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Assessing Health Financing Progress Towards Universal Health Coverage in Nigeria (2015-2022)

Osaretin G. Okungbowa, Ph.D.

4th August, 2023

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Preface

Since 2011, the National Institute for Legislative and Democratic Studies has been at the forefront of shaping public policies in Nigeria and the West African subregion. As the think tank of the National Assembly, the role of the Institute is to ensure that proposals and positions advanced by the legislators are informed by the requisite research and analytical support. To this end, the Institute recognizes the importance of the health sector to national development, especially Universal Health Coverage (UHC) as a veritable pathway for poverty reduction and sustainable development in Nigeria. Consequently, the role of the legislature in the pursuit of this laudable objective cannot be overemphasized. Thus, the legislature can accelerate the drive towards UHC goals through oversight, lawmaking, appropriation, amongst other functions. Accordingly, we are committed to assisting the legislators by providing it with the requisite knowledge and capacity-building to informing health-related public policy. This effort is in line with our mandate as provided in Section 2(f) of NILDS Act, 2017: *"the Institute shall have powers to improve the capacity of legislators to sustain and consolidate democratic governance through deliberation and policy formulation"*. Thus, this research is a part of fulfilling NILDS's mandate.

Furthermore, I am pleased that the need to increase health financing in order to achieve UHC goal by 2030 is receiving significant attention in the 10th National Assembly. Thus, this research aims at providing valuable insights into the progress and challenges of achieving UHC. The leadership of NILDS Governing Council and the 10th National Assembly are dedicated

to improving the health sector through legislative actions. I would like to acknowledge the effort of Dr. Osaretin Okungbowa for conducting this research. He passionately shared the findings of the research in a seminar that were attended by stakeholders in the health sector including the World Health Organization (WHO) representative. It is worth mentioning that in 2021, Osaretin was selected from a global pool of applicants by the WHO to participate in the 6th WHO-Advanced Health Financing Course towards Universal Health Coverage in Geneva, Switzerland. Although the in-person training was canceled due to the coronavirus pandemic, it was conducted online successfully. Undoubtedly, the capacity-building has been beneficial in helping Dr. Okungbowa analyze health-related legislations with a broader perspective. But more than that, Dr. Okungbowa has taken the initiative to establish a partnership between NILDS and WHO to consolidate that engagement. Thus, the Institute is excited to deepen the collaboration with WHO and form a united front to promote the progress of Universal Health Coverage (UHC) in Nigeria.

Professor Abubakar O. Sulaiman

DG, NILDS

About the Author

Dr Okungbowa is a development economist with over 20 years of experience in academia, banking, and public policy. He is currently a Research Fellow at the National Institute for Legislative and Democratic Studies, National Assembly, Nigeria. Equipped with analytical tools such as EVIEWS, Stata, Microsoft Excel and PowerBI, his research has focused on addressing the intersection of health, gender, financial inclusion, climate change, governance, amongst others. Dr Okungbowa has conducted extensive studies on the impact of social and economic policies, projects, and programs on development outcomes, particularly for children, women and vulnerable populations. Before his current role, Dr Okungbowa was a Lecturer 1 and Ag. Head of Department at Wellspring University, Benin City where he taught undergraduate and postgraduate courses. Apart from being a member of the University Senate, he spearheaded a collaboration with Google LLC that resulted in the capacity building of over 500 undergraduate students in digital skills. Also, Osaretin was previously a Bank Manager at United Bank for Africa Plc, arguably the largest brand in Africa. As part of his work for the bank, Osaretin led teams to generate business leads targeted at retail clientele. He provided financial solutions to over 10,000

underserved populations leading to increase in revenue by over 80% for the bank. Furthermore, Osaretin was formerly a high school Mathematics Tutor at Greater Tomorrow Secondary School, Benin City-one of the biggest schools in south-south Nigeria. Osaretin is skilled in stakeholder engagement, coalition building, and advocacy. He has assisted government agencies and non-profit organizations by providing technical support to enhance their ability to create and execute impactful policies.

Dr Okungbowa, holds a Ph.D. degree in economics from the University of Benin, Benin City, Nigeria. In addition, he possesses the following degrees: BSc (Mathematics and Economics); Masters of Business Administration (MBA); and Masters of Economics (MSc) from the same University. Furthermore, Osaretin has obtained multiple certificates from capacity-building courses offered by reputable institutions: Blavatnik School of Government-University of Oxford; Harvard University; Georegetown University; Harvard University, International Capacity Development-International Monetary Fund (ICD-IMF), among others. Dr. Okungbowa has undergone the WHO-capacity building Courses on UHC including the 6th Advanced Health Financing Course for UHC, Geneva, Switzerland. He is a member of WHO-Health Financing Technical Network (HFTN Sub-community), and has participated in several health governance and financing conferences. In addition, he is a member of Nigeria UHC Forum, and works closely with the Global Burden of Disease Collaborators, leveraging data-driven insights to shape healthcare policies. Also, Osaretin is a Community Development Volunteer at Health of the Mother Earth Foundation, where he involved in grassroots initiatives to address environmental and social challenges. Dr Okungbowa has developed a nuanced understanding of the context and dynamics in developing countries, as well as the theory of change that drive progress to development. These extensive knowledge and experiences have equipped him with the necessary skills to navigate complex policy issues to informing public policies. Dr Okungbowa is a member of several professional bodies including the Nigeria Institute of Management (NIM) Chartered, and Nigeria Economic Society (NES). His articles are published in both national and international journals. He is committed to promoting social justice and equity-believing that everyone should have access to quality healthcare, economic opportunities, and a dignified standard of living. In his leisure time, Osaretin enjoys hiking, exploring leadership literature, and playing chess.

Assessing Health Financing Progress towards Universal Health Coverage in Nigeria (2015-2022)

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Abstract

Universal Health Coverage (UHC) is vital to achieving Sustainable Development Goals. It ensures that everyone has access to quality healthcare without financial hardship. Though the reliance on public health expenditure is the gold standard to achieve UHC, however, out-of-pockets payments dominates health financing in low-income countries including Nigeria. Against this backdrop, the present study assessed the drive towards UHC in Nigeria using the newly launched World Health Organisation-Health Financing Progress Matrix (HFPN) 2.0. The result showed that Nigeria's drive towards UHC is hindered majorly by the double whammy of poor governance and inadequate public health financing. While the Abuja Declaration of 2001 mandated African countries to devote at least 15% of government expenditure to the health sector, however, on average, Nigeria spends 4%. It was observed that the large proportion of the informal sector-put at 65% of GDP poses a huge fiscal challenge to the government in raising revenue.

More worrisome is the catastrophic and impoverishing out-of-pockets payments hovering around 70% as against the SDG3.8.2 indicator of at most 25%. Again, the national health insurance only covers less than 7% of the population, mainly government and private employees in urban areas, thus leaving behind a sizeable proportion of the rural population. There is also the problem of

technical inefficiencies as evidenced in a plethora duplication, overlaps, and misalignments of core health system functions across health programs. As things stand, the goals of UHC i.e., Utilization relative to need, financial protection, and quality health care may not be realized if the national and subnational governments do not only scale up public spending but also strengthen the health system by improving; governance, public finance management, amongst others reforms. Thus, framing the drive towards UHC in Nigeria within the context of "development bargain," as Stefan Dercon puts it, holds promise to accelerate the drive towards UHC in Nigeria.

Key words: Universal Health Coverage, Health Financing Progress Matrix, out-of-pocket payments, financial protection, development bargain,

1. Introduction

The Sustainable Development Goal (SDG) Target 3.8 aims to achieve Universal Health Coverage (UHC) by the year 2023. UHC means that all persons are able to access needed healthcare (including prevention, promotion, treatment, rehabilitation, and palliation), of sufficient quality to be effective, without financial hardship (WHO, 2017). To achieve UHC, the World Health Organization (WHO) has set health financing benchmarks. Chiefly, the gold standard that indicates the progress towards UHC is a move away from out-of-pocket spending to public spending (Wagstaff & van Doorslaer, 1998), (Xu, et al., 2021). However, a common feature in less developing countries such as Nigeria is the reliance on out-of-pocket (OOPs) payments (Jowett & Kutzin, 2015). For instance, while it is recommended that OOP should not exceed 25% of household income, however, over 70% of OOP health expenditure in Nigeria runs afoul of UHC (WHO, 2020). This is because OOPs are almost always regressive and a source of financial hardship (Kutzin, 2013). The regressive nature of OOP means that households in the lower rung of income distribution bear a disproportionate financial burden (Cashin, 2017). Thus, underneath all the abstractions and theorizations regarding UHC is resource concerns as it relates to the equitable redistribution of society's resources. That is, whether there are adequate funds within the health system to provide the mix of interventions needed to ensure optimal health for the entire population. Given the health system framework (service delivery, health workforce, health information systems, access to essential medicines, financing, and, leadership/governance), it is pertinent to note that UHC is a critical pathway to reducing poverty in Nigeria (NSHDPF, 2009). Specifically, health financing has both direct and indirect impacts on the goals of UHC. Since the launch of the SDG in 2015, a

comprehensive assessment of health financing progress towards UHC has been carried out by different authors (Gustafson-Wright & Schelekens, 2013) and (Uzochukwu, et al., 2020). However, no assessment has been conducted on the recently launched WHO-Health Financing Progress Matrix 2.0(HFPM). Against this backdrop, this study assesses Nigeria's progress toward UHC based on the recently launched WHO-health financing progress matrix 2.0 (HFPM). The paper aims at assessing the drive toward UHC in Nigeria, focusing on the need for the government to expedite more action in order to achieve UHC in Nigeria.

2. Literature Review on Health Financing in Nigeria

The nexus of health financing and economic development is documented in the literature. For example, (Lucas, 1988), (Rebelo, 1991), and (Barro & Sala-i-Martin, 1995b) provide one of the best-known attempts to explain the spillover effect of health through the human capital, knowledge, and growth nexus. In this context, human capital is seen as the sum of skills, talents, knowledge, medical care, etc, embodied in a nation's population (Schultz, 1960; and Olssen, Codd, & O'Neill, 2004). Furthermore, the Nobel Laureate, Sen (1999), in his treatise, “Development as Freedom”, underscores the importance of health with a broader lens, and conceptualized the term “human capability rather than human. According to Sen, human capacity is concerned with 'what people are actually able to do, (and be) and what real opportunities are available to them'. Thus, the health of a nation's population is an integral part of a nation's human capability. Consequently, Sen's perspective of human capability has informed a new theoretical paradigm that has been adopted by international agencies such as the United Nations Development Programme(UNDP). Whereas, Lucas's theory was built on the idea that individual workers are

more productive, regardless of their skill level, if other workers have more human capital. The important implication of Lucas's model is that under a purely competitive equilibrium, its presence leads to an underinvestment in health because private agents do not take into cognizance the external benefits or costs of human capital accumulation. In addition to that, health is considered a public good with a unique property of non-excludability and non-rivalry (Samuelson,1954c; Buchanan & Musgrave, 1999). Blumel, Pethig, & vond dem Hagen (1986) and (Buchanan, 1968) also noted that as characteristic of every public good, private agents cannot optimally suppy health good because of the free rider problem. According to Musgrave, 1959, it is difficult to exclude other individuals who did not pay for the good from its consumption. This logic points to the justification for the dominance of government health expenditure in the total health financing mix. This is why the (WHO, 2017) states that the gold standard that guranttees the progress towards UHC is the dominance of government health expenditure. Furthermore, the coronavirus pandemic reechoes the fact that health is a public good. Thus, globally, governments fiscal response by increased health expenditure was informed by the non-excludability, non-rivalry, and spillover property of health good. Against the backdrop of the externality property of health good (Barro & Sala-i-Martin, 2003), and (Grossman, 1972) provide the justification for government investment in health. Thus, over the years, several authors, for example, (Filmer & Pritchett, 1999), and (Gottret & Schieber, 2006) have carried out extensive research on the significance of government health expenditure.

Nigeria's history of health financing dates back to 1962. At the time, government-funded universal and free healthcare from

general revenues. However, it was phased out in the 1980s due to slumping crude oil prices (Uzochukwu, et al., 2015). In 1999, the National Council on Health approved and signed a regulation aimed at revamping the health financing model to ensure full private sector participation in what became the National Health Insurance Scheme (NHIS). Though NHIS was launched in 2005 to ensure universal coverage and access to adequate and affordable healthcare, however, only less than 10% of the population is covered by the scheme (Awosusi, 2022).

In 2014, the National Health Act (NHA) was enacted, and for the first time, served as a comprehensive legal framework aimed at strengthening the health system (Awosusi, 2022). For instance, Section 1 of the National Health Act 2014 provides that "there is hereby established for the Federation the National Health system, which shall define and provide a framework for standards and regulation for health services". Furthermore, subsection 1(c.) provides that "the health system shall protect, promote and fulfill the rights of the people of Nigeria to have access to health care services." In the same vein, Section 15(3d) of the Constitution of the Federal Republic of Nigeria, 1999 provides "that there is adequate medical and health facilities for all persons". Pursuant to Section 11 (2) of the Act, the Federal Government of Nigeria (FGN) commits to provide the Basic Minimum Package Health Service (BMPHS) in order to catalyze the drive towards UHC. To operationalize the scheme, Sections 4 and 5(1) of the Act established the National Health Council (NHC) and the Basic Health Care Provision Fund (hereinafter referred to as the Fund).
The NHA provides that the Fund shall be financed by (i) at least 1% of the Consolidated Revenue Fund of the Federation (CRF); (ii) grants by international donors; and (iii) any other sources. The

Fund is disbursed through three gateways; (i) 50% for the provision of BMPHS to all Nigerians via the NHIS, (ii) 45% to NPHCDA to strengthen PHC, and (iii) 5% to the National Emergencies Medical Treatment Committee (NEMTC) for the treatment of medical emergencies. A major problem is that though Section 11(2) (a) of the Act provides for FGN annual grant of not less than 1% of its Consolidated Revenue Fund(CRF) to the Fund, however, the government did not only delay the implementation until the 2018 fiscal year but has also consistently held to the lower bound of 1%. In the same vein, while the Abuja Declaration mandated all African countries to dedicate at least 15% of their annual budget to health, however, allocation to health has remained under 5%. Thus, a combination of inadequate allocation to healthcare, and weak institutions, among other things have worsened the drive towards UHC.

Essentially, these unfavorable health outcomes undermine the achievement of the Sustainable Development Goal (SDG-3), which aims to "ensure healthy lives and promote well-being for all at all ages", and the specific Target (SDG 3.8) of achieving Universal Health Coverage (UHC) by the year 2030. For one, the UHC goal of achieving equitable access to needed healthcare services by all without suffering financial hardship is linked to the goal of eradicating poverty (SDG-1) (Cerf, 2019) (Kieny, et al., 2017). Again, the overall policy goal of Nigeria's Health Policy 2016 is to strengthen Nigeria's health system, particularly the primary health care to deliver effective, efficient, equitable, accessible, affordable, and acceptable and comprehensives services to all Nigerians". Specifically, the National Health Policy (2016) delineates ten (10) policy thrusts namely; Governance, Health Service Delivery, Health Financing, Resources for Health,

medicines, Vaccines, Commodities and Health Technologies, Health Infrastructure, Health Information Systems, Heath Research and Development, Community Ownership/Participation, and Partnerships for Health. These policy directions coupled with the legal framework are in alignment with the SDGs.

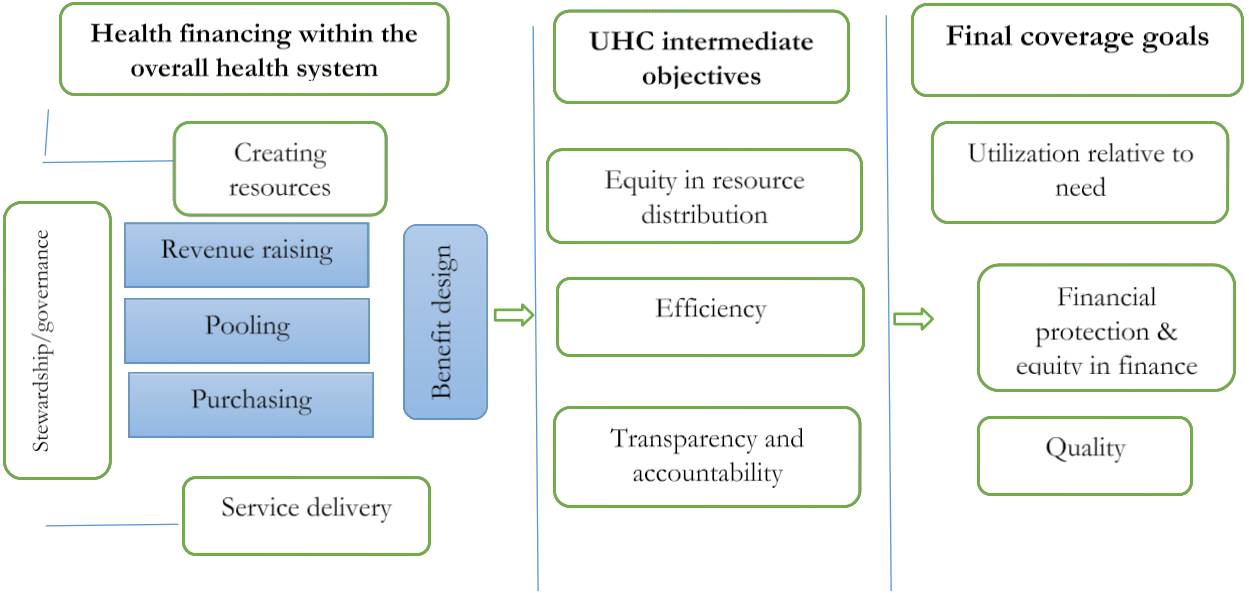
In May 2022, the NHIS Act was replaced by the National Health Insurance Authority (NHIA). Among other things, the NHIA (2022) makes health insurance mandatory for every Nigerian and legal resident, to promote, regulate and integrate health insurance schemes in the country. It authorizes the NHIA to improve and leverage private sector participation in the provision of healthcare services. Despite the availability of the legal framework and policy documents, Nigeria's health system ranks low in the WHO assessment. WHO ranks Nigeria 187 out of 190 in World Health Systems, only ahead of the Democratic Republic of the Congo, Central African Republic, and Myanmar (WHO, 2017). The WHO explains that the path to UHC rests on three pillars: (a) country's ability to raise sufficient funds for the operation of the health system; (b) reduction of reliance on direct payment as a means of financing health care; and (c) improvement in efficiency and equity. Despite the extant legal and policy frameworks, are these three factors sufficiently addressed in Nigeria? The ensuing study seeks to assess these questions. Against the backdrop of lackluster health outcomes and health expenditure, there is no gainsaying the need to stimulate the commitment of the government to prioritize health. Dercon's (2022) recent treatise, “Gambling Development” offers some prescription by detailing how incentivization of the political class can make significant progress in the drive towards UHC. Dercon argues that the answer to moving the needle as

regards paving access to health care for all can be found in the term development bargain'. According to him, a development bargain refers to a situation whereby a country's political elites—including powerful influential legislators, shift from protecting their own positions to gambling on a development-based future. Thus, the ensuing study seeks to add to the literature, by framing health within that context.

3. Methodology and Health Financing Framework

The framework for health financing is conceived within the health system. The health system can be understood "as comprising all the organizations, institutions and resources that are devoted to producing health actions" (WHO, 2000). It suffices that the health system performs four key functions namely; creating resources, stewardship/governance, service delivery and health financing (WHO, 2000). The health financing function is further unpacked into three sub-functions: revenue raising; pooling of funds; strategic purchasing; and benefit design as a fourth policy area of central concern (Kutzin, J, 2001).

Figure1: WHO's Framework for health financing and UHC



Source: Adapted from World Health Organization, (WHO, 2000)

Thus, the sub-functions provide a common denominator for assessing health financing policies and institutions in all heath systems. Accordingly, health financing is focused on revenue raising, pooling, purchasing and benefit design policies that drive progress towards UHC, and ultimately, improvements in population health. As conceptualized in Figure 1, the details of health financing policy are about the pathways through which revenue raising policy impacts on UHC directly or indirectly.

Table 1: Assessment Areas/Domain of Health Financing Framework

Assessment area	Question Text
Health Financing Policy, Process and Governance	Is there an up-to-date health financing policy statement guided by goals and based on evidence?
	Are health financing agencies held accountable through appropriate governance arrangements?
	Is health financing information systematically used to monitor, evaluate and improve policy development and implementation?
Revenue Raising	Does your country's strategy for domestic resource mobilization reflect international experience and evidence?
	How predictable is public funding for health in your country over a number of years
	To what extent are the different revenue sources raised in a progressive way?
Pooling Revenues	Does your country's strategy for pooling revenues reflect international experience and evidence?

Pooling Revenues	To what extent is the capacity of the health system to re-distribute prepaid funds
	What measures are in place to address problems arising from multiple fragmented pools?
Strategic Purchasing and Provider Payment	Do purchasing arrangements promote quality of care?
	Is the information on providers' activities capture by purchasers' adequate to guide purchasing decisions?
	To what extent is the payment of providers driven by information on the heath needs of the population serve?
Benefits and Conditionsof Access	Are there a set of explicitly defined benefits for the entire population?
	Are defined benefits aligned with available revenues, available health services purchasing mechanisms?
Public Financial Management	Is there an up-to-date assessment of key public financial management bottlenecks in health?
	Do budget formulation and implementation support alignment with sector priorities and flexible resource use?
	Do pooling arrangements promote coordination and integration across health programmes and with the broader health system?
	Are public financing management systems in place to enable a timely response to public health emergencies?

Source: World Health Organization -Health Financing Guidance No 8

4. Desirable Attributes in Health Financing

The Health Financing Progress matrix is built on nineteen (19) desirable attributes of health financing policy, crystalizing both theory and empirical evidence about what matter in order to make progress towards UHC (Jowett, et al., 2020). Thus, linking each assessment question to at least one attribute ensures a robust internal logic. Each question captures either fully or partially the attribute on which it builds, with assumption that some policies and modes of implementation are better than others in term of making progress towards UHC. Four progress levels are defined for each question defined as; "Emerging", "Progressing", "Established" and 'Advanced" based on the criteria considered central to making progress on the specific issues being assessed.

Table 2. Mapping of Desirable Attributes in Health Financing

Assessment Area	Desirable Attribute	Question Text
Health Financing Policy, Process and governance	Health financing policies are guided by UHC goals, take a system wide perspective, and prioritize and sequence strategies for bother individual and population-based services	Is there an up-to-date health financing statement guided by goals and based on evidence?
Revenue Raising	Health expenditure is based predominantly on public/compulsory funding sources	Does your country's strategy for domestic resource mobilization reflect international experience and evidence?

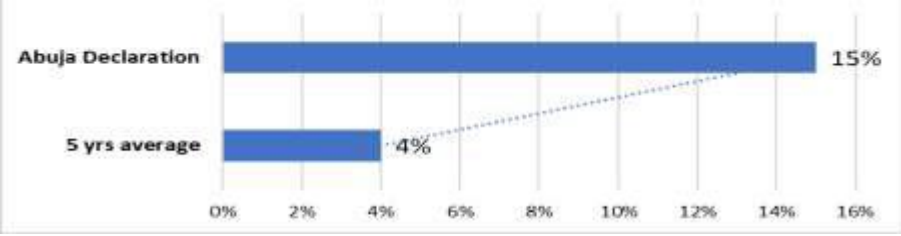
Pooling Revenues	Pooling structure and mechanisms across the health system enhance the potential to redistribute available prepaid funds	To what extent are the different revue sources raised in a progressive way?
Strategic Purchasing and Provider Payment	Resource allocation to providers reflects population health needs, provider performance, or a combination	Are provider payments harmonized within and across purchasers to ensure coherent Incentives for providers?
Benefits and conditions of Access	Defined benefits are aligned with available revenues, health services and mechanisms to allocate funds to providers	aligned with available revenues, available health services, and purchasing mechanism?
Public Financial Management	Providers can directly receive revenues, flexibly manage them, and report on spending and outputs	Is there an up-to-date assessment of key public financial management bottlenecks in health?

Source: World Health Organization –Health Financing Guidance No 8

5. Health Expenditure in Nigeria

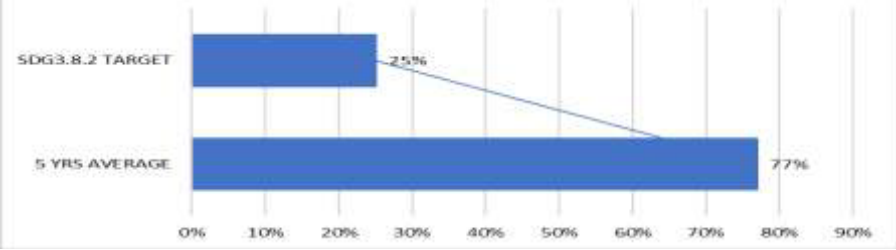
Health expenditure mix in Nigeria comprises public, private, and external health spending. On the average, domestic share of health expenditure is 91% and the rest is externally sourced in the form of both private and official development assistance. The share of public spending in domestic health expenditure is put at 14.6% with out-of-pocket expenditure put at 75.2%. This is one of the highest in the world, and contradicts the SDG3.82 target of at most 25%. Again, the Abuja Declaration of 2001, mandated African countries to devote at least 15% of government expenditure to health. However, on, average Nigeria spends 4%, and actual releases by the Office of the Accountant General of the Federation (OAGF) is less than the budgeted amount.

Figure 5.1: Government health expenditure as a percentage of government expenditure



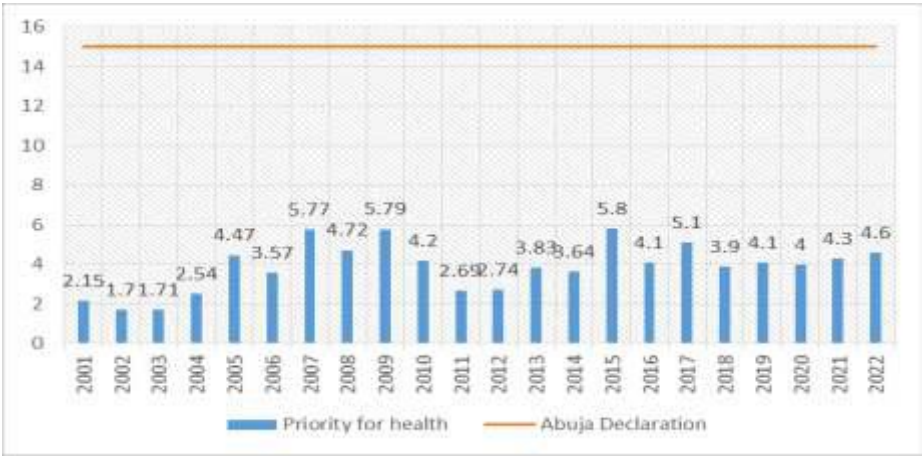
Source: WHO-Health Expenditure Database

Figure 5.2: Out-of-pocket health expenditure in Nigeria



Source: World Development Indicators (WDI)

Figure 5.3: Trends in government health expenditure in Nigeria (2001-2022)



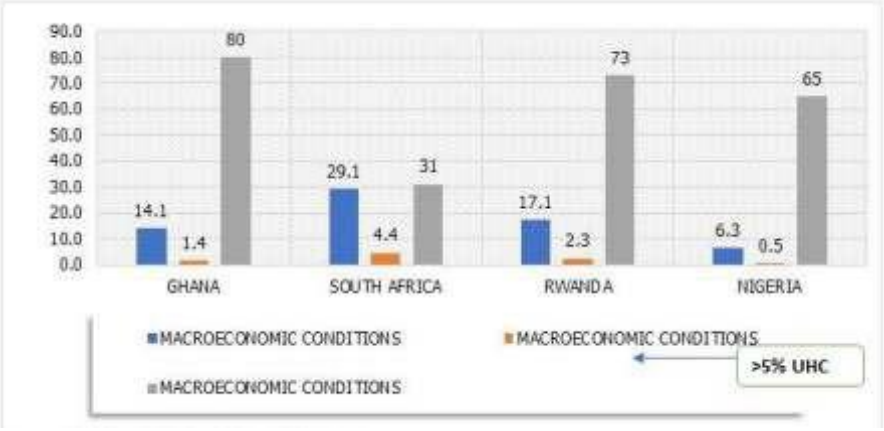
Source: World Development Indicators (WDI); WHO, GHED, 2020

6. Assessment of Revenue Raising

The question tied to this assessment area is, does Nigeria's strategy of resource mobilization reflect international experience and evidence?

Assessment shows that Health financing is Emerging. A major challenge that hinders Nigeria's drive towards UHC goals is her lacklustre fiscal strategy, poor fiscal capacity and lack of political will for innovative revenue generation. At 65%, the informal sector in Nigeria is embarrassingly a significant component of the economy. In the same vein, at $USD443 billion GDP, the biggest economy in Africa (Nigeria) can only raise a meagre 0.5% of GDP against the UHC target of 5% of GDP. In addition to the foregoing, more worrisome drawback is the lacklustre tax effort (TAX/GDP) put at 6.3%.

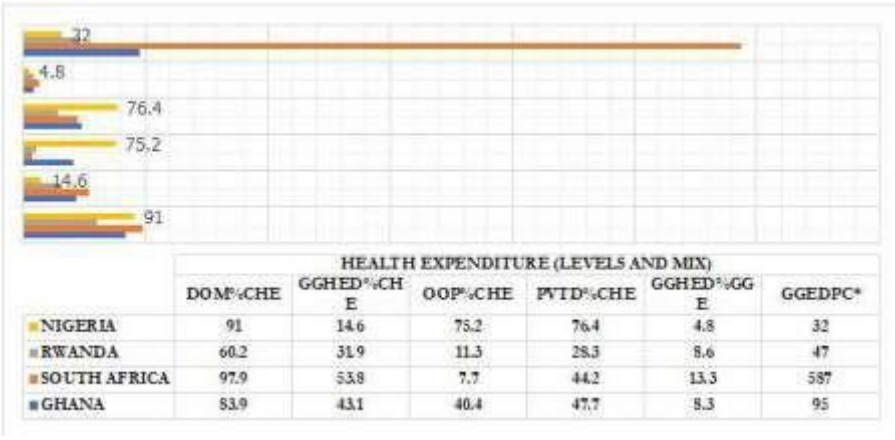
Figure 6.1: Cross Country Comparison of the Macroeconomic Conditions of Selected African Countries



Source: WHO, GHED, 2020; WDI, 2020

In terms of level of funding by the government and revenue mix, Nigeria's progress towards UHC goals is hampered by inadequate government commitment to health. For example, at 4.8% and $USD32, government's priority for health (GGED%GGE) and per capita government health expenditure (GGEDPC*) respectively, runs afoul of the Abuja Declaration (15%) and Chatham House Declaration ($USD86) respectively. This uninspiring government commitment leaves the burden of health financing disproportionately on the poor as shown by the impoverishing and catastrophic OOPs %CHE (75.2%), and PVTD%CHE (76.4%).

Figure 6.2: Cross country comparison of revenue raising mix



	HEALTH EXPENDITURE (LEVELS AND MIX)					
	DOM%CHE	GGHED%CHE	OOP%CHE	PVTD%CHE	GGHED%GGE	GGEDPC*
NIGERIA	91	14.6	75.2	76.4	4.8	32
RWANDA	60.2	31.9	11.3	28.3	8.6	47
SOUTH AFRICA	97.9	53.8	7.7	44.2	13.3	587
GHANA	83.9	43.1	40.4	47.7	8.3	95

Source: WHO, GHED, 2020; WDI, 2020

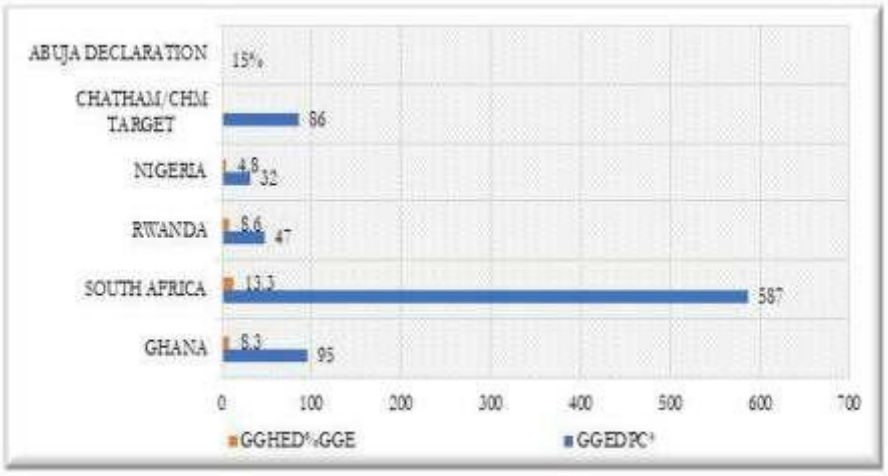
7. Assessment of Pooling

The question raised here is, "to what extent is the capacity of the health system to redistribute prepaid funds limited?

q Assessment reveals that Health Financing is 'Emerging'

The capacity of the health system to redistribute prepaid funds in Nigeria is largely limited by inadequate public expenditure in absolute and relate measures. While the Chatham and Abuja Declaration targets are USD86 (PPP) and 15% respectively, Nigeria only achieved USD32 and 4.8% respectively. Among the African countries sampled, Nigeria has the worst pooling capacity as indicated by the aforementioned measures. This development has adverse implication on the goals of UHC especially on equity in finance which is regressive in Nigeria. It is imperative to note that the *key route to achieving UHC hinges on the pooling capacity is inherent in public health expenditures.*

Proposed Revenue Raising Reform:
Government's efforts aimed at expanding the fiscal space by regulating the informal sector, and increasing tax effort are critical pathways to accelerate the progress towards UHC goals. This fiscal policy thrust would undoubtedly free up sufficient revenue for health financing; an indicator that guarantees the progressive movement towards UHC goals. Overall, the political leadership across all levels and arm of governments that prioritize health as a development agenda is imperative to accelerate the movement towards UHC goals.



Source: WHO, GHED, 2020; WDI, 2020

Proposed Pooling Reform:

The need to increase government health expenditure across all levels of government (national and subnational) cannot be overemphasized. To this end and pursuant to Section 11 (2a) of the National Health Act, (NHA, 2014), the National Assembly through the power of the purse may wish to appropriate a higher percentage say 5% of its Consolidated Revenue Fund to finance the Basic Health Care Provision Fund (BHCPF) instead of sticking to the lowest 1%. Recall that Section 11(2a) states that the BHCPF shall be financed from Federal Government Grant of not less than one per cent of its Consolidated Revenue Fund. Accordingly, this efforts would foster the capacity of Nigeria's health system to redistribute prepaid funds especially to the PHCs in a manner that ensures equity in finance.

8. Strategic Purchasing and Provider Payment

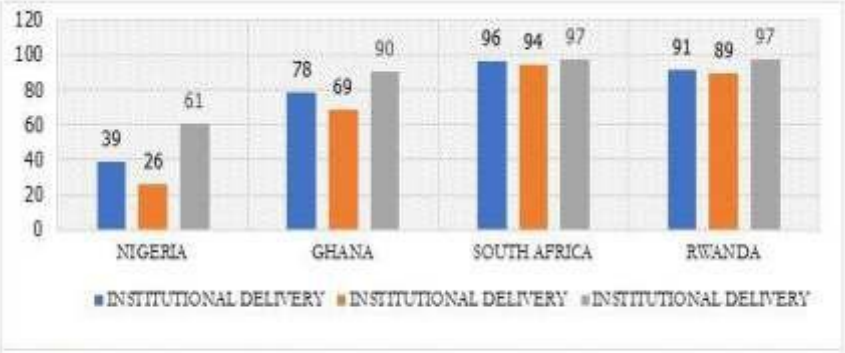
The question tied to this assessment area is, are provider payments harmonized within and across purchasers to ensure coherent incentive for providers?

q Assessment indicates that Health Financing is 'Emerging'

Progress towards UHC is hindered by institutional constraints and inability to incentivize health care providers with the requisite provider payments necessary to drive health provider behavior towards alignment with UHC objectives. For example, in Nigeria, service utilization rates proxied by disaggregated national, urban

and rural maternal health care utilization accentuates the fact that there is no alignment or harmonization of provider payments within or across purchasers. Consequently, the inability of PHC centers to provide basic medical services to Nigerians has made both secondary and tertiary healthcare facilities experience an influx of patients.

Figure 8.1: Maternal Care Utilization (in percentage) in Selected Countries in Africa



Source: UNICEF, 2021; Ghana (MICS 2017-2018), Nigeria (DHS 2018), Rwanda (DHS 2014-2015), South Africa (DHS, 2016)

Proposed Reform:

Reforms aimed at moving away from line-item-budgets, fee-for-service etc. to programmatic budgeting consisting of case-base payments, partial capitation would ensure equitable provision of needed health care services across the population. Overall, provider payment measures that incentivizes the migration of health care providers from urban to rural areas, and provide needed level of health care services for all should be pursued. To this end, measures to intensify the strengthening of the PHCOUR* may be at the front burner of the government.

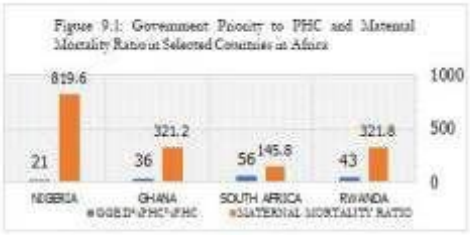
**Primary Health Care under One Roof (PHCOUR) was established in 2011 to avoid the problem of fragmentation in PHC and ensure the integration of PHC services under one authority.*

In terms of level of funding by the government and revenue mix, Nigeria's progress towards UHC goals is hampered by inadequate government commitment to health. For example, at 4.8% and $USD32, government's priority for health (GGED%GGE) and per capita government health expenditure (GGEDPC*) respectively, runs afoul of the Abuja Declaration (15%) and Chatham House Declaration ($USD86) respectively. This uninspiring government commitment leaves the burden of health financing disproportionately on the poor as shown by the impoverishing and catastrophic OOPs% CHE (75.2%), and PVTD%CHE (76.4%)

9. Assessment of Benefit Design

The question raised is that, "*are defined benefits aligned with available revenues, available health services, and purchasing mechanism?"*

Assessment shows Health Financing is 'Emerging' Benefit design is impaired by inadequate budgetary and purchasing instruments to ensure that funds flow to those healthcare services and related concerns defined as a priority. For example, government share of PHC stands at a meagre 21% leading to terrible maternal mortality ratio put at 819.6 per 100,000 live birth.



Source: World Development Indicator; WHO GHED, 2020

PROPOSED REFORM

Affirmative action is required by the government through explicit benefit design and the requisite provider payment mechanisms to incentivize healthcare providers towards service delivery priorities in the PHCs.

In the same vein, Figure 5.2 shows chronic underfunding of PHCs resulting in low healthcare utilization proxied by institutional delivery. Clearly, budget and health priorities are not connected, and the often-touted government's efforts is at best tokenism. As things stand, health expenditure at the PHCs is highly regressive and inimical to the drive towards UHC goals.

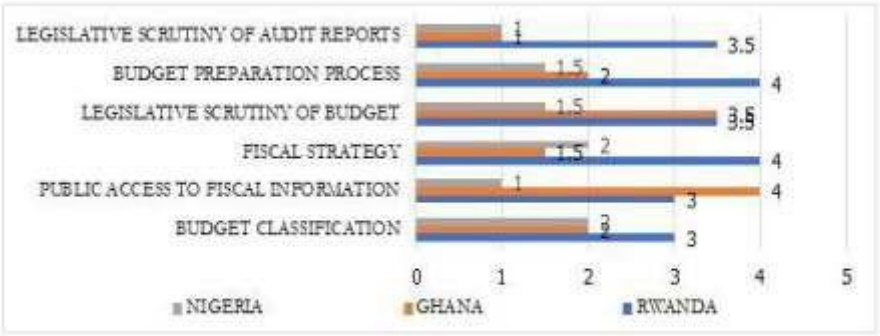
10. Public Financial Management

The question raised, is there an up-to-date assessment of key public financial management bottlenecks in health?

Assessment shows Health Financing is 'Emerging'

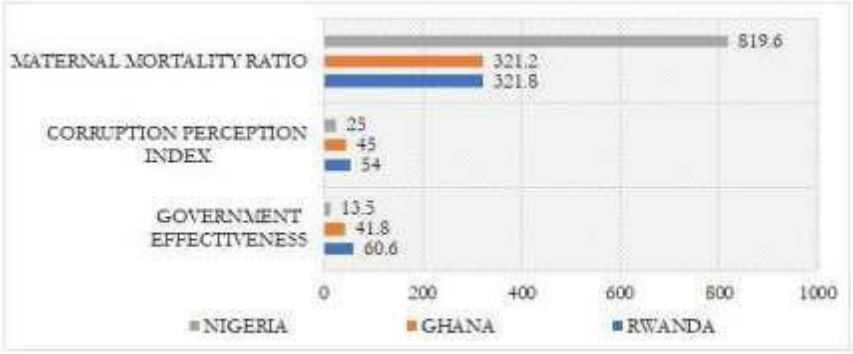
Poor public financial management and governance mutually reinforce to weakening health system performance. Ineffective institutions, rigid budgetary system, systemic corruption, weak fiscal strategy, etc., combine to produce atrocious health outcome as proxied by maternal mortality ratio.

Figure 10.1: Cross Country Comparison of Public Financial Management



Source: Source: Public expenditure Financial Accountability (PEFA, 2020);*

Figure 10.2: Cross Country Comparison of Governance and Maternal Mortality



WGI, 2020; Transparency International, 2020

PROPOSED REFORM

Efforts aimed at strengthening institutional/ governance and public financial management systems is a critical pathway to improving health sector performance in Nigeria

11. Priority Reforms, Recommendations and Conclusion

We set out to assess Nigeria's health financing progress towards using the recently launched Health Financing Progress Matrix 2.0. The results show that the drive towards UHC is emerging. This indicates a lackluster performance in the assessment areas such as revenue raising, strategic purchasing, pooling, Benefit design and provider payment, public financial management. The following recommendation may be considered in order to accelerate Nigeria's health financing progress towards UHC goals.

i. Affirmative action by the Executive arm of government through the Ministry of Health to incentivize healthcare providers' behaviour towards service delivery priorities especially in the rural Primary Health Care is warranted. To achieve this, the relevant *Senate and House Committees on Health may wish to utilize their oversight instrument and hold an interactive session with the officials of the National Primary HealthCare Development Agency.*

ii. The Senate and House Committees on Health as well as the Committees on Appropriation and Finance may wish to liaise with the Ministries of Health and Finance, Budget and National Planning to devise a way of moving away from line-item-budgeting to programmatic budgeting; including case-based payments, partial capitation etc., this is warranted in order to ensure equitable provision of needed health care services across the population.

iii. Pursuant to Section 11 (2a) of the National Health Act,

(NHA, 2014), the National Assembly through the power of the purse may wish to appropriate a higher percentage say 5% of its Consolidated Revenue Fund to finance the Basic Health Care Provision Fund (BHCPF) instead of sticking to the lowest 1%. Recall that Section 11(2a) states that the BHCPF shall be financed from Federal Government Grant of not less than one per cent of its Consolidated Revenue Fund. Accordingly, this efforts would foster the capacity of Nigeria's health system to redistribute prepaid funds especially to the PHCs in a manner that ensures equity in finance.

iv. The National Assembly through its oversight on Ministries, Departments and Agencies of government may wish to intensify efforts aimed at strengthening institutional/governance and public financial management systems in order to improve health sector performance in Nigeria. To this end, a strong leadership committed to good governance especially the political will to fight corruption is needed to accelerating Nigeria's drive towards UHC goals.

Overall, since the achievement of these reforms requires the collaboration of critical stakeholders, Dercon's, seminal prescription remains crucial to our wider understanding of framing policy responses to the drive towards UHC in Nigeria. In the same vein, the same efforts should also be extended to the subnational governments. It is hoped that these efforts would firm up the groundswell of support for the drive towards UHC goals in Nigeria.

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