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IMPROVING THE IMPLEMENTATION OF THE EKITI STATE HEALTH INSURANCE SCHEME

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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
FCT	Federal Capital Territory
MHA	Mutual Health Associations
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
SDG	Sustainable Development Goals
EKHIS	Ekiti State Health Insurance Scheme
ESPHCDA	Ekiti State Primary Health Care Development Agency
TPA	Third Party Administrator
UHC	Universal Health Coverage

EXECUTIVE SUMMARY

This Policy Brief engaged the Ekiti State Health Insurance Scheme (EKHIS or Scheme) 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 setting up Scheme and section 6 analyzed the linkage between the new National Health Insurance Authority Act (NHIA) and the law setting up the Scheme. Section seven is on primary health care and the Basic Health Care Provision Fund (BHCPF) while section 8 dwells on the funding of the Scheme. The penultimate section draws conclusions from the earlier sections. The tenth section is the strategies and recommendations for improving health insurance coverage in Ekiti State which are summarized as follows.

- **Effective Implementation of Compulsory Health Insurance Coverage: (a)** The political leadership should deepen the Scheme by continuing the appropriation of 1% CRF of the State Government for the Scheme; **(b)** Commit Local governments to a minimum of 1% of their CRF to the funding of the equity fund of the Scheme; **(c)** 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 and; **(d)** Take steps to identify the indigent, vulnerable and poor who cannot afford premiums under the scheme 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 allocations to the Scheme. Others are: **(e)** Utmost good faith engagement with Organized Labor and continue the remittance and deduction of agreed percentages by employers and employees; **(f)** Intensify the engagement of the informal sector for commitment to contributions and enrolment; and **(g)** The Scheme should set realistic and realizable targets and timelines for its full implementation.

- **Take steps to implement the Recommendations to Ekiti 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 Ekiti State, they include (but not limited to): **(a)** Provide equity funds for the National Health Insurance Scheme Gateway of the BHCPF; **(b)** The State needs to commence payment of capitations to eligible health facilities, so that the poor and vulnerable who have been enrolled

into the NHIS Gateway of the BHCPF can start to access services; and **(c)** Develop and implement a communications strategy to generate demand for services among the poor and vulnerable who have been enrolled into the NHIS gateway of the BHCPF.

- **Intensify 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 annually, 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 publicly funded healthcare system which provides coverage for every citizen or resident under a free healthcare program. For instance, healthcare services available to indigent and poor persons under the Basic Health Care Provision Fund (BHCPF) under S.11 of the National Health Act (NHA) are not based on any premiums paid by the beneficiary but are funded through the statutory 1 percent of the Consolidated Revenue Fund of the Federal Government.[4] This is also the status of the Ekiti State Equity Fund used to cater to indigent and vulnerable persons created by S.15 (2) (d) of the Ekiti State Health Insurance Scheme (EKHIS) Law.

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.[7] There are three interrelated components of UHC. They 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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[6] See WHO website https://www.who.int/health-topics/universal-health-coverage#tab=tab_1

[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) is reported as follows:

> *"Currently, only about 4.2% of Nigerians are covered under the social health insurance. However, by virtue of expansion of state-supported health insurance schemes, this rate is projected to reach 8.8% by 2021 and 70% by 2030. Coverage growth of different population groups differ; the vulnerable and non-vulnerable groups' coverage are expected to begin at 5% in 2021 and increase to 70% by 2030 while the non-vulnerable informal group has a slower coverage rate and reaches only 59% by 2030. The public sector and their dependents have coverage rate set at 68% by 2021 and is expected to increase rapidly to cover the whole public sector by 2025. With only 3% coverage rate by 2021, the private sector and their dependents have the lowest start-up coverage rate, however, their coverage is expected to grow rapidly to 80% by 2030".*[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 EKHIS Law (S.4 (2)) have made health insurance coverage compulsory and universal. 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".*[11] Making health insurance universal and mandatory for everyone ensures that this goal is achieved. This is validated by S. 5 (1) of EKHIS Law – *ensure that every resident of Ekiti State has good access to health care services.*

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

[10] National Health Insurance Scheme Strategic Plan, 2020-2030

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

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 5 (2) of EKHIS Law - ensure that residents of Ekiti State have financial protection, physical access to quality and affordable healthcare 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 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.[12]

(b) Equity in Financing Health Care: *Ensure equitable distribution of healthcare cost across different income groups* - S.5 (6) of EKHIS 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.[13]

"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.[14]

In Ekiti State, there is an Equity Fund - S.15 (2) (d)) EKHIS Law from which the Equity Health Plan is funded – S.4 (1) (a) EKHIS Law. This is dedicated for the health care needs of the vulnerable persons and indigent persons.

(c) Facilitating the Implementation of the Minimum Core Obligation of the State: *Ensure that the basic minimum package for the poor and vulnerable is delivered subject to the availability of the fund stipulated by the National Health Act* - S.5 (5) of EKHIS Law. 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.

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

(d) To Reduce the Financial Burden on the Government: *Ensure the availability of alternate sources of funding to the health sector for improved services* - S.5 (12) of EKHIS 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.

(e) 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.

(f) 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. This will ensure adequate patronage at all levels [of society] of the health care healthcare delivery system. - S.5 (11) of EKHIS Law.

(g) Building Block for a Vibrant and Healthy Population: Ensure that residents of Ekiti State have financial protection, physical access to protection and affordable healthcare services - S.5 (2) of the EKHIS 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.

(h) Means of Poverty Eradication: *Protect families from financial hardship of huge medical bills* - S.5 (3) of the EKHIS 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.

(I) 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 EKITI STATE HEALTH INSURANCE LAW

This section highlights the salient provisions in the law that provided for the establishment of Ekiti State Health Insurance Scheme (the Scheme). S. 1 of the Law established the Scheme as a corporate body with perpetual succession and a common seal. The Ekiti State Health Insurance Scheme (Scheme) is established in S.1 of the EKHIS Law and it is stated to be compulsory for all residents of Ekiti State - S 4 (2). Specifically, the Scheme *shall be compulsory and apply to all residents of the State that are not covered by an existing health scheme. All existing health schemes in Ekiti State institutions and other similar health financing options in the state shall form part of the scheme- S 4(2) of the EKHIS Law.* Section 4 (3) of the EKHIS Law adds that all residents in the formal or informal sector already covered by an existing health scheme must provide evidence of same to the Scheme.

By S.10 of the EKHIS Law, the functions of the Scheme are provided; ensuring effective implementation of policies and procedures of the Scheme; issuing appropriate regulations and guidelines as approved by the Committee to maintain the viability of the Scheme; coordinating the implementation of the minimum benefit package as defined in the NHA; registering NHIA accredited HMOs, MHAs, state accredited healthcare facilities and other relevant institutions. Other functions include classification of healthcare facilities and providers in a manner that to improve health outcomes; approving contract formats for Third Party Administrators (TPAs) and healthcare providers; creating awareness on the Scheme; determining the percentage of premium from private health plans that shall be payable as cross subsidy to the fund for the purpose of financing the Health Equity Plan; determine after due consideration, capitation, fee for service and other payment mechanisms due to health care providers by HMOs in line with similar schemes; establish quality assurance for the Scheme and receiving and investigating complaints of impropriety leveled against any TPA, healthcare provider and any relevant institution and ensuring that appropriate sanctions are given, etc.

Section 2 of the EKHIS Law provides for the establishment of the Ekiti State Health Insurance Scheme Committee whose Chairman is the Commissioner of Health to be appointed by the State Governor to have general control of the scheme subject to law. Committee's membership includes the Permanent Secretary of the Ministry of Health as the Vice-Chairman and Secretary who shall be the General Manager of the Scheme. Others include one representative of the following: (i) Primary Health Care Development Agency (ii) Hospitals' Management Board (iii) Ministry of Finance (iv) Ministry of Budget and Planning (v) Health Care Providers Association of Nigeria, Ekiti State (vi) Traditional Rulers (vii) The Nigerian Labour Congress, Ekiti State Chapter (vii) NGOs/ Civil Society (ix) The National Health

Insurance Scheme (x) Ministry of Justice (xi) Ministry of Information (xii) Association of Local Government Chairmen of Nigeria, Ekiti State Chapter (xiii) Clerk of the House, Ekiti State House of Assembly (xiv) Ekiti State University Teaching Hospital. –S. 2 (2) EKHIS Law.

The law provides that the representative of a Ministry, Department or Agency shall not be below the rank of a Director in the Ekiti State Civil Service.- S. 2 (3) EKHIS Law.

The Committee's powers, contained in section 9, include but not limited to: determine the organizational structure of the Scheme; determine the overall policies on Health Insurance Scheme, including the financial and operative procedures of the Scheme; approve standards, rules and guidelines for the management of the Health Insurance Scheme under the Law; regulate and supervise the Scheme; issue guidelines and approvals for the administration and release of funds under the Scheme; approve for the Agency Third Party Administrators (TPAs) and other stakeholders as may be needed; ensure the effective implementation of the policies and procedures of the Scheme ensure the maintenance of a databank on all Scheme matters.

S.5 of EKHIS Law states the objectives of the Scheme as follows:

(1) Ensure that every resident of Ekiti State has good access to healthcare services;

(2) Ensure that all residents of Ekiti State have financial protection, physical access to quality and affordable healthcare services,

(3) Protect families from the financial hardship of huge medical bills;

(4) Limit the rise in the cost of healthcare services;

(5) Ensure that the basic minimum package for the poor and vulnerable is delivered subject to the availability of the fund stipulated by the National Health Act;

(6) Ensure equitable distribution of healthcare costs across different income groups;

(7) Maintain high standard of healthcare delivery services within the Health Sector;

(8) Ensure efficiency in health care service delivery;

(9) Improve and harness private sector participation in the provision of healthcare services;

(10) Ensure adequate distribution of health facilities within the state;

(11) Ensure appropriate patronage at all levels of the healthcare delivery system;

(12) Ensure the availability of alternate sources of funding to the health sector for improved services;

(13) In cases where resident do not have available medical services and other health services, to take such measures as are necessary to plan, organize and develop medical services and other health services that are commensurate with the needs of the residents.

The components of the Ekiti State Health Insurance Scheme as provided by S. 4 (1) (a-d) of the EKHIS Law are as follows:

(a) The Ekiti State Equity Health Plan (EKEHP): This shall be a plan for vulnerable groups as defined in Section 49 of this Law. Other criteria for eligibility into the health plan shall be approved by the State Executive council. The only point of entry shall be all public Health Care services who shall refer if necessary to designated public secondary and tertiary health facilities;

(b) The Community Based Health Plan (CBHP): This shall be the 'affordable Plan providing a prescribed package of healthcare services at uniform contributions accessible to all residents at the grassroots and will be accessible from both Public and Private Facilities,

(c) The Ekiti State Private Health Plan (PHP): This shall consist of a variety of packages providing healthcare services in direct proportion to the contribution;

(d) The Formal Health Plan: This shall be a contributory plan for all public and private formal sector employees wherein the employers and employees shall make contributions as determined by the Committee:

Section *15 of the EKHIS Law, establishes the Ekiti State Health Fund which shall consist of the following:*

(a) The initial take-off grant from the Ekiti State Government;

(b) Formal Sector Fund; comprising of contributions from public and private sector employers and employees;

(b) CBHI Fund; comprising of contributions from the informal sector;

(d) Equity Fund; comprising of contributions of not less than 1% consolidated revenue of the Ekiti State Government, funds from NHIS for pregnant women, children under-five (5) years and other relevant programs; donations or Grants-in-Aid from private organizations and Non-Governmental organizations from time to time:

(e) Funds to be provided by federal agencies in accordance with the provisions of the National Health Act and extant regulations;

(f) Such money as may be due from Health Maintenance Organizations and subsidy remittance from Private Plans;

(g) Fines and commissions charged by the Scheme;

(h) Other appropriations earmarked by the national and state implementation of the Scheme;

(i) Funds as may be approved from the Ekiti State Primary Health Care Agency (SPHCA), from the National Primary Healthcare Development Agency (NPHCDA) for the Community Based Health Plan (CBHP), Formal Health Plan (FHP) and other relevant programs:

(j) Dividends and interest on investment and stocks; and

(k) All other money which may, from time to time, accrue to the Scheme:

Section 16 of the EKHIS Law provides for the mode of disbursement of the Ekiti State Health Fund. By S. 16 (1) the Committee shall approve the disbursement of the funds to healthcare providers from the established fund through the participating HMOs, CBHP and MHAs with the recommendation of the Scheme.

Unlike some other state laws, S. 28 of EKHIS Law provides for the participation of Local Governments on the appointment of Focal Persons. *A local Government Chairman in consultation with the Primary Healthcare Development Agency appoints focal person(s) who shall be a senior serving officer in the services of the Department of Health of the Local Government to coordinate and collaborate with the Scheme.*

However, there is no requirement for elected and appointed political office holders to lead by example through contributing a percentage of their basis salary as provided in the Sokoto State Law.

By S. 16 of EKHIS Law, the Scheme is to apply the funds to the actualization of the objectives of the Scheme; cost of administration of the Scheme; payment of fees, allowances and benefits of officers and employees of the Scheme and Committee members; and maintenance of any property vested in the Scheme.

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

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 - S. 13 EKHIS law. 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.[15] 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;
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;

[15] S.12 (d) of the BSHCMAL states one of the functions of the Agency as the implementation of the minimum benefit package as defined under the NHA.

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. 4 (2) of the EKHIS Law provides for compulsory coverage of all citizens of the state and its legal residents both in the formal and in the informal sector. This provides the 'spring board' for attaining UHC in Nigeria including Ekiti State. What needs to be done is the full implementation of the provisions of the NHIA Act at the federal level and the EKHIS Law in Ekiti State 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 functions of the Scheme under S.10 (d) of EKHIS Law is the implementation of the minimum benefit package as defined under the NHA. This shows a concordance in both legislations as to the need for a defined basic minimum health package for citizens.

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 Basic Health Care Provision Fund 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.[16] The BHCPF is like the Equity Fund of Ekiti State to be funded via: 1% of the CRF of the Federal Government; grants by international donor partners; and lastly, other funding sources. S. 15 (2) (d) of the EKHIS Law provides for an Equity Fund to be financed by not less than 1% of the CRF of the State.

7. STATUS UPDATE ON BHCPF AND PHC SERVICE DELIVERY IN EKITI 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 health care system and it is a part of a tripod of the health care 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.[17] The assessment and report employed an adapted qualitative research methodology with secondary data analysis of

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

[17] 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.

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.[18] The State's score is 63/100. The summary findings of the assessment for Ekiti State are given below:

> *"Ekiti State has attained full capacity to utilise BHCPF disbursements from NHIS and NPHCDA Gateways but some eligible PHCs are not receiving and retiring funds from the NPHCDA gateway. The state has failed to provide either its counterpart or its equity funding for the NHIS gateway and although the State has an active oversight mechanism, the State has not sent reports of gateway forum and SOC meetings from Q4 2021 to NHIS. The State does not have a formal sector insurance scheme."*

According to the summary of key steps to improvement relevant to Health Insurance Scheme in the State, the following is recommended:[19]

- As the state has already committed, the state must finalise all steps as mandated by NPHCDA, so that health facilities can start accessing funds from the BHCPF;
- Mandate the quarterly gateway forum meetings of the SPHCDA and SHIA to strengthen implementation of the BHCPF;
- Provide all equity funds for the NHIS gateway of the BHCPF;
- The state needs to 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.
- The state needs to take a multi-sectoral approach to investments in health, by ensuring that health is mainstreamed in all policies and that state budgets deliberately target key social determinants of health.

8. FUNDING OF THE EKITI STATE HEALTH INSURANCE SCHEME

The funding of the Scheme is an important indicator of the implementation of the Law. Tables 1 and 2 show the funding scenario. Table 1 is the budgeted expenditure while Table 2 is on the actual expenditure.

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

[19] State of Primary Health Care Delivery in Nigeria, supra.

Table 1: Budgetary Allocation to Ekiti State Health Insurance Scheme (2018-2022)

Year	Total Allocation (NGN)	Recurrent Expenditure (NGN)	Capital Expenditure (NGN)
2018	42,000,000.00	17,000,000	25,000,000
2019	309,899,611.06	2,899,611.06	307,000,000
2020	265,600,000.00	600,000.00	265,000,000
2021	225,178,189.48	34,678,189.48	190,500,000.00
2022	152,430,114.08	35,728,144.22	116,701,969.86
TOTAL	**995,107,914.62**	**90,905,944.76**	**904,201,969.86**

Source: Ekiti State Budgets (2018-2022)

Budget figures include allocation for Ekiti State Health Insurance Scheme Committee

Table 1 shows a total vote of N995.107milion over the five years. The highest vote was recorded in the year 2019 while the least was in the year 2018. Capital votes constitute the bulk of the appropriation being 90.8 percent of the votes.

The basis of these budget votes is not clear considering that S.15 (2) (d) of the Law establishing the Ekiti State Health Fund requires inter alia, an Equity Fund comprising of not less than one percent of the Consolidated Revenue Fund of Ekiti State annually. It is not clear whether the appropriated sums constitute 1% 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 EKHIS Law the Health 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. It is not yet clear which of the funds have become functional.

Table 2: Actual Budgetary Expenditure of Ekiti State Health Insurance Scheme

Year	Total Allocation (NGN)	Recurrent Expenditure (NGN)	Capital Expenditure (NGN)
2018	500,000.00	500,000.00	0.00
2019	18,156,300.00	1,150,000.00	17,006,300.00
2020	0.00	0.00	0.00
2021	24,486,208.21	24,486,208.21	0.00*
TOTAL	43,142,508.21	26,136,208.21	17,006,300.00

Source: Ekiti State Budgets (2018-2022)

Budget figures include allocation for Ekiti State Health Insurance Scheme Committee
** Indicates that value is as at September, 2021*

From Table 2 above, in 2018, 1.19% of the appropriation was released; in 2019, 5.86% was released; in 2020, no kobo was released while 10.87% of the appropriation was released in 2021. 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.

9. CONCLUSIONS

This policy brief engaged the Ekiti State Health Insurance Scheme 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.[20] Reducing Nigeria's and Ekiti 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 EKHIS Law will be a major first step towards improving health insurance coverage.

However, there is no indication as required by S.15 of the EKHIS Law that the following has commenced:

- Appropriation of the Equity Fund comprising of 1% CRF of the Ekiti 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 Scheme is still low. It appears that the Scheme 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.[21] 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.

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[20] 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
[21] Lee, J.; *Health Care Reform in South Korea: Success or Failure;* see https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447690/ .

10. STRATEGIES AND RECOMMENDATIONS FOR IMPROVING HEALTH INSURANCE COVERAGE

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

10.1 Effective Implementation of Compulsory Health Insurance Coverage

It is commendable that Nigeria has made health insurance coverage mandatory for all. S. 4 (2) of the EKHIS Law made the same provision. One of the key factors required for EKHIS Law 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.

(a) The political leadership should activate the Scheme by continuing the appropriation of 1% CRF of the State Government for the Scheme.

(b) Commit Local governments to a minimum of 1% of their CRF to the funding of the equity fund of the Scheme.

(c) 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.

(d) Take steps to identify the indigent, vulnerable and poor who cannot afford premiums under the scheme 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 allocations to the Scheme.

(e) Utmost good faith engagement with Organized Labor and continue the remittance and deduction of agreed percentages by employers and employees.

(f) Intensify the engagement of the informal sector for commitment to contributions and enrolment.

(g) The Scheme should set realistic and realizable targets and timelines for its full implementation.

10.2 Take steps to Implement the Recommendations to Ekiti 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 Ekiti State (see page 94 - 96 of the report), they include (but not limited to):

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

(b) The State needs to commence payment of capitations to eligible health facilities, so that the poor and vulnerable who have been enrolled into the NHIS Gateway of the BHCPF can start to access services.

(c) Develop and implement a communications strategy to generate demand for services among the poor and vulnerable who have been enrolled into the NHIS gateway of the BHCPF.

10.3 Sensitization on the Benefits of Health Coverage

To deepen health insurance coverage, the Scheme should actively engage in carrying out public awareness and education on the establishment and management of the Scheme as provided in S.10 (j) of the EKHIS 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 Ekiti 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 Ekiti State closer to attaining UHC. Key stakeholders to be engage will include:

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

10.4 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.[22] It should be noted 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.

10.5 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. Enrolment can benefit from and utilize the good offices of the Church and traditional institutions.

10.6 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[23] as a community based health insurance scheme 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.

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

[23] 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,

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 Scheme.

10.7 Ensure Transparency and Accountability

Transparency and accountability in the management of and expenditures under the Scheme 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.

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

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

10.9 Provide Incentives for Compliance

The regulations and guidelines to be enacted by Scheme should boost enrolment and participation in the Scheme 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.

10.10 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.[24] 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. 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.

ORGANISATIONS THAT VALIDATED THE MEMORANDUM

1. National Health Insurance Authority
2. Ekiti State Health Insurance Scheme
3. Ekiti State Primary Health Care Development Agency
4. Nigeria Labour Congress
5. Daily Trust Newspaper
6. Thisday Newspaper
7. Hope Newspaper
8. Disability Not A Barrier Initiative
9. Life and Peace Development Organization
10. Rays of Hope Foundation for Sustainable Development
11. Balm in Gilead Foundation
12. Gender Mobile Initiative
13. Society for Women and Aids in Africa (Nigeria)
14. New Initiative for Social Development
15. Centre for Social Justice

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.

[24] 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