USAID
FROM THE AMERICAN PEOPLE

# AFRICAN STRATEGIES FOR HEALTH

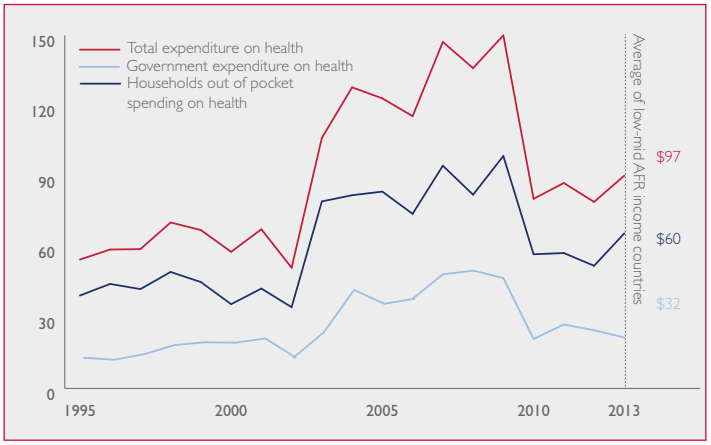
# HEALTH FINANCING PROFILE: NIGERIA

Key country indicators

| Development indicators* | |
|---|---|
| Total population | 173,615,000 |
| Total fertility rate (births per woman) | 6 |
| Gross national income per capita (PPP) | 5,360 |
| **Health care expenditure indicators**** | |
| **Expenditure ratio** | |
| Total expenditure on health as % of GDP | 3.7%<br>↓ avg. low-income countries (5%)<br>↓ global avg. (9.2%) |
| **Level of expenditures** | |
| General government expenditure on health as % of total government expenditure | 6.5%<br>↓ targets set by Abuja Declaration (15%) |
| **Selected per capita indicators** | |
| Per capita total expenditure on health (PPP int.$) | 207 |
| Per capita government expenditure on health at average exchange rate (US$) | 26 |
| Per capita government expenditure on health (PPP int.$) | 49 |
| **Sources of funds** | |
| General government expenditure on health as % of total expenditure on health | 23.9% |
| Private expenditure on health as % of total expenditure on health | 76.1% |
| External resources for health as % of total expenditure on health | 5.5% |
| Out-of-pocket expenditures as % of private expenditure on health | 95.8% |

*Note: WHO aggregates are calculated using absolute amounts in national currency units converted to Purchasing Power Parity (PPP) equivalents*

Per capita expenditure in US$ (constant 2013 US$)**




*World Health Organization (WHO) Global Health Observatory, 2013*
**WHO Global Health Expenditure Database, 2013*

## Contextual Factors

The 2014 Presidential Summit on Universal Health Coverage (UHC) reaffirmed Nigeria's commitment at federal and state levels to address weaknesses currently impeding universal coverage of health services, including inequitable distribution of resources, decaying infrastructure, poor management of human resources for health, and weak referral systems. The implementation of financing initiatives including conditional cash transfers, free health care for vulnerable groups, health insurance for the formal sector, and community-based health insurance (CBHI) schemes for the informal sector, can help to address the widening geographic and socioeconomic disparities in health care access across the country.[1]

Yet, to bring about health care system change, local, state, and federal policymakers need to collaborate more often and more effectively.[2] Across states, the level of financial mobilization for health by the public sector varies widely and depends on the roles they play in health care provision. In Northern Nigeria, the public sector provides over 90% of all health services, in contrast to states in Southern Nigeria, where the private sector provides over 70% of health services, mostly on a fee-for-service basis.[3]

Evidence from a Public Expenditure Review of the health sector and National Health Accounts (NHA) suggests that on average, most states spend less than 5% of their total expenditure on health care. Expenditure from all tiers of government amounts to less than 6% of total government expenditure and less than 25% of total health spending in the country. The private sector accounts for the remaining 75% of health spending, with 90% of this coming from household out-of-pocket expenditures.[3] Coupled with the lack of effective risk protection mechanisms such as fee exemptions and health insurance, the cost of seeking care is prohibitive for many people in Nigeria.

The greatest scope for increasing the fiscal space for health is through domestic resource mobilization, increasing official development assistance targeted at social protection schemes such as health insurance, and through improvements to the financial management of public expenditure.[4]

## Health Financing Functions

- ***Revenue contribution and collection:*** Funding for health-related expenses has been low primarily because tax-based health financing is limited. Considering the country's current Gross Domestic Product (GDP) of about US$300 billion, an increase of tax revenue to 15% of the GDP will result in about US$21 billion. An allocation of 10% of this additional income would result in US$2.1 billion for the health sector.[3] Such re-constitution of revenue collection can represent a great leap forward for the health sector.

Increased development aid grants and debt relief have been used to launch the National Health Insurance Scheme (NHIS).[5] The 2014 National Health Act in Nigeria (NHAct) aims to

substantially increase revenue and improve primary health care services through the Basic Health Care Provision Fund (BHCPF). However, it is essential to ensure accountability between stakeholders at different levels of government for the flow of revenue to reach primary health care services.[6]

- ***Pooling:*** The Nigerian NHIS organizes risk pooling under three main programs. The Formal Sector Social Health Insurance Program (FSSHIP) is available to public employees and the organized private sector, and is implemented via a managed care model funded through percentage contributions from employers and employees. NHIS pools funds at the federal level, and allocates them to health maintenance organizations (HMOs) to make capitation payments and reimbursements to providers on behalf of beneficiaries allocated to HMOs. By 2011, only the federal government and three out of 36 states in Nigeria had adopted the program despite sustained advocacy by the NHIS and HMOs.[7] Almost 4% of the entire population is covered by FSSHIP.[7]

The two other proposed schemes, the Urban Self-Employed Social Health Insurance Program (USSHIP) and The Rural Community Social Health Insurance Program (RCSHIP) are meant to serve the informal sector (almost 70% of the population) and are non-profit, voluntary schemes based on the CBHI model. Revenue is supposed to be generated for the USSHIP by flat-rate monthly payments with contributions dependent on the health package chosen, whereas RCSHIP members are to acquire accreditation according to their health needs and then choose benefits, with cash contributions being made as flat-rate monthly payments or in instalments.[8] Health care providers offering services to the scheme members will be paid in the form of salaries. While enrolment in all three programs remains low, various CBHI pilots have shown promising increases in access and health care utilization.[8]

- ***Purchasing:*** Two purchasing mechanisms operate in Nigeria to determine which health services to purchase, increase value for money, and ensure long-term financing sustainability[9]:

**1. General tax-funded health services:** Tax revenues are pooled at the federal level and are shared between the three tiers of government. These funds are generally inadequate, and merely complement the majority of health spending in the form of household out-of-pocket expenditures. States generate taxes through internally-generated revenue, and state allocations to health are used by the State Ministry of Health (SMoH) to purchase health services for citizens. State-level pools are used, along with contributions from the national pool, for publicly-financed services. The entire population is covered using state-level government budgets, and the SMoHs act as purchasing organizations to allocate budgets for providers at health facilities. Funds are transferred to health facilities mostly in the form of commodities and global budgets.

**2. NHIS:** A single pool across 3% of the total population engaged in the formal sector plans to use payroll tax contributions by employees (proposed 5% of basic salary) and employers (proposed 10% of basic salary) to pay for health services. Private health care organizations such as HMOs will purchase health services and use capitation and fee-for-service to pay providers for primary, and secondary and tertiary care services rendered, respectively.

## Meeting the Goals of Universal Health Coverage (UHC)

UHC can only be achieved when access to health services and financial risk protection are equitably addressed. Equitable financial protection means that everyone, irrespective of their level of income, is free from financial hardship caused by using needed health services.

### *Financial protection & Equity in financing and utilization*

Out-of-pocket expenditures constitute nearly 90% of the total private health spending, placing a significant burden on households.

Studies from Southeast and Southwest Nigeria show that 23% and 11% of all households sampled, respectively, experienced catastrophic payments for health care. This estimate was higher among those enrolled in health insurance in the poorest households and in rural dwellings - and highest among those not enrolled.[10,11] Among those in the richest quintile in Southeast Nigeria, only 8% of households experienced catastrophic costs.[10]

The aim of the NHIS in reducing the burden of health care expenditure will not be achieved if the poor are not given special consideration in the form of free or affordable healthcare. Health care in Nigeria should rely less on individual payments at the point of use, and allow for greater risk pooling and protection, especially for the poorest populations. Expanding the coverage and benefits of NHIS by targeting subsidies or payments to reach the poorest can accelerate the attainment of UHC goals.

### Endnotes


1. Advancing Partnerships for Universal Health Coverage. Workshop Report from 8-9 July 2015 in Kenya, Nairobi. HANSHEP and Health Systems Hub
2. Atim C & Bhatnagar A. Toward Synergy and Collaboration to Expand the Supply of and Strengthen Primary Health Care in Nigeria's Federal Context, with Special Reference to Ondo State. Universal Health Coverage Studies Series (UNICO) No. 3. The World Bank. Washington DC, January 2013
3. Ichoku H & Okoli CI. Fiscal Space for Health Financing in Nigeria. African Journal of Health Economics. 2015 (E-publication ahead of print)
4. Zanker JH & Tavakoli H. An analysis of fiscal space for social protection in Nigeria. Overseas Development Institute (ODI). London, United Kingdom. February 2012.
5. Usoroh EE. Achieving universal health coverage in Nigeria: The National Health Insurance Scheme as a tool. 48th International Course in Health Development. KIT (Royal Tropical Institute). Amsterdam, Netherlands. September 19, 2011-September 7, 2012
6. Uzochukwu B et al. Implementing the Basic Health Care Provision Fund in Nigeria. Health Policy Research Group, College of Medicine, University of Nigeria & RESYST (Resilient and Responsive Health Systems) Research Consortium at London School of Hygiene and Tropical Medicine, London (UK). March 2015.
7. Onoka CA et al. Promoting universal financial protection: constraints and enabling factors in scaling-up coverage with social health insurance in Nigeria. Health Research Policy and Systems. 2013, 11:20.
8. Odeyemi IAO, Community-based health insurance programs and the national health insurance scheme of Nigeria: challenges to uptake and integration. International Journal for Equity in Health 2014, 13:20.
9. Strategic Purchasing Factsheet. Asia Pacific Observatory on Health Systems and Policies and RESYST. October 2014.
10. Onwujekwe O, Hanson K, Uzochukwu B (2012) Examining Inequities in Incidence of Catastrophic Health Expenditures on Different Healthcare Services and Health Facilities in Nigeria. PLoS ONE 7(7): e40811.
11. Ilesanmi OS, Adebiyi AO, Fatiregun AA. National health insurance scheme: how protected are households in Oyo State, Nigeria from catastrophic health expenditure? International Journal of Health Policy and Management. 2014, 2(4), 175-180



Additional information can be obtained from:
African Strategies for Health 4301 N Fairfax Drive, Arlington, VA 22203 • +1.703.524.6575 • AS4H-Info@as4h.org
www.africanstrategies4health.org



*This publication was made possible by the generous support of the United States Agency for International Development (USAID) under contract number AID-OAA-C-11-00161. The contents are the responsibility of the authors and do not necessarily reflect the views of USAID or the United States Government.*