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IMPROVING THE IMPLEMENTATION OF THE IMO STATE HEALTH INSURANCE SCHEME

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Centre for Social Justice

People Rights Organization

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By

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ABBREVIATIONS

BHCPF	Basic Health Care Provision Fund
CRF	Consolidated Revenue Fund
EHP	Equity Health Plan
EPOs	Exclusive Provider Organizations
FCT	Federal Capital Territory
HMOs	Health Maintenance Organisations
ISHIS	Imo State Health Insurance Scheme
MNCH	Maternal, New Born and Child Health
NHA	National Health Act
NHIA	National Health Insurance Authority
NHIS	National Health Insurance Scheme
NPHCDA	National Primary Health Care Development Agency
PHC	Primary Health Care
PHP	Private Health Plan
PPO	Preferred Provider Organisation
SHIA	State Health Insurance Scheme
TPAs	Third Party Administrators
UHC	Universal Health Coverage
WHO	World Health Organization

EXECUTIVE SUMMARY

This Policy Brief engaged the Imo State Health Insurance Scheme (ISHIS 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 minim 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 Scheme. Section 7 reviews the implementation of the Basic Health Care Provision Fund in the State while section 8 reviews the funding of the Imo State Health Insurance Agency. In the penultimate section 9, it draws conclusions from the earlier sections. The tenth section is the strategies and recommendations for improving health insurance coverage in Imo State which are summarized as follows.

- **Effective Implementation of Compulsory Health Insurance Coverage: (a)** The political leadership should activate the Scheme by commencing 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)** Implement the outcome of the June 2019 negotiations with organized Labour which led to the signing of a Memorandum of Understanding with the Imo State branch of Nigeria Labour Congress, Trade Union Congress and Joint Negotiating Committee enabling the deductions from worker's salaries and contributions from the State Government. **(f)** Continue and deepen the engagement of the informal sector for commitment to contributions and enrolment; and **(g)** The Agency should fully implement its programs and outreach in accordance with its earlier set targets and timelines.
- **Take steps to Implement the Recommendations to Imo 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 Imo 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.

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

- **Full implementation of the Agency's Sensitization and Communication Plan which guarantees the simplification of the Cost-Benefit Analysis of Health Insurance Plans and reduction of Bottlenecks (if any) in the Administration of the Scheme.**

- **Improve and Optimize the Expected Benefits of Health Insurance Coverage to Retain Enrollees. In accordance with fit and good practices, the Scientifically Costed Benefit Package of the Scheme should be reviewed after three years of implementation or at intervals taking full cognizance of changes in the macroeconomic fundamentals of the economy.**

- **Guarantee Transparency and Accountability in the Scheme through the Continued use of the Peer Developed and Reviewed Accountability Framework, Quarterly and Yearly Audits.**

- **Subject to availability of fiscal resources, deploy the Best Human Resources in the Management of the Scheme.**

- **Use Patient Centred Quality Care and Service Delivery to provide Incentives for Compliance by Enrollees and other Stakeholders.**

- **The State Government should take steps to 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 Equity Fund used to cater for indigent and vulnerable persons created by S.19 (2) (d) of the Imo State Health Insurance (ISHIL) 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.

(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

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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/

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.

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.

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

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: 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.

Globally, the WHO released the below statistics relating to health care coverage9 :

- *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.*

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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

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

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 as follows in the NHIS Strategic Plan:

> *"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 ISHIL (S.12) 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, 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.14 (a) of the ISHIL – *ensure that every resident of Imo state has easy 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 14 (b) of ISHIL - *ensure that residents of Imo State have protection against financial risks that may arise due to illness*. 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

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[10] National Health Insurance Scheme Strategic Plan 2020-2030.
[11] See https://www.un.org/en/observances/universal-health-coverage-day

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.14 (f) of ISHIL. 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 Imo 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.

(c) Facilitating the Implementation of the Minimum Core Obligation of the State: *Ensure that the poor and vulnerable have access to the basic minimum package of healthcare as defined in the National Health Act* - S.14 (g) of ISHIL. 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.

(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.14 (l) of the ISHIL 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

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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.

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 *improve the attitude of Imo State residents in respect of being more care4ful about their health, thereby increasing life expectancy* - S.14 (d) of the ISHIL.

(g) Building Block for a Vibrant and Healthy Population: *Ensure that residents of Imo State have access to financial freedom, access to effective good quality and affordable healthcare services* - S.14 (m) of the ISHIS 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.*14 () of the ISHIL*. 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 IMO STATE HEALTH INSURANCE LAW

This section highlights the salient provisions in the law that provided for the establishment of Imo State Health Insurance Agency (Agency). S. 3 of the Law established the Agency as a body corporate with perpetual succession and a common seal. The Imo State Health Insurance Scheme (Scheme) is established in S.11 of the ISHIL and it is stated to be mandatory for all residents of Imo State. Specifically, the Scheme *shall be compulsory and apply to all residents of the State including-(a) the general public; (b) all employers and employees in the public and organized private sector and firms with five staff and above; (c) informal sector employees and; (d) all vulnerable persons in Imo State* – S.12 (1) of ISHIL.

By S.4 of the ISHIL, the Agency is responsible for the management of the Scheme; ensuring effective implementation of policies and procedures of the Scheme; issuing appropriate regulations and guidelines as approved by the Board; coordinating the implementation of the minimum benefit package as defined in the NHA; registering third party administrators, state accredited healthcare facilities and other relevant institutions. Other functions include classification of healthcare facilities; approving contract formats for Third Party Administrators (TPAs) and healthcare providers; creating awareness on the Scheme; developing targeting mechanisms to identify the poor and vulnerable who will benefit from the Scheme; establishing 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 5 of ISHIL provides for the establishment of Agency's Governing Board to be appointed by the State Governor to manage the affairs of the Agency. Board members' tenure (with the exception of ex-officio members) can be a maximum of eight (8) years, consisting of two (2) four-year tenures if their first tenure is renewed. The Board's powers, contained in section 9, include but not limited to: determine the organizational structure of the Agency; 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.14 of ISHIL states the objectives of the Scheme as follows:

- Ensure that every resident of Imo State has easy access to effective, quality and affordable healthcare services;
- Ensure that residents of Imo State have protection against financial risks that may arise due to illness;
- Limit the inflammatory rise in the cost of healthcare services;
- Protect families from financial hardship of huge medical bills;
- Improve the health-seeking behaviour of Imo State residents thereby increasing life expectancy;
- Ensure equitable distribution of healthcare costs across different income groups;
- Ensure that the poor and vulnerable shall have access to the basic minimum package of healthcare as defined under the National Health Act;
- Maintain high standard of health care delivery services within the Health Sector;
- Ensure efficiency in healthcare delivery within the Health Sector;
- Improve and harness private sector participation and investment in the provision of healthcare services in health sector of Imo State;
- Harness the great potentials of diaspora investment in the Imo State Health System
- Ensure appropriate utilization of services at all levels of the healthcare delivery system
- Ensure the availability of alternate sources of funding to the health sector for improved services

The components of the Scheme are by S. 12 (2) of ISHIL as follows: (a) Mandatory public health insurance scheme for all; and (b) Voluntary (private) health insurance plans which may be purchased by residents to complement or supplement the Mandatory Public Health Insurance Scheme.

By S.13 of ISHIL, contributions to the Scheme are as follows:

(a) contributions from the formal sector which shall be contributions from all organisations with five or more employees in the public and private sector wherein the employers and employees shall make such contributions as determined by the Board;

(b) contributions from informal sector which shall be contributions from
(i) organisations with less than five employees
(ii) persons who are self employed

(c) equity contribution of not less than one percent of the Consolidated Revenue fund of Imo State

S.19 provides for the establishment and management of the Imo State Health Insurance Fund:

(1) There is hereby created for the Scheme the Imo state Health Insurance Fund (hereinafter referred to as 'the Fund' to be managed by the Agency.

The Fund shall consist of:
(a) the initial take-off grant from the Imo State Government;

(b) formal sector fund; comprising of contributions from public and private sector employers and employees;

(c) informal fund comprising of contributions from the informal sector;

(d) equity fund comprising of contributions of not less than 1% of Consolidated Revenue Fund of the Imo State Government;

(e) donations, grant in aid from private organization, philanthropist, international donor organization and non-governmental organisations;

(f) funds to be provided by the NHIS in accordance with the provisions of the National Health Insurance Authority Act;

(g) fines and commissions charged by the Agency

(h) Other appropriations earmarked by the National, State and Local Governments purposely for the Scheme

(i) dividends and interests on investments and stocks; and

(j) All other money which may from time to time accrue to the Agency.

Unlike some other state laws, Local Governments were not 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 basis salary.

By S.20 of ISHIL, the Agency 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 Agency and Board members; and maintenance of any property vested in the Agency.

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

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 Act 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;

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

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;n)
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. 11 and S.12 of the ISHIL provide 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 Imo State. What needs to be done is the full implementation of the provisions of the NHIA Act at the federal level and the ISHIL in Imo 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 Agency under S.4 (d) of ISHIL is the coordination of the minimum benefit package as defined under the NHA. This shows a concordance in both legislations as to there being a 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 Imo 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 ISHIL 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 IMO STATE

By S.24 (3) of the NHIA Act, 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. By S.13 (1) of the NHIA, all states and the FCT are mandated to establish health insurance and contributory scheme for the purpose of providing access to health services to residents. By S.13 (8) of the NHIA, the state health insurance scheme is the vehicle for participation and accessing the BHCPF by states. By S.11 of the NHA, the major focus of the BHCPF is on primary health care.

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

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 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 54/100. The summary findings of the assessment for Imo State are given below:

> *"Imo State has capacity to utilise BHCPF disbursements from the NPHCDA Gateway but eligible PHCs are not receiving and retiring funds. Enrollees on the NHIS Gateway have not started accessing care and providers payments have not commenced. The State has failed to provide either its counterpart or its equity funding for the NHIS Gateway, and has not sent reports of any gateway forum and SOC meetings from Q4 2021. The state also does not have a formal sector health insurance scheme".*

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

- Provide equity funds for the National Health Insurance Scheme Gateway of the BHCPF;
- 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;
- 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.

8. FUNDING OF THE IMO STATE HEALTH INSURANCE AGENCY

The review of the finances available to the Agency and its implementation will give an insight into the implementation of the Scheme. Table 1 below shows the amount appropriated for the Agency from 2019 to date.

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[15] 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.

[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: Allocation to Imo State Health Insurance Agency

Year	MDA	Personnel	Overhead	Capital
2022	Imo State Health Insurance Agency			210,000,000
2019	Ministry of Health - NHIS Community Primary Healthcare Coordination		1,000,000	
	Ministry of Health - Imo State health Insurance Scheme	5,000,000	10,000,000	
	Total	5,000,000	11,000,000	210,000,000

Source: Imo State Approved Budgets 2019-2022

Table 1 shows a total vote of N226milion over the four years. However, there are no votes for the years 2020 and 2021. 2019 had paltry votes for personnel and overhead and no capital vote. 2022 had no votes for personnel and overhead but a moderate capital vote. The basis of these budget votes is not clear considering that S.19 (1) of the Law establishing the Imo State Health Insurance Fund requires inter alia, an equity fund comprising of not less than one percent of the Consolidated Revenue Fund of Imo 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 ISHIL the Health Insurance 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.

9. CONCLUSIONS

This policy brief engaged the Imo 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 Imo 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 ISHIL will be a major first step towards improving health insurance coverage.

[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

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

- Appropriation of the Equity Fund comprising of 1% CRF of the Imo 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.

10. STRATEGIES AND RECOMMENDATIONS FOR IMPROVING HEALTH INSURANCE COVERAGE

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

10.1 Effective Implementation of Compulsory Health Insurance Coverage: It is commendable that Nigeria has made health insurance coverage mandatory for all. S. 12 of the ISHIL made the same provision. One of the key factors required for ISHIL 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 commencing 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.

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

(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) Implement the outcome of the June 2019 negotiations with organized Labour which led to the signing of a Memorandum of Understanding with the Imo State branch of Nigeria Labour Congress, Trade Union Congress and Joint Negotiating Committee enabling the deductions from worker's salaries and contributions from the State Government

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

(g) The Agency should fully implement its programs and outreach in accordance with its earlier set targets and timelines.

10.2 Take steps to Implement the Recommendations to Imo 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 Imo State (see page 108-109 of the report), they include (but not limited to):

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

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(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 Continue and Deepen 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.4 (j) of the ISHIL. Scaling up citizens' sensitization on the benefits of health insurance coverage is an approach that possesses the potential of improving health insurance coverage in Imo 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 Imo 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 Full implementation of the Agency's Sensitization and Communication Plan which guarantees the simplification of the Cost-Benefit Analysis of Health Insurance Plans and reduction of Bottlenecks (if any) in the Administration of the Scheme: 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 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.

Formalities and bottlenecks of registration and administration 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.

10.5 Improve and Optimize the Expected Benefits of Health Insurance Coverage to Retain Enrollees. In accordance with fit and good practices, the Scientifically Costed Benefit Package of the Scheme should be reviewed after three years of implementation or at intervals taking full cognizance of changes in the macroeconomic fundamentals of the economy: 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.

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.

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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, 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.

10.6 Guarantee Transparency and Accountability in the Scheme through the Continued use of the Peer Developed and Reviewed Accountability Framework, Quarterly and Yearly Audits: 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.

10.7 Subject to Availability of Fiscal Resources, 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.

10.8 Use Patient Centred Quality Care and Service Delivery to provide Incentives for Compliance by Enrollees and other Stakeholders: The regulations and guidelines to be enacted by Scheme should also 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.

10.9 The State Government should Take Steps to 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.

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[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

LIST OF ORGANISATIONS AT THE VALIDATION MEETING

1. Imo State Health Insurance Agency
2. Imo State Primary Health Care Development Agency
3. Imo State Ministry of Health
4. Office of the Head of Service
5. National Human Rights Commission
6. Imo State House of Assembly
7. Leadership Newspaper
8. Sun Newspaper
9. Christian Association of Nigeria
10. Medical and Health Workers Union of Nigeria
11. American Cancer Hospital
12. International Federation of Women Lawyers (FIDA)
13. Better Community Life Initiative
14. Child Welfare and Orientation Network