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IMPROVING THE IMPLEMENTATION OF THE RIVERS STATE HEALTH INSURANCE SCHEME

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Clarmar Development Foundation

First Published in September 2022

By

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This Memorandum is researched and published by the Centre for Social Justice Limited by Guarantee (CSJ) through the Strengthening Civic Advocacy and Local Engagement (SCALE) project with the generous support of the American people through the United States Agency for International Development (USAID). The contents are the sole responsibility of CSJ and do not reflect the views of the United States Government.

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ABBREVIATIONS

BHCPF	Basic Health Care Provision Fund
CRF	Consolidated Revenue Fund
EHP	Equity Health Plan
EPO	Exclusive Provider Organization
NHA	National Health Act
HMO	health Maintenance Organization
NHIA	National Health Insurance Authority
NHIS	National Health Insurance Scheme
PHC	Primary Healthcare
PPO	Preferred Provider Organization
POF	Point of Service
RSCHPP	Rivers State Contributory Health Protection Program
RSCHPPL	Rivers State Contributory Health Protection Program Law
SDG	Sustainable Development Goals
UHC	Universal Health Coverage

EXECUTIVE SUMMARY

This Policy Brief engaged the Rivers State Contributory Health Protection Programme Law (RSCHPPL or Law) with the objective of providing policy recommendations to increase health insurance care coverage in the State. The first section discussed the concept of health insurance and its various forms while the second section discussed Universal Health Coverage (UHC) and its components. In the third section, the study established a link between health insurance coverage and UHC as the former is a tool for attaining the latter. Section four discussed the arguments for compulsory health insurance to include achieving UHC, financial risk protection, equity in health care financing, realization of the minimum core obligation on the right to health, etc.

In section 5, the study reviewed the key provisions in the Law and section 6 analyzed the linkage between the new National Health Insurance Authority Act (NHIA) and the Law. In the penultimate section, it draws conclusions from the earlier sections. Section eight is the strategies and recommendations for improving health insurance coverage in Rivers State which are summarized as follows.

- **Effective Implementation of Compulsory Health Insurance Coverage: (a)** Provide political leadership and establish the Board of the Programme as the Board is key to the takeoff of the Programme; **(b)** The political leadership should activate the Programme by commencing the appropriation of 2% CRF of the State Government for the Programme. **(c)** Commit Local Governments to a minimum of 2% of their CRF to the funding of the Equity Fund of the Programme. **(d)** Review the personal income tax regime to make contributions to the Equity Fund by individuals, up to a maximum of 25% of personal income tax, a tax deductible expenditure. **(e)** Take steps to identify the indigent, vulnerable and poor who cannot afford premiums under the Programme and use the empirical evidence for budgetary allocations vis, the number of vulnerable and indigent persons multiplied by the cost of the minimum service package to get the actual cost which should be the basis of the budgetary allocations to the Programme. **(f)** Utmost good faith negotiation with Organized Labor and commence the remittance of agreed percentages by employers and employees. **(g)** Start engagement of the informal sector for commitment to contributions and enrolment. **(h)** The Board should set realistic and realizable targets and timelines for the full implementation of the Programme. **(i)** Create a pipeline for private sector involvement in overcoming the health infrastructure deficit in the State, by aligning with the new national drive to adopt a PHC building on its strong Diaspora community

- **Take steps to Implement the Recommendations to Rivers State in the Assessment Report on *"State of Primary Health Care Service Delivery in Nigeria 2019-2021"***: Following its findings, recommendations to improve the implementation of BHCPF in the States of the Federations were categorized into *"Quick Wins"* and *"Other key Recommendations"*. For Rivers State (see page 156 of the report), they include (but not limited to): **(a)** Provide counterpart and equity funds for the National Health Insurance Scheme Gateway of the BHCPF. **(b)** Complete all required trainings,

- establishment of health facility management committees and regularization of primary health facility bank accounts in all wards, so that health facilities can start accessing funds from the BHCPF;

- **Start and deepen Sensitization on the Benefits of Health Coverage.**

- **Simplify the Cost-Benefit Analysis of Health Insurance Plans.**

- **Reduce the Bottlenecks of Registering and enrolling under the Scheme.**

- **Improve and Optimize the Expected Benefits of Health Insurance Coverage to retain enrollees.**

- **Ensure Transparency and Accountability in the Scheme.**

- **Deploy the Best Human Resources in the Management of the Scheme.**

- **Provide Incentives for Compliance by Enrollees and other Stakeholders.**

- **Reduce Extreme Poverty and Restructure the Economy for Productivity and Value Addition.**

1. INTRODUCTION

1.1 What is Health Insurance?

Health insurance is an insurance contract taken to cover the cost of medical care. The contract can be annual, monthly or over other fixed and certain periods of time. It typically caters for health care expenditure such as medical, surgical, prescription drugs, dental and other expenses incurred by the insured.[1] Health insurance can be comprehensive or apply to a limited range of medical services. It may provide for full or partial payment of the costs of specific services. This is usually dependent on the quantum of the premium. Health insurance can reimburse the insured for expenses incurred from illness or injury treatments accessed or pay the health care provider directly.[2] It ensures that individuals and families have access to health care services without any financial difficulty as opposed to out-of-pocket expenditure.

The major difference between health insurance and out-of-pocket health expenditure is that the latter insists that patients pay upfront to access health care services whilst health insurance provides the insured or enrollees access to health care services which payments would be settled from the pool of contributions (premiums) paid by all the insured in the health plan. The salient elements that are basic to all the health insurance varieties include: advance remittance of premiums into the pool, gathering funds together, and being eligible to enjoy the benefits for payment of premiums made, or for being employed in situations where employment entitles a person to enjoy the benefits of health insurance.[3]

It is imperative to distinguish between health insurance and a publicly funded healthcare system that provides coverage for every citizen or resident under a free healthcare program. However, healthcare services are available to indigent and poor persons under the Basic Health Care Provision Fund (BHCPF) established by S.11 of the National Health Act (NHA). The service is not based on any premiums paid by the beneficiary but it is funded through the statutory 1 percent of the Consolidated Revenue Fund of the Federal Government.[4] This is also the status of the Equity Funds under the Equity Health Plan used to cater to vulnerable groups created by S.2 (1) (a) of the RSCHPPL.

1.2 What are its Different Forms and Variations?

There are four broad types of health insurance plans.[5] However, the contractual terms and actual wording of the health insurance contract defines the services provided and the terms of its provision.

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[1] https://en.wikipedia.org/wiki/Health_insurance

[2] Supra.

[3] See https://www.britannica.com/topic/health-insurance

[4] S. 25 of the National Health Insurance Authority Act 2022 provides for a Vulnerable Group Fund from which funds will be made available to treat indigent and vulnerable persons - not based on their payment of premiums.

[5] Although there is a fifth – "Indemnity"; see https://www.pulse.ng/news/metro/the-4-types-of-health-insurance-plan-you-should-know/15ph9km . Also see https://www.healthcare.gov/choose-a-plan/plan-types/

(I) Preferred Provider Organisation (PPO): This health plan encourages the insured to use a specific network of preferred health professionals and hospitals. The insured pays less if they use the providers in the health plan's network. It also provides the opportunity for the insured to access care from physicians, hospitals and health providers outside of the network without a referral from their primary care doctor although this comes with an additional cost. Its benefits include flexibility over other plans, sizeable discounts, and an opportunity to choose from a vast network of professionals for greater value.

(ii) Health Maintenance Organisations (HMOs): This plan provides health care services through a network of doctors and health providers who have contractual arrangement with the HMOs for a monthly or annual fee. In contrast to PPO plan, this plan restricts the insured to access only in-network care; exceptions are made in cases of emergency. The insured can consult a specialist only when a referral has been made by the primary health care doctor. Its key advantage is that it is a low budget plan as premium payments are made on per-member basis and not frequency of services accessed.

(iii) Point of Service (POS): This health plan typifies a combination of both PPO and HMO. One needs to choose primary health care doctor(s) and must obtain their referral to consult a specialist just as in HMO plan. It is an affordable plan for usage out-of-network coverage because the additional cost that obtains in PPO plan no longer obtains when the primary health care provider made the referral to out-of-network provider.

(iv) Exclusive Provider Organizations (EPOs): This health care plan is almost similar to HMOs in that under EPO, an insured must obtain health care services strictly from the health professionals or hospitals contracted with the insured EPO except during emergencies. Under EPO, referrals are not required to see a specialist which is a key advantage over HMOs. EPO networks are also wider than those of HMOs.

(v) Indemnity: This plan is otherwise referred to as “fee-for-service” health insurance plan. Despite its debatable validity as a health care plan, it is a thorough insurance plan in that it allows the insured to pick and visit any health care professional or hospital for health care services. The insurance company pays a pre-agreed percentage of costs for a given health service while the insured takes care of the rest. Its advantages are the amount of flexibility and the vast measure of protective cover it offers.

2. WHAT IS UNIVERSAL HEALTH COVERAGE (UHC) AND ITS KEY COMPONENTS?

The World Health Organization (WHO) defines Universal Health Coverage (UHC) as a situation where everyone have access to the health care services they require, at the time and place they require them without financial hardship.[6] UHC connotes a scenario where all persons and communities have access to the health services they need, at the necessary time and where they are needed without financial hardship. The services being referred to include: essential health services ranging from health promotion to prevention, treatment, rehabilitation and palliative care.

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[6] See WHO website https://www.who.int/health-topics/universal-health-coverage#tab=tab_1

To deliver these services, sufficient and capable health and care workers with optimal skills mix at facility, outreach and community levels are needed; they are to be evenly distributed and appropriately supported. UHC strategies enable everyone to access the services that address the most significant causes of disease and death in their society and also ensures that the quality of those services is good enough to improve the health of the people who receive them. UHC covers interventions at all three levels of health care – Primary, Secondary and Tertiary Health. As Primary Health Care (PHC) is the foundation of attainment of UHC, interventions at Secondary and Tertiary health levels broaden the horizon for improvement of health outcomes thereby edging a nation closer to attaining UHC. There are three interrelated components of UHC[7]: The relate to comprehensiveness, quality and affordability.

i. ***The full spectrum of health services according to need***: This refers to the whole gamut of health care services needed by an individual to stay healthy. They range from immunisation to therapeutic treatments and to special health care services.

ii. ***Financial protection from direct payment for health services when consumed***: This refers to the insulation from pecuniary hardship that would have been experienced by an individual when out-of-pocket payments are made for health services accessed.

iii. ***Coverage for the entire population***: As the name implies, this reflects the true essence of UHC. It asks the question of "who is covered" and encourages the extension of coverage to the non-covered.

The foregoing components are linked to the cardinal parameters necessary for the enjoyment of the right to the highest attainable standard of physical and mental care. These parameters are availability of functional health care facilities, services and goods; accessibility which includes physical, non-discrimination, economic and information accessibilities; acceptability of the service to society and the quality of the service.

3. THE LINK BETWEEN HEALTH INSURANCE AND UNIVERSAL HEALTH COVERAGE

> *"The goals of UHC are to ensure that all people can access quality health services, to safeguard all people from public health risks, and to protect all people from impoverishment due to illness, whether from out-of-pocket payments for health care or loss of income when a household member falls sick".* [8]

Full scale expansion of health insurance is pivotal to the attainment of the above goals. Improved health outcomes are hinged on the possibility of attaining UHC in that as more persons are covered, their basic health needs are met. Protecting people from the financial hardship of having to make out-of-pocket expenditure for health services reduces the risk of their sliding into poverty when unexpected ill-health necessitates using up life savings, selling assets, or even borrowing, etc.

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[7] See https://elibrary.worldbank.org/doi/10.1596/978-1-4648-0297-3_ch1 ; see also https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4541093/

[8] See *"Universal Health Coverage for Inclusive and Sustainable Development"*, https://www.worldbank.org/en/topic/health/publication/universal-health-coverage-for-inclusive-sustainable-development

Globally, the WHO released the below statistics relating to health care coverage[9] :

- *Over 930 million people globally spent at least 10% of their household income on health care.*
- *100 million people are driven into poverty each year through out-of-pocket health spending.*
- *75% of National Health Policies, Strategies and Plans are aimed at moving towards Universal Health Coverage.*
- *Half of world's population do not have access to the health care they need.*

In Nigeria, the enrolment numbers into the various plans of the former National Health Insurance Scheme (now National Health Insurance Authority) and various private health insurance schemes across the Federation is reported at 10million, about 5% of the population.[10] This scenario contributes largely to the nation's poor health indices. This situation requires drastic and targeted measures to improve health insurance coverage.

4. REASONS FOR MAKING HEALTH INSURANCE UNIVERSAL AND COMPULSORY

Already, two relevant legislation vis the National Health Insurance Authority Act (S.14) and RSCHPPL (S.2 [7]) have made health insurance coverage compulsory and universal.[11] The following are the reasons justifying health insurance being made mandatory and universal. For indigent persons, their premiums will be covered by state contributions accruing from taxes, levies, special funds, etc.

(a) To Achieve Universal Health Coverage: UHC connotes availability of health care services for all, especially the poorest segment of the society. Its goal, as laid out by the United Nations General Assembly (UNGA), is "*to promote physical and mental health and well-being and to extend life expectancy for everyone … thus leaving no one behind*"[12]. Making health insurance universal and mandatory for everyone ensures that this goal is achieved. This is validated by S.3 (a) of the Law – *ensure that every person in the State has access to effective, quality and affordable health care services.*

Achieving UHC is the thrust of the Sustainable Development Goals 3 – *"ensure healthy lives and promote well-being for all ages"* which can be measured with the indicators – *proportion of a population that can access essential quality health services* and *the proportion of the population that spends a large amount of household income on health.*

(b) Financial Risk Protection in Accessing Health Care: S. 3 (b) and (c) of the Law - *protect families from the financial hardship of huge medical bills*; and *limit the inflationary rise in the cost of health care services*. This is another key objective of making health care universal. It is one of the critical hallmarks of health accessibility. Health financing policy impacts financial protection directly. Financial protection works by ensuring that payments made to obtain health

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[9] See WHO website https://www.who.int/health-topics/universal-health-coverage#tab=tab_1

[10] See the Guardian Newspaper of 25th September 2020: https://guardian.ng/features/Over 170 million Nigerians without health insurance — Features — The Guardian Nigeria News – Nigeria and World News

[11] The RSCHPPL seems to equivocate on the mandatory nature of health insurance. in one breadth, it states in S.1 (2) that the programme is voluntary while in S.2 (7), it compels every resident of Rivers State to pay the premium for the minimum health package notwithstanding their subscription to any private health plan. The objectives of the programme provided in S.3 of the Law lean towards a mandatory health insurance regime.

[12] See https://www.un.org/en/observances/universal-health-coverage-day

care services do not expose people to financial difficulty and do not threaten living standards. Necessary for this to work is the collection of premium payments so as to pool funds for health care provision instead of relying on out-of-pocket payments for health care services at the time of use. Nigeria's out of pocket expenditure on health is one of the highest in the world and has been stated by the World Bank at 70.52 percent. This is in contrast to the Sub-Saharan Africa average of 29.98 percent.[13]

(c) Equity in Financing Health Care: *Ensure equitable distribution of healthcare cost across different income groups* - S.3 (d) of the Law. Equity and efficiency can go hand in hand in healthcare delivery. Equity financing is the process of pooling funds through the process of premium collections so as to offer equitable health care services to all members of the population. Overall, this can lead to a more efficient health care system.[14]

"Equity" is distinct from "equality" in that as the former refers to allotting healthcare services according to the various needs of persons, the latter evens up what is offered to everyone. Equity in health care financing allows for policy options such as putting some intervention in health care services in regions of a given country where life expectancy is lower or disease burden is higher than the other parts of the country.[15]

In Rivers State, there is an Equity Fund from which the Equity Health Plan is funded. This is dedicated for the health care needs of the vulnerable persons and indigent persons.

(d) Facilitating the Implementation of the Minimum Core Obligation of the State: The right to health imposes a minimum core obligation on the state to satisfy at the very least minimum essential levels of health provisioning including primary health care. This is to be provided on the basis of the maximum of available resources. Resources can come from government or citizens. Health insurance expands the pool of available resources and walks the talk of domestic resource mobilization.

(e) To Reduce the Financial Burden on the Government: "*Improve private sector participation in the provision of healthcare services"* and "*Ensure the availability of alternate sources of funding to the Programme for improved services"* - S.3 (g) and (j) of the Law. The fiscal space and elbow room for social interventions including health has shrunk in Nigeria. Between January and April 2022, the Federal Government of Nigeria borrowed N310billion to augment its retained revenue in order to service debts. Many States of the Federation are owing backlogs of salaries, pensions and gratuities. Therefore, continuing the sole reliance on public funding for health is an invitation to further the deterioration of already poor health indicators. The responsibility of funding health care through public health care systems and other interventions are drastically reduced by health insurance system. This frees up resources for the government to invest and build other sectors of the economy.

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[13] https://data.worldbank.org/indicator/SH.XPD.OOPC.CH.ZS?locations=NG, 2019
[14] Tulane University blog, 2nd July 2021; *"What is Healthcare Equity?"* See https://publichealth.tulane.edu/blog/healthcare-equity/
[15] Footnote 12, supra.

(f) Sustainability and Credibility of Health Financing: Public health financing at the federal and state levels is beset with credibility challenges. The resources budgeted usually do not meet the 15 percent of budget target as required in the Abuja Declaration. Furthermore, the appropriated votes are not fully released and the released sums sometimes do not get fully utilized. Thus, the budget figures do not provide credible evidence of expenditure. Oftentimes, this is based on poor revenue forecasting. Health insurance funds on the other hand are predictable and promises of services will not be bugged down by claims of lack of resources. Policy implementation can proceed as planned and sustainability will be built into the system
.

(g) Facilitating Whole-of-Society Approach to Health: When all workers and residents who earn a livelihood are contributing to the pool of health funds through remitting their premiums, the whole of society is involved and sensitized on the operations and challenges of health financing. It creates a sense of individual and social responsibility that facilitates the adoption of healthy and reduced risk lifestyles. Paying premiums also creates a sense of empowerment for citizens to demand accountability for available public funding of healthcare.

(h) Building Block for a Vibrant and Healthy Population: *Maintain a high standard of healthcare delivery services within the health sector* and *Ensure efficiency in healthcare service delivery* - S.3 (e) and (f) of the Law. Health care coverage ensures that everyone gets the health care needs they require and at the time they require it thereby improving the overall health of a people. This is an advantage of pursuing UHC as opposed to leaving health expenditure to out-of-pocket payments by citizens.

(i) Means of Poverty Eradication: *Protect families from the financial hardship of huge medical bills* - S.3 (b) of the Law. One characteristic feature of out-of-pocket health expenditure is the possibility of the patients or their family being impoverished and sliding into extreme poverty. UHC as promoted by health insurance eliminates the possibility of this outcome by working on the principle that everyone gets the health care services they require without suffering any financial hardship as a result. This feature of UHC provides the foundation for economic prosperity as citizens would devote their energy to productive ventures and become viable economic agents to increase productivity and service delivery in the economy.

(j) To Reduce Inequality and Uplift the Low Strata of the Society: Health insurance provides a veritable tool for reduction of inequality as it offers affordable health care services to every class of the society in so far as they are able to pay the premium. Access to decent health care is made available to the lower class of the society given their enrolment into the Scheme. This service would have otherwise not been possible if the payment method is out-of-pocket which makes health services unaffordable to the poor.

5. REVIEW OF KEY PROVISIONS IN THE RIVERS STATE HEALTH INSURANCE LAW

This section highlights the salient provisions in the law that provided for the establishment of Rivers State Contributory Health Protection Programme (Programme). S.1 (1) of the Law established the Programme while S.4 established the Rivers State Contributory Health Protection Board (Board) as a corporate body with perpetual succession and a common seal. By S.5 of the law, the objective of the Board is to promote and implement the Programme. The Programme includes employers with a minimum of five staff, employees in the public and private sectors, informal sector employees and vulnerable persons in the state.[16] Furthermore,

[16] S.2 (6) of the Law.

it includes every resident in the state covered by any form of private health plan and they shall pay for the minimum health benefit package, notwithstanding their subscription to any private health plan.[17]

By S.3 of the Law, the objectives of the Programme are defined vis:

- *Ensure that every resident of the State has access to effective, quality and affordable healthcare services;*
- *Protect families from financial hardship of huge medical bills;*
- *Limit the inflammatory rise in the cost of healthcare services;*
- *Ensure equitable distribution of healthcare costs across different income groups;*
- *Maintain a high standard of health care delivery services within the Health Sector;*
- *Ensure efficiency in healthcare service delivery;*
- *Improve private sector participation in the provision of healthcare services;*
- *Advice on adequate distribution of health facilities within the State;*
- *Ensure appropriate patronage at every level of the healthcare delivery system; and*
- *Ensure the availability of alternate sources of funding to the Programme for improved services.*

By S.7 of the Law, the powers of the Board are defined as follows. The Board has power to approve health plans; determine the overall policies, including the financial and operative procedures of the Programme; ensure the effective implementation of the policies and procedures of the Programme; supervise the effective implementation of the Programme; and establish standards, rules and guidelines for the management of the Programme. Furthermore, it has powers to engage, support and supervise mutual health associations and any other institution relating to the Programme; issue guidelines and approval for the administration and release of funds under the Programme; approve any recommendation relating to research, consultancy and training in respect of the Programme; ensure the maintenance of a State data bank on every matter of the Programme; determine the remuneration and allowances of staff of the Board; determine the level of co-payment for the health plans of the Board; and develop a mechanism to identify the poor and vulnerable who will benefit from the premium subsidy from the EHP contribution of the State pursuant to section 2 (1) (a). Others are to appoint directors and other employees, required in the discharge of its functions; pay to any person appointed under paragraph (m), remuneration and allowances applicable in the Public Service of the State; promote and discipline its staff in line with the Public Service rules; establish and maintain offices, subsidiary divisions, sections and units; make any administrative arrangement necessary for the effective performance of its functions across the Local Government Areas of the State, and perform any other function, which in its opinion are necessary or expedient for the discharge of its functions.

[17] S.2 (7) of the Law.

S.8 of the Law defines the functions of the Board. The functions of the Board are to: ensure the effective implementation of the policies and procedures of the Programme; issue appropriate regulations and guidelines, and maintain the viability of the Programme; manage the Programme in accordance with this Law; register accredited health care facilities and other relevant institutions; approve standard of contracts for the health care providers; carry out public awareness and education on the establishment and management of the Programme; ensure that contributions are kept in accordance with guidelines issued by the Board; and establish a quality assurance system. Furthermore, the board is to determine, after due consideration, Provider Payment Mechanisms due to health care providers; advise the relevant bodies on the relationship of the Programme with other social security services; coordinate research and statistics; establish quality assurance for stakeholders; collect, collate, analyse, and report on monthly and quarterly returns from the health facilities and every other relevant stakeholders; and exchange information and data with the National Health Insurance Scheme, State Health Management Information System, relevant financial institutions, development partners, Non-Governmental Organisations and any other relevant body.

The components of the Programme are stated in S. 2 of the Law. It consists of an equity Health Plan for vulnerable groups. By the interpretative S.52, vulnerable persons are pregnant women, children under five, the aged as defined by the Board, the disabled, the poor and others falling within the group. The second is the Informal Health Plan which is an affordable health plan providing a prescribed package of healthcare services accessible to every person resident in the state and across public and private facilities. Informal sector refers to those in enterprises not registered or 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.[18]

The third is the Formal Health Plan which is a contributory plan for public and organized private sector employees where the employers and employees make contributions as determined by the Board. It is for persons employed in enterprises registered and licensed to conduct business and whose employees earn regular salaries and wages. The fourth is the Private Health Plan which means a variety of packages providing extra healthcare services in direct proportion to the contribution made by the individual.[19]

By S.19 of the Law, there is established the Rivers State Contributory Health Protection Fund ('the Fund') which is to be managed by the Board. The Fund consists of:

- *An initial take-off grant from the State Government;*
- *Formal sector funds comprising contributions from employers and employees in public and private sector organisations;*
- *Informal sector funds comprising contributions from workers in the informal sector, community members and students in tertiary institutions;*
- *Equity funds comprising contribution of not less than 2% Consolidated Revenue of the State Government;*
- *Funds from NHIS for pregnant women, children under 5 years and any other defined target populations;*

[18] See the definitions in S.52 of the Law

[19] See the definitions in S.52 of the Law.

- *Donations or Grants-in-Aid from private organisations, philanthropists, international donor organisations and non-governmental organisations;*
- *Funds to be provided by the NHIS in accordance with the National Health Act;*
- *Fees, fines and commissions charged by the Board;*
- *Any other appropriation by the National, State and Local Governments for the implementation of the Programme;*
- *Dividends and interests on investments; and*
- *Any other money which may accrue to the Board.*

Unlike some other state laws, Local Governments were not expressly required to contribute a percentage of their consolidated revenue fund and no direct reference to the Basic Health Care Provision Fund and all it components as sources of funding. Furthermore, there is no requirement for elected and appointed political office holders to lead by example through contributing a percentage of their basic salary.

By S.20 of the Law, the Board is to apply the funds to the attainment of its objectives; funds are to be earmarked and ring-fenced solely for the purchase of health services; cost of administration; payment of fees, allowances and benefits of officers and employees of the Board and Board members; and maintenance of any property vested in the Board.

6. LINKING THE NATIONAL HEALTH INSURANCE AUTHORITY (NHIA) ACT AND THE LAWL

6.1 The Links

It is imperative to start by stating that insurance is item 33 on the Constitutional Exclusive Legislative List reserved for the legislative competence of the National Assembly. In the event of any conflict with state law, the NHIA will prevail. Health on the other hand is not solely reserved for the National Assembly, States and Local Governments can legislate on them.

The NHIA was enacted in 2022, to repeal the National Health Insurance Scheme Act (2004), to enact the National Health Insurance Authority Act to provide for the promotion, regulation and integration of Health Insurance Schemes in Nigeria and for related matters.[20] S. 1 establishes the National Health Insurance Authority as a body corporate with perpetual succession and an official seal while S. 3 provides for its functions to include but not limited to:

a) *promote, integrate and regulate all health insurance schemes that operate in Nigeria;*
b) *ensure that health insurance is mandatory for every Nigerian and legal resident;*
c) *enforce the basic minimum package of health services for all Nigerians across all health Insurance Schemes operating within the country, including Federal, States and FCT as well as private health insurance schemes;*
d) *promote, support, and collaborate with States through State Health Insurance Schemes to ensure that Nigerians have access to quality health care that meets national health regulatory standards;*
e) *ensure the implementation and utilisation of Basic Health Care Provision Fund as required under the National Health Act and any guidelines as approved by the Minister under that Act;*

[20] Act No.17 of 2022 with a commencement of May 19, 2022.

f) *seek and advocate for funds for the Basic Health Care Provision Fund;*
g) *grant accreditation and re-accreditation to Health Maintenance Organisations, Mutual Health Associations, Third Party Administrators and Health Care Facilities and monitor their performance;*
h) *accredit insurance companies, insurance brokers and banks desirous of participating in health insurance schemes under the Authority;*
i) *maintain a register of licensed health insurance schemes and accredited health care facilities;*
j) *subject to S.13, approved contributions to be made by members of the various health insurance schemes;*
k) *approve, after consultation with Health Care Facilities, formats for contracts for health service purchasing proposed by Health Maintenance Organisations and Mutual Health Associations for all Health Care facilities;*
l) *approve, after consultation with Health Care Facilities and bodies representing them, capitation and other payment due to Health Care Facilities by Health Maintenance Organisations and Mutual Health Associations;*
m) *ensure that tariffs agreed with Health care facilities are reviewed on a three-yearly basis to the mutual satisfaction of Health Care Facilities, Health Maintenance Organsiations, Health Insurance Schemes and the Authority;*
n) *devise a mechanism for ensuring that the basic health care needs of indigents are adequately provided for;*
o) *in conjunction with states, devise a mechanism for ensuring that the basic health care needs of vulnerable persons are adequately provided for;*
p) *undertake on its own or in collaboration with relevant bodies a sustained public education on health insurance;*
q) *provide mechanisms for receiving and settling complaints by members of the Schemes and Health Care facilities, Health Maintenance Organisations, Mutual Health Associations and Third Party Administrators*.

S. 3 (b) of the NHIA Act, under the functions of the Authority, provides for the NHIA to ensure mandatory health insurance for every Nigerian and the country's legal residents. This is further supported by S.14 (1) of the NHIA. On the other hand, S. 2 (7) and S.3 (a) of the Law suggest compulsory coverage of all citizens of the state and its legal residents both in the formal and in the informal sector. However, S 1 (2) provides that the programme is voluntary for every person resident in the State. By the authority of the supremacy of Constitution clause in S.1 (3) of the 1999 Constitution, the provisions of the NHIA Act prevails.

This provides the 'spring board' for attaining UHC in Nigeria including Rivers State. What needs to be done is the full implementation of the provisions of the NHIA Act at the federal level and State levels to facilitate the attainment of UHC.

S. 3 (c) of the NHIA Act provides for the NHIA to enforce the basic minimum package for health services for all Nigerian citizens across the various public and private health insurance schemes. One of the objectives of the programme is to ensure that every resident of the State has access to effective, quality and affordable healthcare services, which in its practical application enforces the basic minimum package of health services for all. This shows a concordance in both legislations.

S. 13 (8) of the NHIA provides that, every state which has established a state health insurance or contributory scheme and which complies with the requirements of the Act shall be eligible to participate in the BHCPF as established under the NHA and its guidelines.

Under the NHA, the BHCPF serves as a conduit for the Basic Minimum Package for Health Care Services and also adds to the overall health sector financing.[21] The BHCPF is like the Equity Fund of Rivers State to be funded via: 1% of the CRF of the Federal Government; grants by international donor partners; and lastly, other funding sources. S. 19 (d) of the Law provides for an Equity Fund to be financed by not less than 2% of the CRF of the State Government.

6.2 Status Update on BHCPF and PHC Service Delivery in Rivers State

By S.24 (3) of the NHIA, the Authority shall work in conjunction with the States to achieve the objectives of the BHCPF and to provide minimum package of care as defined in guidelines developed for the implementation of the BHCPF.

PHC is the first point of contact of citizens with the healthcare system and it is a part of a tripod of the healthcare system consisting of PHC, secondary and tertiary health care. The *"State of Primary Health Care Service Delivery in Nigeria 2019-2021"* is an assessment report of the BHCPF implementation in all States of the Federation and the FCT.[22] The assessment and report employed an adapted qualitative research methodology with secondary data analysis of existing reports, consultative in-depth and key informant interviews from across the States; findings were validated by the stakeholders.

The assessment study utilised a set of twenty (20) indicators in conducting its ranking of States which included, among others: the progress on implementation of BHCPF; status of health legislation and policy; budgetary commitments; human resources for health; implementation system; progress update on basic vaccinations; MNCH indicators, and the state of public facilities in the state.[23] The State's score is 50/100. The summary findings of the assessment for Rivers State are given below: According to the State of Primary Health Care Delivery in Nigeria, 2019-2021;[24]

> *Rivers State has not attained full capacity to utilize BHCPF disbursements from the National Primary Health Care Development Agency (NPHCDA) Gateway or the National Health Insurance Scheme (NHIS) Gateway although the state has received disbursements from the national level.*

According to the summary of key steps to improvement, the following recommendations relevant to health insurance are imperative[25]

- Provide political leadership for the establishment of a State Health Insurance Agency;
- Provide counterpart and equity funds for the NHIS gateway to the BHCPF;
- Complete all required trainings, establishment of health facility management committees and regularization of primary health facility bank accounts in all wards, so that health facilities can start accessing funds from the BHCPF;

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[21] See https://www.globalfinancingfacility.org/sites/gff_new/GFF-Annual-report/nigeria.html

[22] The report was published by One Campaign, in partnership with National Advocates for Health (N4H), Nigeria Health Watch, Public and Private Development Centre (PPDC) and Corona Management Systems (CMS), with technical support from the World Bank/International Finance Corporation (IFC) and the United Kingdom (UK) Foreign, Commonwealth, and Development Office (FCDO). The Presidential Reform Committee on Basic Health Care Provision Fund (BHCPF) led by the Bureau for Public Sector Reforms (BPSR) also provided steering leadership on the specific aspects of the assessment.

[23] You can access the report via www.sphcn.ng; see pages 8 and 9.

[24] State of Primary Health Care Delivery in Nigeria, supra at page 154.

[25] State of Primary Health Care delivery in Nigeria, supra at page 156.

- Develop a Health System Wide Accountability and Performance Management Framework, and engage technical assistance to support its implementation;

- Create a pipeline for private sector involvement in overcoming the health infrastructure deficit in the State, by aligning with the new national drive to adopt a PHC building on its strong Diaspora community.

Table 1 below shows the amount appropriated for the Agency from 2018 to date.

Table 1: Allocations to Rivers State Health Insurance Scheme

Year	Rivers State Contributory Health Insurance Scheme
2022	4,000,000,000.00
2021	3,000,000,000.00
2020 (Revised)	3,500,000,000.00
2019	9,500,000,000.00
2018	9,500,000,000.00
Total	**29,500,000,000.00**

Source: Rivers State Approved Budgets

Table 1 shows a total vote of N29.5billion over the five years. The report on the actual expenditure in terms of releases and utilization is not available. The votes for 2018 and 2019 were the highest. However, the basis of these budget votes is not clear considering that S.19 (3) (d) of the Law establishing the Rivers State Contributory Health Protection Fund requires inter alia, an equity fund comprising of not less than two percent of the Consolidated Revenue Fund of Rivers State annually. It is not clear whether the appropriated sums constitute 2% of the CRF of the state in the budget years. Furthermore, the vote to support the indigent and vulnerable members of society in an Equity Fund arrangement should be based on empirical evidence vis, the number of vulnerable and indigent persons multiplied by the cost of the minimum service package to get the actual cost which should be the basis of the allocations. There is no information on the basis for the calculation of these allocations.

In accordance with the Law, the Contributory Health Protection Fund also consists of initial take off grant from the State Government, formal sector funds consisting of contributions from public and private sector employees and employers, informal sector funds based on contributions from the informal sector, funds to be provided under the National Health Insurance Authority Act, etc.

Evidently, the scheme needs more funds to meet its goal and objectives especially for the provision of health services to the poor and vulnerable and to fund campaigns to increase enrolment and activate and maximize the use of resources available from the BHCPF.

7. CONCLUSIONS

This policy brief engaged the Rivers State Contributory Health Protection Programme with the objective of providing policy recommendations for increasing health insurance coverage in the State.

Out-of-pocket expenditure in accessing health care services is reported to have been responsible for dragging over 100 million persons worldwide into extreme poverty every year.[26] Reducing Nigeria's and Rivers State's very high out-of-pocket health expenditure would entail scaling up and expanding health insurance coverage over the population. Implementing the beautiful provisions of the RSCHPP will be a major first step towards improving health insurance coverage.

However, there is no indication as required by S.19 of the Law that the following has commenced:

- Appropriation of the Equity Fund comprising of not less than 2% CRF of the Rivers State Government.
- Formal sector contributions from public and private sector employers and employees.
- Informal sector contributions.
- Financial commitments from Local Governments.
- Counterpart and equity funding required to fully kick off the NHIS Gateway of the BHCPF has been provided.

Public awareness on the Programme is still low. It appears that the Programme is still in its days of infancy and needs to be supported to take urgent, concrete and targeted steps to improve on its performance.

There is a lesson to be learnt from the experience of South Korea.[27] Before 1977, the country had voluntary health insurance in operation but made it compulsory in 1977 for employees and their dependants of large firms with more than five hundred (500) members of staff at first. It then expanded the mandatory insurance to other groups, stage by stage, first to government employees and to industrial employees. Next was regional expansion: from the urban residents to the rural residents. All these culminated in the achievement of UHC in twelve (12) years.

8. STRATEGIES AND RECOMMENDATIONS FOR IMPROVING HEALTH INSURANCE COVERAGE

The following strategies could be employed to improve the health insurance coverage in Rivers State:

8.1 Effective Implementation of Compulsory Health Insurance Coverage

It is commendable that Nigeria through the NHIA Act has made health insurance coverage mandatory for all. One of the key factors required for RSCHPP to yield the desired result is political will and the resolve to make the system work on the part of the highest political decision makers and critical stakeholders.

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[26] See https://www.who.int/news/item/20-02-2019-countries-are-spending-more-on-health-but-people-are-still-paying-too-much-out-of-their-own-pockets

[27] Lee, J.; *Health Care Reform in South Korea: Success or Failure;* see https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447690/

(a) Provide political leadership and establish the Board of the Programme as the Board is key to the takeoff of the Programme;

(b) The political leadership should activate the Programme by commencing the appropriation of 2% CRF of the State Government for the Programme.

(c) Commit Local Governments to a minimum of 2% of their CRF to the funding of the Equity Fund of the Programme.

(d) Review the personal income tax regime to make contributions to the Equity Fund by individuals, up to a maximum of 25% of personal income tax, a tax-deductible expenditure.

(e) Take steps to identify the indigent, vulnerable and poor who cannot afford premiums under the Programme and use the empirical evidence for budgetary allocations vis, the number of vulnerable and indigent persons multiplied by the cost of the minimum service package to get the actual cost which should be the basis of the budgetary allocations to the Program.

(f) Utmost good faith negotiation with Organized Labor and commence the remittance of agreed percentages by employers and employees.

(g) Start engagement of the informal sector for commitment to contributions and enrolment.

(h) The Board should set realistic and realizable targets and timelines for the full implementation of the Program.

(i) Create a pipeline for private sector involvement in overcoming the health infrastructure deficit in the State, by aligning with the new national drive to adopt a PHC building on its strong Diaspora community

8.2 Take steps to Implement the Recommendations to Rivers State in the Assessment Report on *"State of Primary Health Care Service Delivery in Nigeria 2019-2021"*:

Following its findings, recommendations to improve the implementation of BHCPF in the States of the Federations were categorized into *"Quick Wins"* and *"Other key Recommendations"*. For Rivers State (see page 156 of the report), they include (but not limited to):

(a) Provide counterpart and equity funds for the National Health Insurance Scheme Gateway of the BHCPF.

(b) Complete all required trainings, establishment of health facility management committees and regularization of primary health facility bank accounts in all wards, so that health facilities can start accessing funds from the BHCPF;

8.3 Sensitization on the Benefits of Health Coverage

To deepen health insurance coverage, the Program should actively engage in carrying out public awareness and education on the establishment and management of the Program as provided in S.8 (f) of the Law. Scaling up citizens' sensitization on the benefits of health insurance coverage is an approach that possesses the potential of improving health insurance coverage in Rivers State. This would enlighten the population that are oblivious of the concept and heighten their awareness that having a health insurance cover is in their interest. This would in turn edge Rivers State closer to attaining UHC. Key stakeholders to be engage will include:

- Civil Society Organizations in a sensitize the sensitizers scheme
- Town Union leadership on sensitize the sensitizers scheme
- Leadership and followership of the Church and the Mosque
- Women's Groups
- Youth Groups
- Market and Artisanal Associations
- Cooperatives

8.4 Simplify the Cost-Benefit Analysis of Health Insurance Plans

Further to the last recommendation and for ease of comparison by prospective enrollees, simplifying the comparison of the costs and benefits of health insurance plans can help citizens to understand better which plan to go for.[28] It should be noted that that simplifying information alone may not guarantee increasing health coverage in a situation where other bottlenecks to enrollment still persists such as poverty and existence of a less-aware population on the benefits of health coverage. But simplification is a critical first step.

8.5 Reduce the Bottlenecks of Registering under the Scheme

Formalities and bottlenecks of registration should be reduced to a minimum so as to encourage residents especially in the informal sector to register in the Scheme. Enhancing enrolment can benefit from and utilize the good offices of the Church and traditional institutions.

8.6 Improve and Optimize the Expected Benefits of Health Insurance Coverage to Retain Enrollees

It has been found that enrollees do not keep their health insurance cover if they are not satisfied with the services rendered or when they are exposed to low quality cover. This is the experience recorded in Burkina Faso[29] as a community based health insurance scheme

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[28] J-Pal, (2021). "Strategies to Increase Health Insurance Enrollment". https://www.povertyactionlab.org/policy-insight/strategies-increase-health-insurance-enrollment

[29] J-Pal, (2021). "Strategies to Increase Health Insurance Enrollment". https://www.povertyactionlab.org/policy-insight/strategies-increase-health-insurance-enrollment
See Fink, Günther, Paul Jacob Robyn, Ali Sié, and Rainer Sauerborn. (2013). "Does health insurance improve health? Evidence from a randomized community-based insurance rollout in rural Burkina Faso." Journal of Health Economics 32, no. 6: 1043–1056. Research Paper. See also: Robyn, Paul Jacob, Günther Fink, Ali Sié, and Rainer Sauerborn. (2012). "Health insurance and health-seeking behavior:

paid health centres uniform rates for treating patients irrespective of what services rendered. Health care workers were then dis-incentivized and as a result, lowered the quality of care given to the insured.

This obtains in Nigeria as most medications and services administered to enrollees of the old NHIS and other average health plans are of lower quality. Thus, the system encourages out-of-pocket expenditure. This situation needs to be addressed going forward under the Programme.

8.7 Ensure Transparency and Accountability

Transparency and accountability in the management of and expenditures under the Program will guarantee value for money in terms of optimum impact from available resources. Regular reporting and publication of progress will facilitate public engagement, confidence building and provide opportunities for course correction in the event of manifest implementation challenges.

8.8 Deploy the Best Human Resources in the Management of the Scheme

The Board should recruit and deploy the finest of the available human resources for the management of the Programme because the quality of human resources greatly impacts on service delivery. Where staff have already been hired, continued training and retraining is imperative.

8.9 Provide Incentives for Compliance

The regulations and guidelines to be enacted by Board should boost enrolment and participation in the Program through incentives. The incentives may be financial for early enrolment and payment of premiums or recognitions for good performance across communities and social groups. Enrolment could also be coupled with programs like the Anchor Borrowers program, the Social Investment disbursements, etc.

8.10 Reduce Extreme Poverty and Restructure the Economy for Productivity and Value Addition

The World Bank estimates that 95.1million Nigerians would be below the poverty line by the end of 2022, from the current value of over 80 million people.[30] The report, *"Nigeria Poverty Assessment 2022: A Better Future for All Nigerians",* analyzed the nature of poverty in Nigeria and made recommendations on the way forward one of which is rolling out of social protection.

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[30] Evidence from a randomized community-based insurance rollout in rural Burkina Faso." Social Science and Medicine 75, no. 4: 595–603. Research Paper.
See https://www.worldbank.org/en/news/infographic/2022/03/21/afw-nigeria-poverty-assessment-2022-a-better-future-for-all-nigerians ; also access the full report via https://documents1.worldbank.org/curated/en/099730003152232753/pdf/P17630107476630fa09c990da780535511c.pdf

Expanding social protection cannot be gone about in isolation; it has to go concurrently with state level effective restructuring of the economy to become more productive and provide opportunities for job creation and value addition. An economically empowered population is best positioned to afford health insurance coverage plans.

[22] J-Pal, (2021). "Strategies to Increase Health Insurance Enrollment". https://www.povertyactionlab.org/policy-insight/strategies-increase-health-insurance-enrollment
See Fink, Günther, Paul Jacob Robyn, Ali Sié, and Rainer Sauerborn. (2013). "Does health insurance improve health? Evidence from a randomized community-based insurance rollout in rural Burkina Faso." Journal of Health Economics 32, no. 6: 1043–1056. Research Paper. See also: Robyn, Paul Jacob, Günther Fink, Ali Sié, and Rainer Sauerborn. (2012). "Health insurance and health-seeking behavior: Evidence from a randomized community-based insurance rollout in rural Burkina Faso." Social Science and Medicine 75, no. 4: 595–603. Research Paper.

ORGANISATIONS THAT VALIDATED THE MEMORANDUM

1. National Health Insurance Authority
2. Rivers State Agency for the Control of AIDS
3. Rivers State Ministry of Health
4. Institute of Human Virology of Nigeria
5. Nigerian Labour Congress
6. Nigerian Union of Teachers
7. Nigeria Union of Petroleum and Natural Gas Workers
8. Rivers State College of Health Sciences and Technology
9. Justice, Development and Peace Commission (JDPC)
10. Niger Delta Budget Monitoring Group
11. Pius Dukor Foundation
12. Youth Educators and Health Initiative
13. ProHealth HMO
14. Rivers State Television
15. Family Love 97.7 FM
16. Clamar Development Foundation
17. Centre for Social Justice