare than the poor.

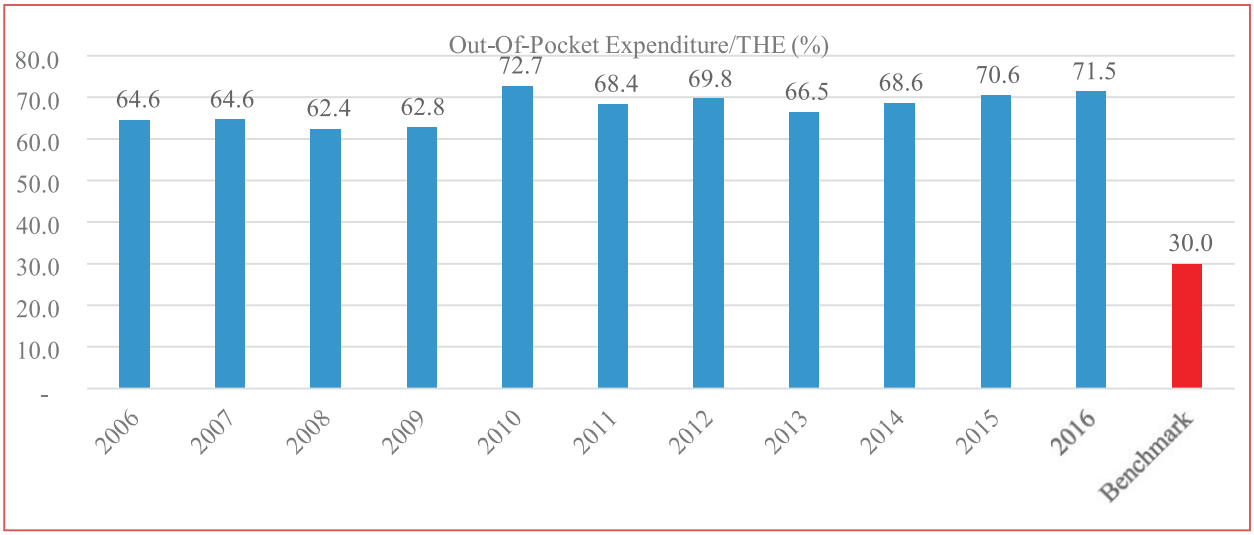
The percentage of Nigerians covered by any form of a pre-payment scheme is 4.3% of the population. Those covered are mostly federal civil servants and the formal private sector, leaving out the more vulnerable segments of the population who ordinarily have higher disease burdens, lower incomes and are in most need of protection.

Figure 6: Population Coverage on any form of Risk Protection Mechanism



Currently the government provides an intrinsic form of risk pooling for the poor by directly funding, through fiscal transfers, the State Ministries of Health, National Primary Health Care Development Agency (NPHCDA), collaborative donor support programs for health service provision, vertical programs to combat specific health needs and more recently the Basic Healthcare Provision Fund (BHCPF) and the National Health Insurance Scheme NHIS). Unfortunately, most of these funds are highly fragmented and focused on inputs rather than results. Combined with a paucity of accountability structures, results are often less than optimal for the monies invested. It is nearly impossible to achieve universal coverage through insurance schemes when enrolment is voluntary (World Health Report 2010). Currently, healthcare costs continue to increase faster than public revenues available for the health sector and economic constraints appear to have limited the amount of funds available to ensure UHC. This has negative implications on the pooling function of the health system with regressive and negative consequences for the poor and vulnerable and by extension the entire healthcare system due to the impact of negative externalities.

Figure 7: Out of Pocket Expenditure on Health as a percentage of the Total Health Expenditure



Source NHA 2010-2016

Achieving equitable and effective pooling will therefore require addressing the following issues:

a. Fragmented pools of health insurance and other financial risk protection schemes;
b. Very poor funds pooling and management mechanisms;
c. Government and donor funded health schemes targeted at the poor and vulnerable are managed vertically;
d. Un-pooled donor funding leading to many vertical projects;
e. Major contributor to health expenditure is un-pooled OOPE.
f. The current NHIS Act provides for health Insurance to be voluntary;
g. Federal employees are still not making their 5% contribution to the NHIS, so the government is fully subsidizing its workers while the unemployed and poor are left out;
h. Most states are still without state-based Social Health Insurance Schemes;
i. Poor public finance management
j. Poor access and referrals for essential health services

2.3.3 Purchasing of Health Services

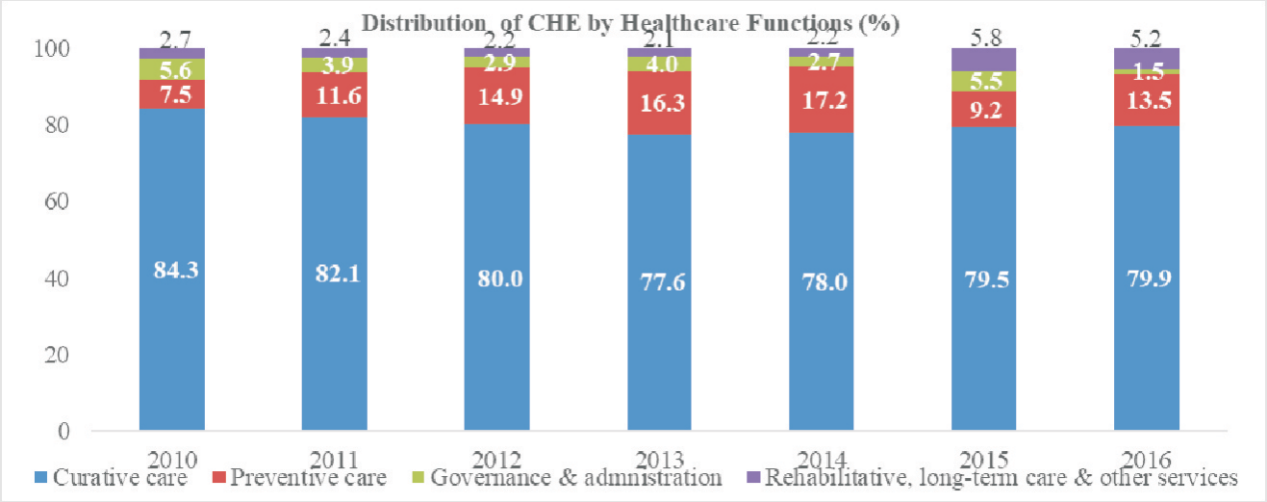
Purchasing refers to the process by which funds are allocated to providers to obtain health services on behalf of a designated population. If designed and undertaken strategically, purchasing can improve health systems performance by promoting quality, efficiency, equity and responsiveness of health service provision and, in doing so, facilitate progress towards Universal Health Coverage (RESYST, 2016).

According to the FMOH, efficiency considerations in the Nigerian health system reveal that

lower costs do not automatically imply efficiency unless one controls for quality of services and the outcomes (FMOH 2011). Allocation of public resources towards tertiary and secondary health facilities in urban areas at the expense of PHCs in rural areas, contributes to inefficiency of the healthcare system.

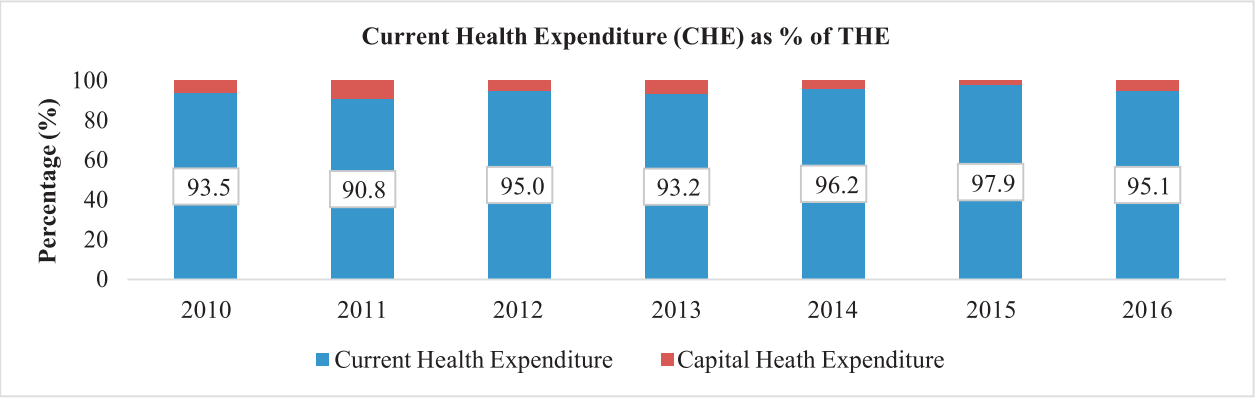
Between 1998 and 2005, curative care received 70% of the THE, compared to 15% of THE for preventive services despite our National Health Policy focus on primary health care, which is principally preventive in nature. Currently, spending on primary health care (PHC) is only 20% in 2014, while about 80% of healthcare fund is still spent on curative care (NHA 2016). With relatively good number and mix of health workers in the country, these workers are mostly idle in public facilities as absenteeism is recorded at 29% on the average, with average patient load of 3 per day (SDI 2013).

Figure 8: Healthcare Spending by Healthcare Functions: Source NHA 2010-2016



In 2016, the current health expenditure as a percentage of THE was 95%, while capital health expenditure was only 5% (NHA 2016). Average stock-out of essential drugs is at 67%, while only 25% of PHC have basic minimum equipment (SDI 2013).

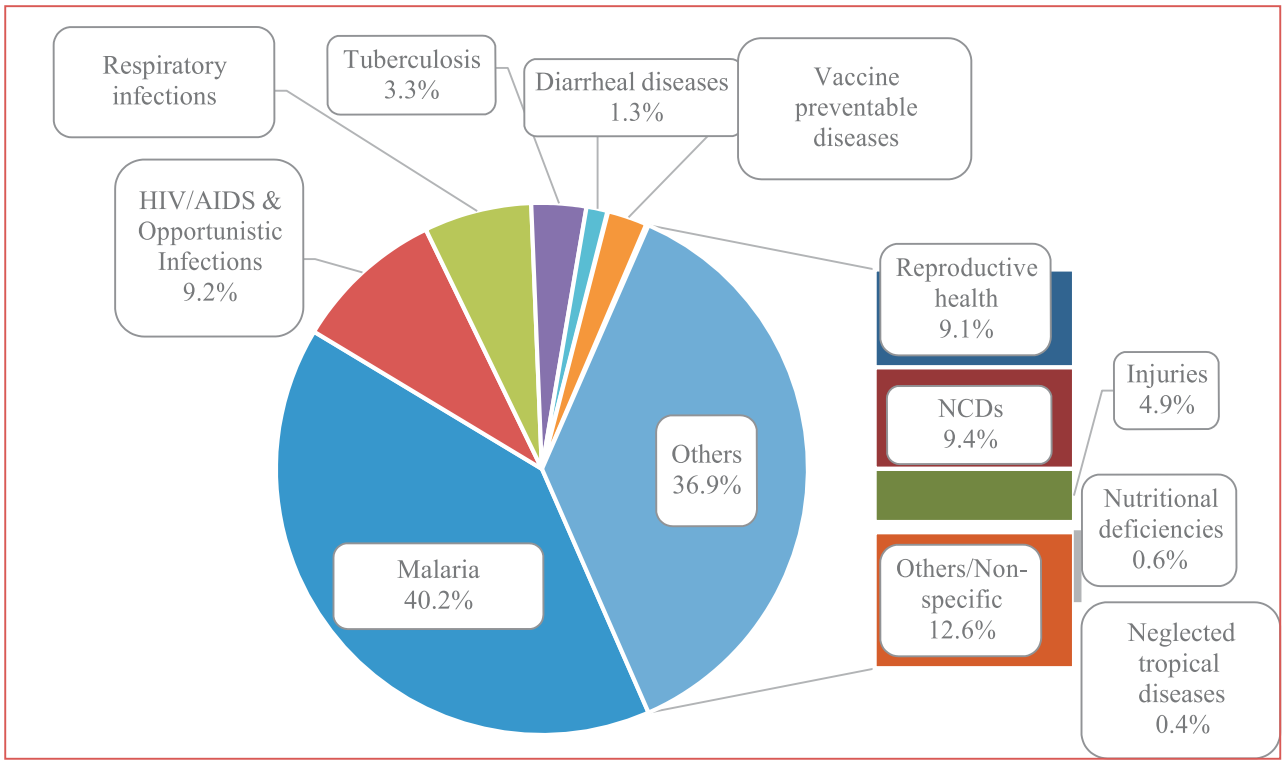
Figure 9: Current Health Expenditure (CHE) is consistently over 90% of Total Health Expenditure (THE);



The Nigerian healthcare system, for a long time, has focused on input funding instead of outputs. However, input funding is not accountable for results as the quanta of funds injected into the system do not depend on measurable outcomes. This lack of systemic accountability results in poor outcomes for the health system.

There is therefore a need to increase the efficiency of expenditure and strengthen the link between health expenditure and outcomes, which would allow Nigeria to achieve the same outcomes with lower levels of spending or achieve better outcomes at the same level of spending. There is also a need to understand the different population groups who are to be covered, the depth and breadth of the intended coverage of services, the quality and cost of the services being procured and who is providing those services in addition to how these services are purchased. Given the current resource constraints, it is important to streamline all stakeholder interests with national health priorities using performance and outcome measuring tools which are linked to public finance management and funds disbursement.

Figure 10: Share of Current Health Expenditure by Diseases or Conditions; NHA 2010-2016



Source NHA 2010-2016

The key issues with purchasing of health services are:

a. Low level of strategic purchasing of health services;
b. Disproportionate funding of curative health services at the expense of preventive care;
c. Low level of funding of primary healthcare and other high priority healthcare services;
d. More than 85% of Federal Ministry of Health Budget is devoted to recurrent expenditure with over 65% of the budget going to tertiary hospitals;

e. Low level of consumer satisfaction with health services and available benefit package;
f. Payment for services not linked to outputs, but to inputs;
g. Poor employee morale as evidenced by constant strike actions by public sector health providers;
h. Perverse division of health services into primary, secondary and tertiary services with major responsibilities on delivery given to the three tiers of government.
i. Even Tertiary health facilities are heavily paid and reimbursed for primary health care services under the NHIS rather than PHCs
j. Poor accountability to citizens.
k. inefficient deployment of scarce donor funds

2.4 Public Finance Management (PFM) System in Nigeria

It is difficult to complete health financing reforms without reforms in public finance management (PFM) systems. The PFM system in Nigeria assumes the separation of powers of the various administrative structures of government into the executive, the legislative, and the judiciary arms in the process of formulation, enactment, implementation, monitoring, and review of budgets. The executive arm of government establishes policies and proposes the budget that helps to achieve the policy objectives of government.

The legislature appropriates funds and approves executive budget proposals. These arms of government are replicated at the federal, states and LGA levels with the legislature at the federal level bi-cameral (i.e., Senate and House of Representatives). The states obtain fiscal information, (e.g. the projected volume of crude oil production, the price of oil, expected inflation rate, etc.,) upon which to base their state budgets. The major revenues (crude oil sales, custom duties, Value Added Tax (VAT)) are pooled at the centre as the Federation Account and shared among the states using defined vertical and horizontal sharing formulas.

The budget structure defines the composition of the budget — the revenue and the expenditure sides. Revenue is projected based on what government expects to get in the fiscal year. The health budget is derived from the overall budget envelop proposed by the government.

However, a number of factors lead to delays or poor budget execution in Nigeria at all levels of government. These could be summarized to include, (a) poor planning particularly in respect of capital budgets, (b) disagreements between the executive and legislature particularly in respect of appropriation and constituency projects[2], (c) late passage of the Budget Act arising from late presentation, late release of approved budgets, (d) over centralization of the procurement processes at the state levels also contribute significantly to delays as the state

[2] Constituency project are projects and programs which are sited in the geographical locality from which the members of the national assembly come from. These projects are supposed to be evidence of what the member has attracted to his/her people as evidence of effective representation and helps to ensure that the member is re-elected next time. These constituencies often over blow the budget and make it difficult to implement.

Executive Council must have to approve every capital budget and their execution are beyond the Ministries, Agencies, and Departments on behalf of which the procurements are made[3].

The failure to execute the approved budget often leads to wide variances between approved and actual budget execution. For example, a study[4] reports that in 2012, only 52.1% and 55.3% of the total amount budgeted for capital projects in education and health, respectively, were actually utilized, indicating wide variance between approved and actual execution.

2.5 Evidence Generation for financing UHC

Even though health is naturally believed to be essential by all, health has been regarded as a social service with huge inefficiencies by policy makers and holders of the nation's economy. With fiscal constraints and keen competition from other sectors, strong justification for increase in budgetary allocation and investment in health is needed such that health outcomes and dividends are presented in economic language understood and appreciated by fund holders.

2.5.1 Investment Case for Health

In consideration of the above, the FMOH has commenced conscious effort to generate and use new economic evidence that makes a case for health as an investment with great returns to Nigeria's GDP in terms of job creation and increase in productivity compared with those in other sectors (agriculture, education, works, oil, manufacturing, defence, etc.). This effort is built around the NSHDP II and will be extended to its various components such as the RMNCAH, Communicable Diseases, NCDs, Mental Health, elderly care, emergencies, etc.

2.5.2 Health Accounts (NHA) and Public Expenditure Tracking Survey (PETS)

NHA is designed to facilitate the successful implementation of health system goals by policy makers who are entrusted with the responsibility of providing an optimal package of goods and services to maintain and enhance the health of individuals and populations. This is done through tracking of expenditures on healthcare activities in countries. NHA is therefore used for monitoring health expenditure patterns and to provide requisite information to improve the capacity of decision-makers to identify health system problems and improve health system performance.

The Federal Ministry of Health (FMoH) has carried out National Health Accounts estimations for the periods 1998-2002, 2003-2005, 2006-2009, 2010-2014, and currently, 2015-2016 to inform the health policy processes, domestic and external resource mobilization as well as public finance management frameworks. While the previous NHA studies were excel-based

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[3] This situation is regularly highlighted by reports from Public Expenditure Reviews carried out at state levels by the World Bank, UNDP and other Development Partners in states

[4] Hamid, K. T. (2013). Good Governance and New Public Sector Financial Management Reform in Nigeria. *A Paper Presented at the Executive Mandatory Professional Training Programme for Fellows of the Chartered Institute of Finance and Control of Nigeria (CIFCN), Abuja on 15th and 16th June, 2013.*

and conducted in select states, the NHA 2010-2014 and 2015-2016 study were conducted in all 36 states and FCT using the accounting framework of 'System of Health Accounts (SHA) 2011' used by OECD countries. Results of these NHA studies have largely provided evidence used in the development of this NHFP&S.

The conduct of NHA studies so far has been episodic and resource intensive. Part of the current effort is not just to close the gap and coordinate the annual conduct of the study but to institutionalize routine collection and analysis of health financing data to provide real-time evidence for health planning and resource mobilization. Some of the strategies to achieve this include: dedicated budget line for NHA at Federal and States; dedicated NHA Team with requisite capacity and tools; and integration of health financing data collection into routine health data management system (DHIS). At the moment, the FMOH has dedicated budget line for NHA on the 2016 budget and proposed same in 2017. Advocacy for replication of same in all 36 States and FCT is ongoing. A Public Expenditure Tracking Survey (PETs) pilot has been concluded in Niger and Ekiti states with support from the World Bank to test instruments for routine collection of health financing data even from health facilities.

2.6 The National Health Act (NHAct) 2014 and the Basic Healthcare Provision Fund

Following persistent advocacy efforts of a coalition of stakeholders over a 10-year period, the National Health Act (NHAct[5]) was signed into law in 2014. The Act, which streamlines the organization of health services and clarifies citizens' right to health services, states that **all Nigerians shall have access to a basic minimum package of health services (BMPHS)**. In addition, Section 11 of the Act establishes the Basic Health Care Provision Fund (BHCPF or "The Fund") and stipulates three (3) sources, namely

(i) An annual Federal Government grant of not less than one per cent (1%) of its Consolidated Revenue Fund (CRF),
(ii) Funds from international donor partners; and
(iii) Funds from other sources.

As this fund is additional to the monthly State allocations from the federation account for which specific proportions are not mandated for healthcare, the NHAct 2014, further sets out a disbursement guide as follows:

(a) Fifty (50%) per cent of the Fund shall be disbursed through the National Health Insurance Scheme (NHIS) and deployed towards the provision of the BMPHS in eligible primary or secondary health care facilities;
(b) Forty-five (45%) per cent of the Fund shall be disbursed through the National Primary Health Care Development Agency (NPHCDA) and deployed to strengthening Primary Healthcare Centres (PHCs) in eligible primary healthcare facilities (20% for essential drugs, vaccines and consumables; 15%

[5] FEDERAL REPUBLIC OF NIGERIA. *National Health Act, 2014. Act No. 8. Vol. 101. Pages A139 – 172* (2014) Lagos: Federal Government Printer

for provision and maintenance of facilities, equipment and transport; 10% for development of human resources); and

(c) Five (5%) percent of the Fund shall be disbursed through a Committee appointed by the NCH and deployed towards emergency medical treatment.

The Act requires all States to establish State PHC Development Boards or Agencies through which the component (45%) of the funds to be channeled through the NPHCDA are transferred to the respective States.

The BHCPF is therefore a predictable and sustainable earmarked fund deployed by the Government of Nigeria to address equity and access to BMPHS. This will, in the first 5 years, focus on the rural population targeting reproductive, maternal, neonatal, child, and adolescent health (RMNCAH), Nutrition, selected Non-Communicable Diseases, Road traffic Injuries and other public health emergencies (FMOH 2017, BHCPF Guidelines).

Disbursements will be through 3 gateways: the NHIS gateway; the NPHCDA gateway and the Emergency Medical Treatment gateway. The BHCPF will primarily be utilized for 3 purposes: (i) Paying for the provision of the BMPHS through the NHIS gateway; (ii) Funding operational expenses of the Primary Healthcare Centres across Nigeria through the NPHCDA gateway, and; (iii) Funding the provision of basic emergency medical services through the Emergency Medical Treatment gateway.

Considering Nigeria's requirement for financing UHC, the BHCPF is not currently sufficient to plug the gap in supply or demand side financing for healthcare at the primary level. The BHCPF is therefore designed to leverage and galvanize domestic and external investments from the public and private sectors including donor funding to increase fiscal space for health.

2.7 Equity

Prepaid financing of health through financial risk pooling is essential for equity in healthcare, financial risk protection and social protection. Coverage of insurance schemes is currently very low while out-of-pocket payments are very high. Vulnerable population groups such as young children, the elderly, the indigent and the working poor are unable to afford prepayments, and thus need to be fully subsidized by government. Unfortunately, government spending is also quite low. There is the need for states to set up their state health insurance schemes and contribute to coverage of these population groups. As some states are already setting up their insurance schemes, it is expected that the number of states doing so will grow and the health insurance coverage will expand. It is also pertinent that a framework to pool all the separate pools in the state takes effect at the outset. It is also expected that the NHIS gateway of the BHCPF will be deployed to provide subsidies for this segment of the population.

2.8 Demographic Structure, Transition and Dividends

The population structure is reminiscent of an early stage of demographic transition where mortality and fertility rates are high, fertility changes lag substantially behind mortality improvements, leading to high rates of population growth. Age dependency ratio is still rising and population growth rate is also rising. Despite about 50% reduction in under-5 mortality between 1970 and 2013, total fertility rate reduced by only one child over the 43-year period. Children under 15 years currently account for 44% of total population, which is higher than the 30% threshold for the opening of the window of opportunity for demographic dividend6. Based on existing trends, it is projected that the window will not open until 2070.

Recent estimates of the demographic dividend from national transfer accounts (NTA 2004, 2010) yielded an aggregate lifecycle deficit that indicates a demographic burden instead of a dividend. While the demographic age dependency ratio is 0.9, the economic dependency ratio is higher at 2.0 owing to youth unemployment, rising informality and other conditions of the labour market that extended economic dependency to age 26.7 The surplus of labour income over consumption of the working-age population falls well below the deficits generated by the young and the older dependent population groups.

Based on the estimates, aggregate labour income needs to grow by at least 46% for there to appear any form of demographic dividend. This is indicative of the need for substantial increases in workforce-to-population ratio, labour force participation, productive employment and labour earnings.

An efficient health system is central to creation of productive labour force, which is essential for economic growth. Child health is an essential input into learning and acquisition of productive skills, and subsequently important contributions to the economy through labour earnings, consumption and investment in adulthood.

At the same time, child health is essential for women's labour force participation. A disease-free environment, strong health system and competitive healthcare packages are essential to attracting and retaining productive workforce in the dynamic globalized economy.

2.9 Conclusion

Despite the commitment of the different levels of government to the UHC and a Presidential declaration on UHC in 2014, Nigeria is still lagging behind with regards to financing healthcare an providing some level of health services equitably, affordable and of good quality to her citizens.

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6 UNESA 2004
7 NTA 2004, 2010

Some of the key health financing challenges in Nigeria are: Low level of government financing of healthcare, at all three levels with governments contributing to less than 35% of total health expenditure; High level of out-pocket spending (OOPS) in the country (more than 65% of total health expenditure); High incidence of catastrophic health expenditure and impoverishment due to high rate of OOPs; Low level of coverage with health insurance and other pre-payment and financial risk protection mechanisms, and more than 99% of the informal sector have no health insurance.

There are also inefficiencies in use of health resources and challenges with governance and accountability, weaknesses in generation and use of health financing resources, and fragmentation in pooling of funds and provision of services.

In order to achieve UHC, Nigeria will need to significantly address these issues. The enactment of the National Health Act (NHAct) in 2014 and setting up of the BHCPF are major steps in addressing these challenges. As this is still work in progress, the next chapters will elaborate a set of strategic pillars, which if implemented over the next five years will bring Nigeria closer to UHC.

CHAPTER 3 | HEALTHCARE FINANCING POLICY AND STRATEGY GUIDING FRAMEWORKS

Guided by the pursuit of a more equitable society geared towards sustained economic and social development, the Government of Nigeria is committed to providing quality universal coverage for essential health services for all of its citizenry.

The National Health Financing Policy and Strategy to achieve universal health coverage has been formulated within the framework of established policies including:

- The National Economic Recovery and Growth Plan (ERGP) 2017.
- The National Health Policy (2016), with a vision to achieve Universal Health Coverage for all Nigerians
- The National Health Act (2014), which aims to substantially increase Government spending on Health and improve Primary Health care services through the Basic Health Care Provision Fund.
- The Abuja declaration of 2001, which aims for an allocation of at least 15% of national annual budgets for the health sector.
- The UN Sustainable Development Goals (SDG) 3 with reference to "good health and well-being for all at all ages".
- The 2014 Nigerian Presidential Declaration on UHC.
- The Vision 20:2020 which articulates Nigeria's economic growth and development strategies for the period between 2009 and 2020. For the health sector, the Vision 20:2020 proposed to enhance access to quality and affordable health care.

To develop a framework for this strategy, a wide stakeholder consultation among the public, private, academia, development partners, CSOs, and community members was conducted. In addition to this, models of health financing strategies were studied from different countries including African countries, and a mixture of different strategies for revenue generation, resource allocation, pooling, purchasing and governance have been proposed by the stakeholder groups for this document.

3.1 Goal and Objectives

Goal: a fundamental right of every Nigerian is access to affordable, efficient and equitable healthcare. This can only be ensured through adequate and sustainable funding for universal health coverage for Nigeria. The primary goal of the National Health Financing Policy and Strategy is therefore to ensure that all Nigerians have access to affordable, efficient and equitable healthcare services they need without any financial barriers or impediments at the point of accessing care and risk of impoverishment.

Objectives: over the next five (5) years, the National Health Financing Policy and Strategy has been developed to

vii. Increase General Government Health Expenditure (GGHE) as a percentage of General Government Expenditure (GGE) by 5%
viii. Improve the coverage of Nigerians on health risk protection mechanisms by 30% by extending health insurance to 50 million Nigerians;
ix. Reduce out-of-pocket expenditure (OOPE) on health as a percentage of Total Health Expenditure (THE) by 20%
x. Improve health expenditure on primary healthcare and preventive health services by 20%
xi. Ensure that the NHIS and 50% of health risk protection schemes have Performance Based Financing as provider payment mechanism to ensure quality and efficiency
xii. Establish and strengthen healthcare financing systems to ensure accountability, transparency and sustainability at the federal, 36 states, the FCT, and the 774 Local Government Authorities.

3.2 Guiding Principles and Values

The National Health Financing Policy and Strategy is guided by the following principles and values:

1. Equity and Financial Risk protection: The health financing system should provide equitable financial and geographic access to quality health services for all Nigerians regardless of age, gender, socio-economic background, statehood, religion or ethnicity. Financing for the health system should be, and be seen to be fair. Access to health care should be based on need rather than ability to pay to ensure protection for the poor and vulnerable.

2. Responsibility: Commitment by all tiers of the Nigerian government to mobilize and utilize all available resources rationally and responsibly in order to ensure every Nigerian has access to essential health services.

3. Prioritization: Good quality health care assured through cost-effective interventions that are targeted at priority health problems, preventative care, progressive universality; starting with covering the most vulnerable and high risk groups and lastly, interventions that promote the ideals of families as “creators “ of health

4. Accountability: A high level of efficiency and transparency in the development and management of the national health system. Effective partnerships and collaborations between various stakeholders shall be pursued while safeguarding individual identities. Since health is an integral part of overall development, inter-sectorial cooperation and collaboration between the different health-related and finance Ministries, development agencies and other relevant institutions shall be ensured.

5. Evidence-based decision-making: Effective policy-making optimizes decision making by relying on evidence from research that is conducted according to mainstream scientifically accepted protocol. There is therefore a need to apply best practice approaches in order to ensure that lean resources are managed properly.

6. Multi-sectorial: The determinants of the health of the population to an extent lie outside the purview of the healthcare sector. Nutrition, water and sanitation, education, climate change etc., all play a major role. A multi-sectorial approach calls for holistic inter-MDA and organizational collaboration, which involves key stakeholders including (but not limited to), health, education, psychosocial, and security.

3.3 Theory of Change and Strategic Pillars

The theory of change for this health financing strategy posits that strengthening health financing mechanisms, including governance and accountability will produce enhanced health financing functions in terms of improved resource mobilization, pooling and strategic purchasing. Enhanced health financing functions will in turn lead to UHC, predicated on key health financing outcomes of improved access to quality services, financial risk protection, efficiency, and equity. This theory therefore rests of four (4) interrelated strategic pillars:

1. **Strengthened Health Financing Governance and coordination**: The Federal Ministry of Health (FMOH) provides legal frameworks, policy guidance and strategic support for national health financing reforms. Effective partnerships with States, Local Governments, Community Members, CSOs, Private Sector Actors and Development Partners, will accelerate stewardship and ownership in putting appropriate health financing institutional arrangements in place to improve health financing functions, use of data, communications, transparency and accountability.

2. **Adequate revenue generation**: Through improved Government spending, the BHCPF, donor funds, pre-payment schemes, and funds from the private sector, revenue generation mechanisms for health will be optimized to finance essential packages for all for health while ensuring that funds would be used to pay for healthcare services within and outside the basic minimum package.

3. **Effective pooling and financial risk protection**: Pooling of resources so raised guarantees risk distribution, risk sharing, and cross subsidization, from the rich to the poor, the healthy to the sick and the gainfully employed to the unemployed. Effective pooling therefore will lead to financial risk protection for health thereby reducing the very high OOPE which is catastrophic to the Nigerian population.

4. **Efficient and strategic purchasing**: Nigerians have full value for money spent on health such that top quality health services including healthcare provider services including diagnostics and treatment commodities are provided at the lowest possible costs. Every Naira spent on healthcare is tied to results and outcomes and traced to provision of a package of services to Nigerians. The rights and choices of consumers and providers are hereby ensured and protected while the Federal level ties accountability for health system outcomes and results to fiscal transfers to States and LGAs.

Figure 11: Health Financing Strategy Theory of Change

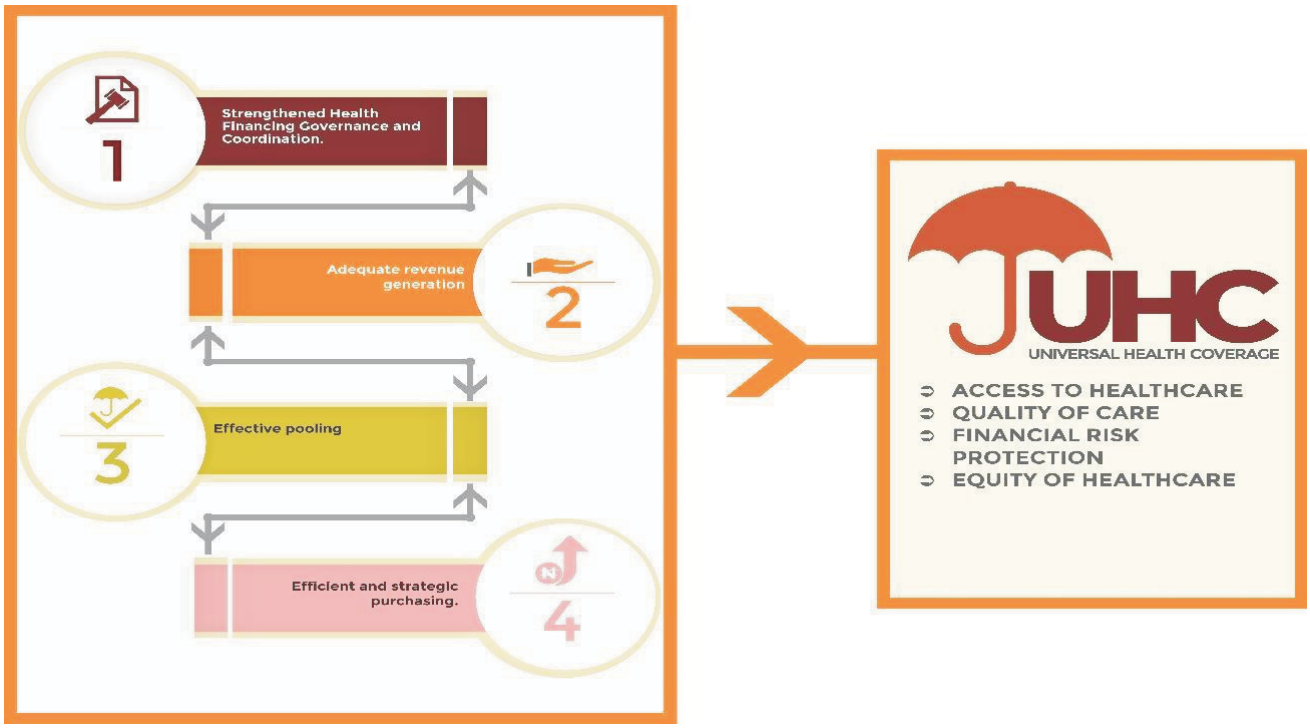
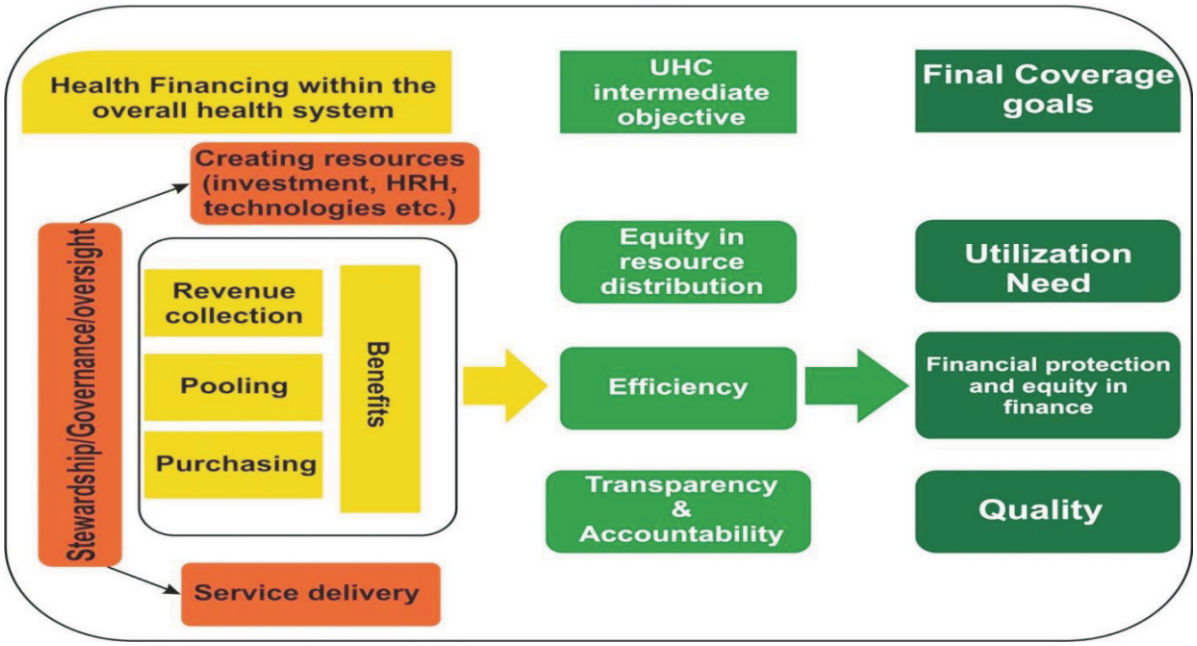


Figure 12: Health Financing Functions: Revenue generation, Pooling, and Strategic Purchasing



Source: Kutzin et al.

CHAPTER 4 | HEALTH FINANCING POLICY AND STRATEGY

The major thrusts of the National Health Financing Policy and Strategy shall rest on the following four (4) interrelated pillars: strengthened governance and coordination, adequate revenue generation; effective pooling and management of funds; and efficient strategic purchasing of health services.

4.1 Adequate Revenue Generation

Currently, revenue generation for healthcare in Nigeria is regressive, with OOP payments accounting for over 68% of the THE. In addition, revenue generation per capita is rather low. The BHCPF will be the primary vehicle for financing the BMPHS for all Nigerians. Revenues for the BHCPF will be derived from the Federal Government's annual grant of not less than 1% of the (CRF), grant from donors, and fund from other sources (NHAct 2014). Although this is not enough to fund full expansion of health services to universal health coverage, it can be used to leverage and galvanize all stakeholders' healthcare spending including States, the private sector and non-governmental organizations with national priorities and health needs of the population.

As there is not one single route to achieving UHC, Nigeria shall pursue the following supply and demand side strategies to expand the fiscal space for healthcare:

Supply Side Strategies:

(a) The BHCPF shall form the basis for Nigeria's UHC Funding Basket.
(b) The Federal government shall re-evaluate the level of funds to be allocated as BHCPF and progressively increase it over time
(c) Government at all levels (Federal, State and Local Government) shall allocate not less than 15% of their total budgets to health in accordance with the Abuja declaration of 2000
(d) Government at all levels shall earmark not less than 0.5% of the Total Vat Pool for health
(e) Government shall earmark a percentage of taxes on tobacco, alcohol, harmful environmental pollutants, and unhealthy foods as Sin taxes to generate revenue for health as follows:
    a. 5% on Alcohol Tax
    b. 20% on Tobacco Tax
    c. 3 kobo/second on all phone calls
    d. 0.5% on Companies income tax (CIT)
    e. 0.5% on all aviation (air) tickets
(f) Governments at all levels shall develop and implement strategic plans for mainstreaming 'Health in all Policies' (HiAP) for mobilization of funds from non-core health sector

(g) The FMOH, NHIS and NPHCDA shall ensure the careful and systematic development of well-articulated and costed proposals by states and LGAs for funding through the BHCPF
(h) The payment of counterpart funding by states and LGAs for the BHCPF shall be entrenched in the design and implementation of the BHCPF, so as to generate more funds and ensure that more beneficiaries are covered.
(i) Fiscal transfers between Federal and State Governments shall be tied to previous health outcomes, budget expenditure tracking and current State budgets for healthcare in order to improve accountability and revenue mobilization.
(j) Governments at all levels shall make special financial provisions for diseases of public health significance such as malaria, HIV/AIDS, TB, Leprosy, vaccine preventable diseases and others
(k) Government shall ensure that donor funds are mobilized for identified national health priorities and directed into the BHCPF
(l) All domestic and external aids for health shall be harmonized and monitored and evaluated in line with health priorities and plans at all levels of government
(m) Domestic philanthropy and charities shall be encouraged, promoted and harnessed to improve resource availability for health at all levels of government and community level in line with the national priorities for healthcare.
(n) Fiscal discipline, accountability and tracking of funds shall be ensured in the mobilization of funds for health financing
(o) Public-Private Partnerships for health financing shall be encouraged at all levels and policies developed to incentivize health investments

Demand Side Strategies:

(b) Mandatory health insurance shall be scaled up to expand the pool of funding in health, to ensure viability and sustainability of health insurance schemes, and to foster cross-subsidization and risk distribution.
(c) Governments and their partners shall increase population coverage on health insurance to at least 30% in the next 5 years
(d) Governments shall increase the healthcare coverage to the informal sector and ensure contributions from all who can pay.
(e) Private Health Insurance shall continue to be available and purchased based on individual choice to supplement the mandatory insurance.
(f) Government and partners shall engage with labour and other stakeholders to ensure that all government and non-government workers pay their employee contributions to the Formal Sector Social Health Insurance Programme of the National Health Insurance Scheme and similar social health insurance schemes at the sub-national levels
(g) Government at all levels shall create health safety nets or equity funds, subsidies, or direct fiscal transfers to pay their insurance contributions for the poor and other vulnerable groups, (including women, children, elderly, and disabled). Funding from local and international organizations; Local earmarked and sin taxes; funding from Sovereign Wealth Fund (through social investments), interests from unclaimed

dividends, NHIS investments, State and Federal budgets, shall also be deployed for this purpose.

4.2 Effective Pooling and Fund Management

The NHIS has a statutory function to regulate the provision of health insurance in Nigeria. As at 2016, population coverage on health insurance was 6.9 million Nigerians and has not increased significantly since then. In order to improve population coverage on financial risk protection mechanisms, expand pre-payment schemes for health, and reduce the currently high OOPE significantly, there is a need to reduce the fragmentation in pooling of funds and increase risk distribution across income and patient groups. This will require significant expansion in the current enrollee base across the country as well as the contributions among formal and informal groups.

Considering the political economy of health in Nigeria, acceleration of success will depend on engagement all 36 States and FCT. Recognizing the above roles of the different tiers of government in this regard, the Federal Government has identified the NHIS gateway of the BHCPF as the health financing vehicle to expand pooling for primary healthcare. The BHCPF allocates 50% of its fund to the NHIS to purchase a BMPHS for Nigerians.

Since financial risk protection for UHC depends on cross-subsidization and risk-distribution of the different income groups and between the healthy and unhealthy, this implies that the bigger the pool the more viable it becomes. While centralized National pool is the most desirable, it has currently proven not to be feasible in Nigeria under the NHIS due to the current level of political capital required to effect it. However, mandatory state insurance (contributory) schemes in Nigeria with a population of over 180 million, promise to have adequate risk pools because of the huge population in each state, hence not likely to suffer the harmful effects of fragmentation.

In our quest towards achieving UHC therefore, effective pooling and fund management strategies shall be deployed as follows:

a. Financing mechanisms shall involve pooling of funds, risk pooling and fund management
b. Government at all levels and other relevant health system actors shall develop and implement mandatory Social Health Insurance schemes for all and expanded to cover the informal sector as a means of increasing resources for health, ensuring universal access to care and providing financial protection to the poor and vulnerable.
c. NHIS Act shall be amended to make health insurance mandatory and re-position the scheme towards UHC
d. States and FCT shall establish mandatory State Health Insurance (Contributory) Schemes to ensure financial risk protection for all especially those most in need.
e. All employers in formal, informal and organized private sector shall cover their employees with mandatory health insurance

f. Existing Community Based Health Insurance Schemes shall be integrated into the State Health Insurance (Contributory) Schemes to reduce fragmentation and ensure cross-subsidization and risk distribution
g. Private Health Insurance shall continue to be available and purchased based on individual choice to supplement the basic minimum package on the mandatory schemes
h. Federal and state governments shall ensure mandatory coverage on health insurance for all children under 12 years and pregnant women with funding from federal, state and LGA government budgets, special earmarked taxes, donor funding and other funding sources such as part funding from UBEC resources for school children
i. There shall be a split between funding and purchasing and the powers for both shall not reside in same agency
j. Mechanisms shall be put in place to avoid adverse selection and cream skimming in pooling schemes
k. Mechanisms for risk equalization amongst schemes such as risk equalization fund and re-insurance funds, sovereign guarantees etc., shall be established
l. The FMOH and NHIS shall create awareness among trade unions, civil servants, religious groups, market groups, etc. on the need to create large pools
m. Government shall ensure the development and institutionalization of efficient, equitable and transparent funds management systems
n. Development Partners shall ensure that the pooling of donor funds be transparently managed
o. Third-party agents can be public, quasi-public, CSOs, or private entities depending on the context, preferences of the different levels of government, and specific roles assigned to them.

4.3 Strategic Purchasing and Efficient Resource Allocation

Efficiency gains from purchasing arrangements provide better value for money and therefore provide additional financing for the health system (Hensher, 2001).

Taking into account national priorities, interventions under the BMPHS will be prioritized for purchase. Resources are to be allocated equitably but special considerations should be made such as the provider's location relative to the population and their ability to provide the services needed.

Performance based financing (PBF) is an output based model of paying for health services which rewards a provider for the quantity and quality of healthcare services provided. PBF schemes improve output for healthcare services and align services that are to be purchased with the national and state level priorities. Learning from PBF Pilots in Adamawa, Nasarawa, and Ondo States, performance based incentives can also ensure appropriate behaviour among health personnel such that providers offer services according to agreed standards. To ensure good economy, efficiency, and effectiveness of health resources through strategic purchasing in Nigeria, the following strategies shall be implemented:

1. Appropriate strategic purchasing mechanisms shall be adopted by purchasers such as the main governments, Ministries of Health, Departments, Agencies and other third party agents to ensure that only needed services are purchased at the best cost.
2. Government at all levels shall develop and implement results-based financing mechanisms to improve efficiency in all health spending including insurance or contributory schemes for the purposes of personnel and provider payments
3. Governments at all levels shall ensure the presence of at least one functional primary healthcare facility per ward and one secondary health facility per LGA for referral that can deliver the minimum defined benefit package
4. There shall be a split between purchasing and provision and the powers for these functions shall not reside in same agency
5. The purchasers can be public, quasi-public, CSOs, or private entities depending on the context and preferences of the different levels of government
6. Both public and private facilities shall be involved in the provision of health services irrespective of the funding mechanism
7. Allocation of resources shall be made according to defined objective criteria in a cost effective manner that ensures more health for money.
8. Government and its partners shall ensure that expenditure tracking mechanisms are instituted and routinely applied at all levels of government where there is spending on health
9. Government shall ensure the institutionalization of the medium-term sector strategy (MTSS) and medium-term expenditure framework (MTEF) in the allocation and management of public sector health expenditure shall be adopted at all levels
10. Priority shall be given to the purchase of cost-effective services and those essential for achieving the SDGs and national priorities
11. A framework for regular evaluation of benefits and costs of interventions and technologies shall be put in place to ensure optimal choices
12. Appropriate mechanisms will be developed to ensure quality assurance for services purchased and provided, irrespective of funding mechanism and level of care.
13. Public-Private Partnerships shall be encouraged in the purchase of health services in line with national priorities and in tertiary hospitals
14. Government at all levels shall ensure that all spending on health including salaries is targeted towards the delivery of a package of health services to Nigerians. This can be operationalized in phases given the peculiarities of States, FCT, and their various contexts.
15. Government at all levels shall integrate funding from government revenue for existing free health services for high priority life-saving vertical public health services into the Health Insurance (contributory) pools to ensure efficiency and reduce fragmentation. Such services will include immunization services; prevention and treatment of HIV/AIDS, tuberculosis (TB) Malaria and some non-communicable diseases; maternal, Neonatal and Child health services, especially antenatal, child birth and postnatal services.

4.4 Strengthened Health Financing Governance and Coordination among different levels of government and stakeholders

Nigeria is a federating nation and the responsibility of healthcare provision is divided among the Federal, State and Local Governments. The Federal level through the FMOH is responsible for providing legal and policy frameworks and coordinate implementation of national health strategies through the NCH. However, each level of government can and often does act independently. With the roll out of SHISs and SPHCDAs, there is a greater tendency to fragment the fund pools into even smaller units.

The coordinating role of the FMOH, NHIS and NPHCDA are thus quite important in mobilizing other State level apparatus and actors around an agreed health financing strategy in order to achieve UHC cost-effectively.

It is useful to foster inter-sectorial and inter-governmental collaboration around health financing functions to strengthen this position. The Federal Government shall adopt appropriate incentives to align interests of stakeholders towards achieving its health financing goals and objectives.

As good governance is central to achieving UHC, the Federal Ministry of Health shall provide policy direction and oversight to health stakeholders and foster inter-sectorial collaborations, public-private partnerships, and collaboration with community members, CSOs, and Development Partners to ensure improvement of health financing functions. Other strategies include:

1. Governments at all tiers shall continually and publicly declare and reaffirm that the achievement of Universal Health Coverage (UHC) in Nigeria is a priority
2. A strong coordination framework for health financing shall be developed and entrenched at all tiers of government
3. Governments at all tiers shall establish health financing equity and investment units within the Ministries of Health
4. Governments at all tiers shall develop health financing policy and strategy to provide strategic direction to all stakeholders
5. Government and its partners shall continually generate and use evidence to improve health financing functions towards UHC in Nigeria
6. Governments at all levels to develop investment case and business case for health priorities to demonstrate the contribution of health to increase in productivity and increase in GDP
7. Government and relevant health system actors shall institutionalize routine and annual National and sub-national health accounts
8. Strategic linkages and collaboration between NHIS and state health insurance schemes as well as NPHCDA and SPHCDAs, shall be developed by the FMOH, NHIS, NPHCDA, and State governments
9. Government at all levels shall establish sustainable systems to ensure competency-based training of health professionals on health financing and priority health needs

10. Governments at all levels shall explore the use of an Independent Health Quality body to ensure health quality standards and compliance
11. Mechanisms for improved donor coordination in health financing should be developed.
12. Governments at all levels shall incrementally allocate at least 1% of the health budget to national health research systems, including health financing research.
13. Governments at all levels shall establish mechanisms for joint learning towards UHC.

CHAPTER 5 | IMPLEMENTATION STRATEGY

Policy implementation begins with policy making. Success in this direction will require consistency, political commitment, and efficient coordination of relevant stakeholders. To ensure implementation of this National Health Financing Policy, a 5-year plan is as follows:

Table 2: Implementation Matrix

	Activity	Indicators	Responsibility	Timeline (Years)
Governance and Coordination	Establish Health Financing Equity and Investment Units at Federal, 36 States, and FCT	Number of States and FCT with Healthcare Financing Equity & Investment Units	SMOH; FMOH	1-3
	Establish Coordination Frameworks and TWGs for health financing at Federal, 36 States, and FCT	Number of States and FCT with Healthcare Financing Equity & Investment TWGs	SMOH; FMOH	1-3
	Institute Public Finance Management (PFM) reforms at the Federal and State levels	Number of States with functional PFM Systems	FMoF; MB&NP; FMOH; SMOH; CBN; HCFN; PSHAN	1-5
	Develop Health Financing Policy & Strategy at Federal, 36 States, and FCT	Health financing policy approved and adopted by FMOH; Number of States and FCT with approved Health Financing Policy & Strategy	FMoF; MB&NP; FMOH; SMOH; CBN; HCFN; PSHAN	1-3
	Develop Business and Investment Case for UHC priorities at Federal, 36 States, and FCT	FMOH, SMOH, & FCT HHSS have approved investment cases for UHC priorities	FMoF; MB&NP; FMOH; SMOH; CBN; HCFN; PSHAN	1-3
	Establish systems for health financing evidence generation and management at Federal, 36 States, and FCT	FMOH has institutionalized routine NHA; Number of States and FCT that have updated SHA	SMOH; FMOH	1-3

	Establish sustainable systems for training of health personnel on health financing and management	Number of personnel trained on health financing and management; Number of training institutions offering professional/certificated health financing courses	SMOH; FMOH	1-3
	Coordinate phased implementation of the BHCPF	% of population covered by BHCPF; Number of Health Facilities receiving operational expenses from the BHCPF; Number of Donors contributing to the BHCPF; % of private sector investments in the BHCPF	FMoF; MB&NP; FMOH; SMOH; CBN; HCFN; PSHAN	1-3
Revenue Generation	Establish Framework to tie fiscal transfers to previous health budget expenditure at State and LGA levels	Number of States reaching annual budget implementation of 80%	CBN, FMOF, FMOH,FG, SG	1
	Align health allocations to national priorities	Number of national health priorities in MTEF	CBN, FMOF, FMOH,FG, SG	1
	Include national health priorities into MTEF and align all States, agencies and donors to it.		CBN, FMOF, FMOH, FMoF; MB&NP	2-5
	Expand the BHCPF by crowding-in Donor Funding and Funding from other sources (including the private sector)	Number of Donors contributing to the BHCPF; % of private sector investments in the BHCPF External resources as a % of THE BHCPF as a % of GHE BHCPF as a % of THE	FMoF; MB&NP; FMOH; SMOH; CBN; HCFN; PSHAN	2-5
	Advocate for increase in government annual budget and spending on health	GHE as a % THE; GHE as % of GGE GHE as % of GDP	FMoF; MB&NP; FMOH; SMOH	2-5

	Develop and implement resource mobilisation strategy including Sin Taxes, Telecom Taxes, VAT, Aviation Taxes, etc.	Total Health Expenditure as % of GDP	FMoF; MB&NP; FMOH; SMOH	1 to 5
Risk pooling	Engage Stakeholders to increase enrolment and contribution to Health Insurance	OOPE as a % of THE % of Nigerian population covered by any risk protection mechanisms	NHIS, FMOH	1
	Amend NHIS Act to make health insurance mandatory	OOPE as a % of THE % of Nigerian population covered by any risk protection mechanisms	NHIS, FMOH, National Assembly	1
	Develop Framework for consolidation of fund pools at state levels	Number of States with Community-Based Health Insurance Scheme or free health services that have been integrated into the State health insurance and contributory schemes	NHIS, FMOH, SSHIS	3-5
	Establish and expand State Health Insurance and contributory Schemes in 36 States & FCT	Number of states that have established State Health Insurance and contributory Schemes % of population covered by pre-payment and risk pooling schemes at the Federal and States levels % of people re-enrolling in the scheme per year Total premium of health insurance as a % of total expenditure on health insurance % of low income population covered by risk pooling mechanism OOPE as a % of THE	NHIS, FMOH & SGs	1-5

	Strengthen technical capacity of health personnel on health insurance and contributory schemes	Number of States using their staff for health insurance functions.	NHIS, FMOH, SMOH	1-5
Strategic Purchasing	Review Provider Payment mechanisms in the Nigerian health sector including insurance schemes to focus on RBF	Number of Health MDAs with PBF as provider payment mechanism % of health fund spent through PBF	FMOH, NHIS, NPHCDA	1-5
	Disseminate lessons learned from Nigeria's experience with strategic purchasing at facility level using results based financing to achieve outcomes in line with national priorities	Health Facility Bi-annual reports developed and disseminated	FMOH, NHIS, NPHCDA	1
	Develop National Framework to link purchasing to output and results instead of the typical inputs linked approach	Number of technical resources developed and implemented to strengthen provider payment mechanisms by results	FMOH, NPHCDA, NHIS	1
	Develop Framework for competition between public and private sector providers in the allocation of new resources for healthcare	Number of technical resources developed and implemented to strengthen competition Number of healthcare providers accredited into risk pooling and provider payment mechanisms	FMOH, SMOH, NCH	1
	Establish Independent National Quality and HTA Systems to determine which health interventions are cost effective	Nigeria HTA Bill passed into law. Nigeria HTA Agency established	FMOH,NHIS, NPHCDA, SMOH	25
	Institutionalize routine Health Accounts and expenditure tracking mechanisms at State and Federal levels	Number of States conducting routine SHA; FMOH conducts routine NHA	FMOH, FMOF, CBN, Budget Office	1
	Institutionalize Public Finance Management (PFM) reforms at the Federal and State levels	Number of States with functional PFM Systems	FMoF; MB&NP; FMOH; SMOH; CBN; HCFN; PSHAN	1-5

CHAPTER 6 | MONITORING & EVALUATION

Monitoring and evaluation involves continuous collection of data with which to measure at regular intervals, performance in the implementation of the policy. The M&E strategy will focus on monitoring a set of indicators which are directly linked to the health financing policy strategies. This will provide the basis for corrective action(s) if there are any deviations from the plan during implementation.

The success of the national Health financing Policy would depend on how well its provisions are implemented. In this regard government shall ensure:

1. That citizens have access to information on health revenue, expenditures and health financing in general
2. The integration of National Health Financing Policy Monitoring and Evaluation systems in the NHMIS at the Federal, State and LGA levels to measure progress in the implementation of the policy and to run a national assessment profile of the health financing mechanisms;
3. Development and compilation of indicators for monitoring the National Health Financing Policy as an integral part of the national Health Information System, and evaluating these indicators at all levels of health care at the local, state and federal governments;
4. Development and implementation of effective management information system for the NHIS and other financing mechanisms.
5. Putting in place adequate legal framework for routine collecting, storing, analysing and disseminating information on health financing
6. Collaboration between policy bodies, stakeholders and academic institutions in capacity building for implementation, monitoring and evaluation
7. Effective monitoring of all financing mechanisms
8. Publication of government's and their MDA annual budgets and expenditures at all levels
9. Dissemination and sharing of appropriate health financing data and evidence locally and internationally
10. Annual production and dissemination of health accounts at all levels
11. Full evaluation of the implementation of the National Health Financing Policy every five years

6.1 Health Financing Indicators

The health financing indicators listed below are some common and necessary tools to track the progress or lack, of the health financing strategy and determine its impact on its stated goal of expanding access to universal healthcare. In this regard, indicators are listed below:

6.1.1 UHC Indicators

i. % of Total health expenditure in gross domestic product
ii. % of Out-of-pocket spending in total health expenditure
iii. % of the population is covered by pre-payment and risk pooling schemes
iv. % of Government spending on healthcare
v. % coverage of vulnerable population groups with social assistance and safety-net programmes
vi. % of the poorest 40% of the population that have effective coverage to quality health services
vii. Proportion of population with access to affordable essential drugs on a suitable basis
viii. Proportion of pregnant women without financial access to health services
i. Proportion of children under 5 years without financial access to health services
ii. Proportion of people living with HIV/AIDS, TB and Malaria without financial access to health services.
iii. Immunization coverage

6.1.2 Revenue Generation and Mobilization Indicators

6.1.2.1 Health Revenue

i. Total real funds available from different sources of health financing
ii. Ratio of total expenditure to allocation from federation account
iii. Ratio of total health expenditure to total revenue
iv. Ratio of donor health funding to total health expenditure

6.1.2.2. Government Expenditure on Health

i. Government-funded health expenditure as percentage of GDP
ii. Ratio of capital to recurrent expenditure
iii. Ratio of salary to non-salary expenditure (within recurrent expenditure)
iv. Recurrent to total health expenditure
v. Total expenditure on preventive health as a percentage of total health expenditure
vi. Ratio of expenditure on preventive health to expenditure on curative health
vii. Ratio of expenditure on specific health programmes to total health expenditure
viii. Government-funded health expenditure as percentage of total health expenditure
ix. Government-funded health expenditure as percentage of total government expenditure

6.1.2.3. Out-of-pocket Health Expenditure

i. Out-of-pocket health expenditure as percentage of total health expenditure
ii. Out-of-pocket health expenditure as percentage of total private health expenditure
iii. Private prepaid plans as percentage of private expenditure on health
iv. Out- of- pocket expenditure as a percentage of household income

6.1.2.4. Private Sector Investment into Health Sector

i. Total private investment into sector as a percentage of THE (including PPPs)

ii. Total Public Private Partnership investment as a percentage of THE

6.1.2.5. External Health Sector Aid

i. Total external health sector grant aid as share of total expenditure
ii. Bilateral and multilateral debt stock for health as percentage of total government debt stock

6.1.3. Pooling and Fund Management Indicators

6.1.3.1. Health Insurance

i. Per cent of total population covered by different health insurance schemes
ii. Per cent of people covered by private health insurance to those covered by social health insurance
iii. Prepayment ratio in health insurance plans
iv. Per cent of people using different plans in the social insurance scheme
v. Per cent of people re-enrolling in the scheme per year
vi. Total expenditure on health insurance as a percentage of total health expenditure
vii. Total premium of health insurance as a percentage of total expenditure on health insurance
viii. Per cent of health expenditures from different health insurance mechanisms.

6.1.3.2. Financial Risk Protection

i. Population exposed to catastrophic health expenditure as percentage of total population
ii. The number of people confronted with excessive or catastrophic expenditure in relation to their capacity to pay
iii. The intensity of catastrophic health expenditure (e.g. Ratio of OOP to expenditure on food)
iv. Incidence of health-related poverty measured as percentage of population falling into poverty due to ill health
v. Per cent of poor and vulnerable population covered by social safety nets

6.1.4. Purchasing and Allocation Indicators

6.1.4.1. Equity in Health Expenditure

i. Benefit incidence ratios of different financing mechanisms (health expenditure by zones, states, LGAs, urban/rural, gender, age, income groups, level of care etc.)
ii. Financial incidence ratios of different financing mechanisms

6.1.4.2. Equity in Service Access and Use

i. Ratio of per capita health service use of lowest income quintile to per capita health service use of highest income quintile

6.1.4.3. Health Expenditure

i. Total expenditure on Health as percentage of Gross Domestic Product (GDP)
ii. Per capita health expenditure
iii. Annual real growth of Total health expenditure; and Per capita health expenditure

GLOSSARY OF TECHNICAL TERMS

Adverse selection: A situation in which individuals are able to purchase insurance at rates which are below actuarially fair rates, because information known to them is not available to insurers.

Benefit package: A minimum set of services that are offered to an insured person within a level of contributions.

Capital cost, Capital expenditure: Cost of inputs whose useful life is usually longer than one year. In terms of health investments, refers to expenditure on physical assets such as hospitals, beds, health centres, medical and diagnostic plant and equipment, etc.

Catastrophic health expenditure: A situation where a household spends on health more than 40% of its income after paying for subsistence needs, e.g. food. It can be caused by catastrophic illness, either high cost but low frequency event or by low cost and high frequency events.

Contracting: The process in which a legal agreement between a payer and a subscribing group or individual such as purchasers and insurers, takes place which specifies rates, performance covenants, the relationship among the parties, schedule of benefits, and other pertinent conditions.

Co-payment: A fixed amount of payment, which must be paid by a beneficiary for each service at time of service use.

Cost: Resources in monetary terms expended in carrying out activities.

Recurrent cost: Costs of inputs whose useful life is less than one year.

Cost-effectiveness analysis: A form of economic evaluation where costs are expressed in money terms but consequences are expressed in physical units. It is used to compare different ways of achieving the same objective.

Costing: The techniques and processes of ascertaining the expenditures the amount of expenditure incurred on particular products and services.

Cream Skimming: A situation where insurance firms select people with lower risks so their expenditure through reimbursements is reduced (Usually achieved by making it hard for people with risk to enrol)

Cross-subsidies: Amounts effectively paid when the wealthy members pay more than poor, or when the healthy pay the same as the sick for lower expected benefits. The poor and the sick are said to receive cross-subsidies from the wealthy and healthy.

Debt stock: Total value of borrowings of an entity such as a sovereign country or a firm, which constitutes a liability of the entity, measured at a given point in time.

Decentralization: Transfer of administrative power from a central to a local authority. Also referred as "devolution of power".

Demand: The level of consumption preferred by consumers at different prices.

Deferral and Exemption: Deferral and Exemption scheme aims at guaranteeing access to quality health care to the mass population of the poor in the society. It tends to encourage those who temporarily lack the capacity to pay cash immediately for the treatment or other health service to have the service and later come back at a specified period for payment (deferral). Those who permanently lack the money to pay for the service can also access the service without personally paying for it (exemption). These are the unemployed and others unable to pay for economic and social reasons

Earmarked Tax: Contribution dedicated to health or particular function. Earmarked taxes sometimes reduce flexibility over time in allocating public funds to the best possible use. It may also reduce accountability of agencies to which funds are allocated when those revenues are determined by factors independent of the number or quality of services provided.

Effectiveness: The effect of the activity and the end results, outcomes or benefits for the population achieved in relation to the stated objectives. It is an expression of desired effect of programme, service intervention in reducing a health problem or improving an unsatisfactory health situation.

Efficiency: The effect or end results achieved in relation to the effort expended in terms of money, resources and time.

Technical efficiency: The production of the greatest amount or quality of outcome for any specified level of resources.

Allocative efficiency: An allocation of the mix of resources for maximal benefit, i.e. such that no change in spending priorities could improve the overall welfare.

Equity: The absence of systematic disparities in health between social groups who have different levels of underlying social advantage or disadvantage - that is, different positions in a social hierarchy. Inequities in health systematically put groups of people who are already socially disadvantaged such as by virtue of being poor, female, and/or members of a disenfranchised racial, ethnic, or religious group at further disadvantage with respect to their health.

Fair financing: A way health care is financed is perfectly fair if the ratio of total health contribution to total non-food spending is identical for all households, independently of their income, their health status and their use of health services.

Fee for service: Payments to a provider for each item or services provided.

Foreign Direct investment (FDI): Investment by firm based in one country in actual productive capacity or other real assets in another country, normally through creation of a subsidiary by a multinational corporation. Used as a measure of globalization of capital. Effects on growth and inequality in developing countries disputed.

Formal sector: Enterprises, which are registered and licensed to conduct business and whose employees earn regular salaries and wages.

Functions of health care financing: The core functions of health financing are: collecting revenue, pooling of resources and purchasing:

- **Collecting revenue:** is the process by which health systems receive money from households, companies and institutions as well as from donors. Various ways of collecting revenues are general taxation, social health insurance, private health insurance, out-of pocket payments and grant and charitable donations and multilateral borrowing.

- **Pooling of resources:** the process of accumulation and management of revenues to ensure that the risk of having to pay for health care is borne by all the members of the pool and not by each contributor individually. Various forms of tax and social health insurance schemes aiming at sharing the financial risk and funds among the contributing members are the main focus of this function.

- **Purchasing:** of health services is the process by which the most needed and effective health interventions are chosen and provided in an efficient and equitable manner, and the providers are paid appropriately from the pooled financial resources for delivering defined sets of services and interventions. Purchasing has three interwoven elements; "allocating financial resources", establishing “provider payment options” and “contracting” with providers.

Funders: Organizations contributing to the coverage of health care expenditures or providing the funding for health care through budgets, contracts, grants or donations to a health care provider.

Gross domestic product (GDP): The total value of goods and services produced within a country each year.

Health insurance: Financial protection against medical care costs arising from disease or injury. The reduction or elimination of the uncertain risks of loss for the individual or

household, by combining a larger number of similarly exposed individuals or households who are included in a common fund that makes good the loss caused to any one member.

Community based health insurance (CBHI): A micro-insurance scheme managed independently by community members, a community-based organization whereby the term community may be defined as members of a professional group, residents of a particular location, a faith-based organization etc.

Social health insurance: Compulsory health insurance, regarded as part of a social security system, funded from contributions – often community rated- and managed by an autonomous legal entity.

Private health insurance: A health insurance scheme often characterized with the following features: voluntary, managed outside the social security system where premiums are risk-rated rather than community-rated, managed by an independent legal entity (an incorporation, organization, association or foundation) not by a state/quasi state body, operating for profit or non-profit.

Voluntary health insurance: Health insurance that offers benefit to its members entitled on a voluntary basis, which can be managed by a private, public or quasi-public body.

Health Maintenance Organization (HMO): An organization that accepts responsibility for organizing and providing a defined set of services for its enrolled population, in exchange for a predetermined, fixed, periodic payment for each person or family unit enrolled (see also Managed Care).

Health spending: As one of the Health for All global strategy, WHO advised the Member States to spend minimum 5% of GDP on health. In many countries only one disease, such as diabetes could consume the entire amount. High level of spending may not necessarily lead to high health outcomes. At any given level of income and spending health outcome varies. Therefore, efficient use of available funds becomes critical. It is also important to correct imbalances, low spending in some areas and high spending in others.

Informal sector: Enterprises, which are not registered and licensed to conduct business but do so in an entrepreneurial, independent manner, and whose earnings are not reported or declared as part of a payroll process. Compared with wage-earning workers in the formal sector, the informal sector has more labour-intensive mode of production. Informal production units typically operate at a low level of organization, with little or no division between labour and capital on small-scale labour operations. Their existence is based on casual employment, kinship or personal and social relations rather than contractual arrangements with formal agreement.

Moral hazard: Abuse of insurance benefit by insured people which yields to an increase in health expenditure.

National Health Accounts (NHA): A framework and methodology for measurement and presentation of information on total national health expenditure including public and private sources of funds. NHA tracks financial resources from sources, to providers and functions. It is important because, health systems are complex and policy makers need tools to analyse HCF, how and how much resources used in a health system, what resource allocation patterns, use and options exist.

Out-of-pocket payments: Payment out of private purse as opposed to public made directly by a patient to a health service provider without reimbursement.

Payer: The public or private organization that is responsible for payment for health care expenses. Payers may be insurance companies or self-insured employers or persons.

Pay roll taxes: Contributions levied against labour income. They are inexpensive to administer but easier to avoid than other forms of taxes.

Per capita income: A measure of human progress, using overall well-being to judge the level of a country's development.

Policy: An agreement or consensus among relevant partners on the issues to be addressed and on the approaches or strategies to deal with them.

Poverty gap ratio: is the mean distance separating the population from the poverty line (with the non-poor being given a distance of zero), expressed as a percentage of the poverty line.

Prepayment scheme: A method of paying for the cost of health care services in advance of their use. A method providing in advance for the cost of predetermined benefits for a population group, through regular periodic payments in the form of premiums, dues, or contributions, including those contributions that are made to a health fund by employers on behalf of their employees.

Prepayment ratio: Ratio between the benefit paid by health insurance and total benefit provided to a patient.

Premium: Amount paid to a carrier for providing insurance coverage under a contract. Money paid out in advance for insurance coverage. Contributions are often defined as percentage of salary for formal sector employees or monthly level of payments for informal sector employees to health insurance fund on regular basis.

Provider payment methods: Ways or means of paying health care providers such as on a capitation, case based, fee-for-service or other basis (see also individual definitions).

Purchaser: This entity not only pays the premium, but also controls the premium amount before paying it to the provider. Included in the category of purchasers or payers are patients, businesses and managed care organizations. While patients and businesses function as ultimate purchasers, managed care organizations and insurance companies serve a processing or payer function.

Purchaser Power Parity theory: It predicts that exchange rates should adjust so that equivalent goods are equivalently priced throughout the world. That is, if USD $1 buys a dozen eggs in the United States, the dollar should exchange for enough yen to buy a dozen eggs in Japan.

Reinsurance: The transfer of liability from the primary insurer, the company that issued the contract, to another insurer, the reinsurance company. This mechanism allows a diversification of the risk and enlarges the risk-pooling base, thereby reducing the risk of insolvency.

Resource allocation: The process by which available resources are distributed between competing uses as a means of achieving a particular goal.

Risk Equalization: Such a fund would seek to eliminate cream-skimming and the advantages of positive risk selection (enrolment of healthier people less likely to require services and incur costs) by equalizing risks between schemes, that is, all schemes would contribute a percentage of their earnings into a fund, which would be used to compensate schemes that have a disproportionately adverse risk mix.

Risk pooling: The process by which fluctuations in risk are reduced by averaging the risk over large numbers and heterogeneous memberships.

Social safety nets: A system that would allow economically and socially deprived citizens to continue to receive social services through free services, subsidized care, social insurance and social assistance. The system should assure that citizens retire with dignity and income – pension benefits; citizens are insulated from the loss of income due to economic forces out of their control – unemployment benefits; citizens not bear the full risk and costs for illness and injury – health benefits; and citizens are provided social welfare support.

Special consumption taxes: Taxes used for effectively reducing the demand for harmful substances such as tobacco and alcohol by raising the price closer to its true social cost. These taxes may create a conflict of interest in a way that lowered demand and consumption can affect sources of revenue.

Universal Coverage: Access to key health promotion, preventive, curative and rehabilitative health interventions for all, at an affordable cost, thereby achieving equity in access. Incorporates two dimensions: depth-health care coverage as in adequate health care-and width-population coverage.

User charges: Payment for goods and services according to price list or fee schedule. User fee system is inequitable by its own nature. It makes the patients bear the cost of services and it makes the poor pay proportionally more than the rich.

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ANNEX

Summary of Steps taken to develop the National Health Financing Policy and Strategy

i. Development of concept note and budget by the HCFE&I Branch and reviewed by a sub-committee set up by the TWG in June 2015.
ii. Adoption of the Concept Note and Budget by the TWG
iii. Baseline assessment and situation analysis by the TWG with support from WHO, United States Agency for International Development (Health Finance and Governance [HFG), and Bill and Melinda Gates Foundation. Situation analysis focused on 4 main areas: Governance/Political economy; Fiscal Space; Health Accounts (National & States); and Public Finance Management Systems (PFMs)
iv. Development of the National Health Financing Policy & Strategy Outline and approval by the TWG
v. Engagement of one (1) Consultant to establish the relevant antecedents for the development of the zero draft National Health Care Financing Policy and strategy documents as well as deliver the final draft.
vi. Three (3) meetings of the HCFE&I TWG to articulate and produce a zero-draft of the policy and strategy documents
vii. Four (4) meetings of the Core Technical Team to consider outcomes of the TWG meetings and expound on products towards development of the draft Policy & Strategy.
viii. Development of the zero draft National Health Care Financing Policy and strategy by the TWG on 18 November, 2016.
ix. Engagement of one (1) Consultant to support FMOH with internal expert review and produce first draft of the National Health Financing Policy and Strategy
x. 3-day High-Level National Stakeholders' Policy Dialogue including the States, Finance, Budget and National Planning, Justice, Labour, and end users to agree on policy provisions on health financing functions and finalize the draft policy and strategy documents.
xi. 5-Man Writer's Team to finalize the National Health Financing Policy and Strategy.
xii. 1-day National Stakeholders' Validation meeting to validate the final policy and strategy document
xiii. National Council on Health (NCH) for approval of the finalized NHFP&S
xiv. Federal Executive Council (FEC) approval of the final NCH-approved National Health Financing Policy and Strategy Document.


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