IMPROVING THE IMPLEMENTATION OF THE NATIONAL HEALTH INSURANCE AUTHORITY ACT

STRENGHTHENING CIVIC ADVOCACY AND LOCAL ENGAGEMENT (SCALE)

Centre for Social Justice

First Published in September 2022

By

Right to Health Cluster

Plot 836, Block 1, Emmanuel Aguna Crescent, Off Idris Ibrahim Crescent, Off Obafemi Awolowo Way, Jabi
P.O. Box 11418 Garki, Abuja.
Website: www.csj-ng.org
Blog: csj-blog.org
Twitter: @censoj
Facebook: Centre for Social Justice, Nigeria
Email-censoj@gmail.com

This Memorandum is brought to you by the Right to Health Cluster 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 the Cluster and do not reflect the views of the United States Government.

TABLE OF CONTENTS

ABBREVIATIONS

Act	National Health Insurance Authority Act
Authority	National Health Insurance Authority
BHCPF	Basic Health Care Provision Fund
CRF	Consolidated Revenue Fund
ICT	Information and Communications Technology
NHA	National Health Act
NHIA	National Health Insurance Authority
NHIAA	National Health Insurance Authority Act
NHIS	National Health Insurance Scheme
OOPE	Out-of-Pocket Expenditure
PHC	Primary Health Care
UBEC	Universal Basic Education
UHC	Universal Health Coverage
WHO	World Health Organisation

EXECUTIVE SUMMARY

Part 1 is the introduction and provides a description of the idea of health insurance. Part 2 articulates Universal Health Coverage (UHC) and its key components including coverage of the entire population, full spectrum of health services according to need and financial protection from direct payment of health services when consumed. The link between health insurance and UHC is explored in Part 3 while Part 4 dwells on reasons for making health insurance compulsory. The reasons include achievement of UHC, financial risk protection in accessing healthcare, equity in financing healthcare, facilitating the implementation of the minimum core state obligation on health and reducing the financial burden on government. Part 5 reviews the key operative provisions of the NHIAA. The provisions reviewed include the establishment of the NHIAA, the establishment and powers of the governing council, the establishment of state health insurance and contributory schemes and participation in health insurance to be compulsory. Others are qualifications for operating a private health insurance scheme, licensing and accreditation, the Vulnerable Group Fund (VGF), implementing the Basic Health Care Provision Fund (BHCPF), contributions under health insurance schemes, registration of employers and employees, etc.

Part 6 deals with critical issues arising from the NHIAA and current practice including the fact that the governing council is yet to be established, the compulsive nature of health insurance is yet to kick in, operationalization of state health insurance schemes and the VGF, enlightenment and sensitization, database of vulnerable persons, transparency and accountability as well as the funding of the BHCPF. Part 7 is the conclusions while Part 8 is the recommendations. The summary of the recommendations is as follows:

- Constitute the Governing Council of the NHIAA.
- Operationalise the Compulsory Health Insurance Regime through administrative sanctions and an amendment of the Act to provide sanctions for non-compliance.
- Engage in Massive Enlightenment and Sensitisation.
- Operationalize State Health Insurance and Contributory Schemes.
- Operationalize the Vulnerable Group Fund in accordance with S.25 of the NHIAA through the health insurance levy, SIN taxes and a special intervention fund, etc.
- Establish and Continually Update a Database of Vulnerable Persons.
- Contributions by Federal Employees.
- Improve Accountability and Transparency.
- Properly Fund Basic Health Care Provision Fund to meet the statutory provision of not less than 1% of the CRF and this should be provided as a statutory transfer, instead of being a service-wide vote or just a mere vote under the Ministry of Health. The BHCPF is a ring-fenced fund that should be fully released.

1. INTRODUCTION

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

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

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

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.[5] 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

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

and appropriately supported. UHC strategies enable everyone to access the services that address the most significant causes of disease and death in their society and also ensures that the quality of those services is good enough to improve the health of the people who receive them.

UHC covers interventions at all three levels of health care – Primary, Secondary and Tertiary Health. As Primary Health Care (PHC) is the foundation of attainment of UHC, interventions at Secondary and Tertiary health levels broaden the horizon for improvement of health outcomes thereby edging a nation closer to attaining UHC. There are three interrelated components of UHC[6]: 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.[7] Furthermore, critical indicators for assessing progress towards UHC include Total Health Expenditure (THE) as a percentage of the Gross Domestic Product (GDP) of the country (at least 4%-5%); OOPE as a percentage of THE (not more than 30%-40%; percentage of the population covered by prepayment and risk protection schemes (over 90%); percentage access to health services by the 40% poorest population (80%).[8]

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*

[6] 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/

[7] General Comment Number 14 on the Right to the Highest Attainable Standard of Health of the United Nations Committee on Economic, Social and Cultural Rights

[8] Nigerian Health Financing Policy and Strategy at page 11.

from impoverishment due to illness, whether from out-of-pocket payments for health care or loss of income when a household member falls sick".[9]

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 coverage[10] :

- *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 (NHIS), now National Health Insurance Authority (NHIA) 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".*[11]

This scenario of limited coverage of pre-paid health services contributes largely to the nation's poor health indices. This situation requires drastic and targeted measures to improve health insurance coverage. The low insurance penetration has been attributed to the low awareness and enlightenment on the benefits of health insurance, unwillingness to pay premiums and quality of care delivered under official pre-paid schemes.[12]

This scenario contributes largely to the nation's poor health indices. This situation requires drastic and targeted measures to improve health insurance coverage. It is within the context

---

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

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

[11] National Health Insurance Scheme Strategic Plan 2020-2030.

[12] See page 36 of the NHIs Strategic Plan 2020-2030.

of current health indicators that the Nigerian Health Financing Policy and Strategy (NHFP&S) recognizes that:[13]

> *Improvements in health financing do not depend solely on generating additional resources, but also on the efficient utilization of available resources, and the effective and equitable deployment of resources within different population groups in the country, especially the underserved.*

A functional, effective health insurance and fund pooling system will help to fill these gaps and mainstream efficiency and equity.

4. REASONS FOR MAKING HEALTH INSURANCE UNIVERSAL AND COMPULSORY

The National Health Insurance Authority Act (NHIAA) in S.14 makes 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 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".*[14] Making health insurance universal and mandatory for everyone ensures that this goal is achieved. This is validated by S.3 (b) and (c) of the NHIA – *ensure that health insurance is mandatory for every Nigerian and legal resident* and *enforce the basic minimum package of health services for all Nigerians across all health insurance schemes operating within the country, including Federal, States and the Federal Capital Territory (FCT) as well as private health insurance schemes.*

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: This seeks to protect families from the financial hardship of huge medical bills; and limit the inflationary rise in the cost of health care services. This is another key objective of making health care universal. It is one of the critical hallmarks of health accessibility. Health financing policy impacts financial protection directly. Financial protection works by ensuring that payments made to obtain health care services do not expose people to financial difficulty and do not threaten living standards. Necessary for the effectiveness of this objective is the collection of premium payments so as to pool funds for healthcare provision instead of relying on out-of-pocket payments for healthcare services at the time of use. Nigeria's out-of-pocket expenditure (OOPE) on health is one of the highest in the world and has been stated by the World Bank

[13] Foreword to the Nigerian Health Financing Policy and Strategy.
[14] See https://www.un.org/en/observances/universal-health-coverage-day

at 70.52 percent. This is in contrast to the Sub-Saharan Africa average of 29.98 percent[15] as well as levels of OOPE being 30-40% of Current Health Expenditure recommended for countries to be on track to UHC. Essentially, pooling of resources through health insurance guarantees adequate financial risk protection from catastrophic health expenditure. Health insurance contributes only 0.5% of THE and this needs to be improved upon.[16]

(c) Equity in Financing Health Care: This ensures equitable distribution of healthcare costs across different income groups. 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 healthcare services to all members of the population. Overall, this can lead to a more efficient health care system.[17]It enhances the re-distributional capacity of prepaid funds and facilitates gains from strategic purchasing.

"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 interventions in healthcare services in regions of a given country where life expectancy is lower or disease burden is higher than the other parts of the country.[18]

This appears to be the basis for the establishment of the VGF in S.25 of the NHIAA and its stated objectives of attending to vulnerable and indigent persons in S.26 of the Act.

(d) Facilitating the Implementation of the Minimum Core Obligation of the State: The right to health imposes a minimum core obligation on the state to satisfy at the very least minimum essential levels of health provisioning including primary health care. This is to be provided on the basis of the maximum of available resources. Resources can come from government, the private sector or citizens. Health insurance expands the pool of available resources and walks the talk of domestic resource mobilization. The function of the NHIA of enforcing the basic minimum package of health services across all (compulsory) health insurance schemes is a clear commitment to meeting the minimum core obligation against the background of the provision of the National Health Act in S.1 (1) (c) and (e) which sets the objectives of the National Health System inter alia; provide for persons living in Nigeria the best possible health services within the limits of available resources; protect, promote and fulfil the rights of Nigerian people to have access to healthcare services.

(e) To Reduce the Financial Burden on the Government: S.2 of the Act states the objects to include improving and harnessing private sector participation in the provision of healthcare services. This will ensure the availability of alternate sources of funding to the mandatory health insurance programme for improved services. The fiscal space and elbow room for social interventions including health have 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,

[15] https://data.worldbank.org/indicator/SH.XPD.OOPC.CH.ZS?locations=NG, 2019
[16] Page 39 of the NHIS Strategic Plan, 2020-2030.
[17] Tulane University blog, 2nd July 2021; *"What is Healthcare Equity?"* See https://publichealth.tulane.edu/blog/healthcare-equity/
[18] Footnote 12, supra.

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.

(f) Sustainability and Credibility of Health Financing: Public health financing at the federal and state levels is beset with credibility challenges. The resources budgeted usually do not meet the 15 percent of the 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 bogged down by the claim of lack of resources. Policy implementation can proceed as planned and sustainability will be built into the system. Furthermore, the information and data-gathering/analysis component associated with health insurance will facilitate evidence-based decision-making in the health sector.

(g) Facilitating Whole-of-Society Approach to Health: When all tiers of government-federal, state and local governments as well as 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 public, individual and social responsibility that facilitates the adoption of healthy and reduced risk lifestyles. Furthermore, it creates a sense of prioritization of healthcare in the whole society. Paying premiums also creates a sense of empowerment for citizens to demand accountability for available public funding of healthcare.

(h) Building Block for a Vibrant and Healthy Population: Health insurance and the attendant maintenance of a Vulnerable Group Fund (VGF) facilitates the maintenance of a high standard of healthcare service delivery within the health sector and ensures efficiency in healthcare service delivery. 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 OOPE by citizens.

(i) Means of Poverty Eradication: 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. The NHIA is charged with devising a means to ensure that the basic health care needs of indigent and vulnerable persons are adequately provided.[19]

[19] S.3 (n) and (q) of the Act.

(j) To Reduce Inequality and Uplift the Poor Strata of the Society: Health insurance provides a veritable tool for reduction of inequality and vulnerability as it offers affordable health care services to every class of the society in so far as they are able to pay the premium or have a cover under the VGF. This will mainstream gender, vulnerability, disability, etc., into health provisioning. Access to decent health care is made available to the poor quantile of 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 OF THE NHIAA

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

The NHIA was enacted in 2022, to repeal the National Health Insurance Scheme Act (2004), to enact the National Health Insurance Authority Act to provide for the promotion, regulation and integration of Health Insurance Schemes in Nigeria and for related matters.[20]

(b) Establishment of the S.1 of the National Health Insurance Authority and its Functions: Act established the National Health Insurance Authority as a body corporate with perpetual succession and an official seal. By S.2 of the Act, the objects of the Authority is to promote, regulate and integrate health insurance schemes and improve and harness private sector participation in the provision of healthcare services.

S. 3 provides for its functions inter alia:

a) *promote, integrate and regulate all health insurance schemes that operate in Nigeria;*

b) *ensure that health insurance is mandatory for every Nigerian and legal resident;*

c) *enforce the basic minimum package of health services for all Nigerians across all health Insurance Schemes operating within the country, including Federal, States and FCT as well as private health insurance schemes;*

d) *promote, support, and collaborate with States through State Health Insurance Schemes to ensure that Nigerians have access to quality health care that meets national health regulatory standards;*

e) *ensure the implementation and utilisation of Basic Health Care Provision Fund as required under the National Health Act and any guidelines as approved by the Minister under that Act;*

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

f) *grant accreditation and re-accreditation to Health Maintenance Organisations, Mutual Health Associations, Third Party Administrators and Health Care Facilities and monitor their performance;*

g) *seek and advocate for funds for the Basic Health Care Provision Fund;*

h) *accredit insurance companies, insurance brokers and banks desirous of participating in health insurance schemes under the Authority;*

i) *maintain a register of licensed health insurance schemes and accredited health care facilities;*

j) *subject to S.13, approved contributions to be made by members of the various health insurance schemes;*

k) *approve, after consultation with Health Care Facilities, formats for contracts for health service purchasing proposed by Health Maintenance Organisations and Mutual Health Associations for all Health Care Facilities;*

l) *approve, after consultation with Health Care Facilities and bodies representing them, capitation and other payment due to Health Care Facilities by Health Maintenance Organisations and Mutual Health Associations;*

m) *ensure that tariffs agreed with Health Care Facilities are reviewed on a three-yearly basis to the mutual satisfaction of Health Care Facilities, Health Maintenance Organsiations, Health Insurance Schemes and the Authority;*

n) *devise a mechanism for ensuring that the basic health care needs of indigents are adequately provided for;*

o) *in conjunction with states, devise a mechanism for ensuring that the basic health care needs of vulnerable persons are adequately provided for;*

p) *undertake on its own or in collaboration with relevant bodies a sustained public education on health insurance;*

q) *Undertake research and generate statistics on matters relating to the Authority;*

r) *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) *regulate all health insurance schemes in Nigeria in accordance with the provisions of this Act.*

(c) Establishment and Powers of the Governing Council: By S.4, a Governing Council is established for the Authority and its powers are defined in S.5. The powers of the Council are to approve and register for the Authority Third Party Administrators in any form; determine

the overall policies, including the financial and operative procedures of the Authority; ensure the effective implementation of the policies and procedures of the Authority; regulate and supervise the various health insurances schemes established under this Act; promote, oversee, collaborate and provide guidance to State Health Insurance Schemes; issue guidelines for the administration and release of funds of the Authority; approve, license, regulate and supervise Health Maintenance Organisations, Mutual Health Associations and other institutions relating to the Authority as may be determined. Furthermore, it is to establish standards, rules and guidelines for the management of various schemes under this Act; approved the organisational structure, appointments, promotions and discipline of staff of all categories of the Authority's staff as well as their remuneration; receive and investigate complaints of impropriety levied against any HMO, MHA or other relevant institution and take disciplinary action thereafter (if necessary).

(d) Establishment of State Health Insurance or Contributory Scheme: S.13 states as follows:

> *(1) Every state of the Federation and the Federal Capital Territory may, for the purpose of providing access to health services to its residents, establish and implement a state health insurance and contributory scheme, to cover all residents of the State and Federal Capital Territory respectively.*
>
> *(2) The coverage under subsection (1) shall be at the minimum scope of coverage as outlined in the Basic Minimum Package of the National Health Act.*
>
> *(3) The Authority shall establish a scheme for the coverage of employees of Ministries, Departments, Agencies in the Federal Civil Service and other relevant groups.*
>
> *(4) For the purpose of the implementation of the scheme under subsection (3), the Authority shall, with the approval of the Council, set out operational guidelines for the scheme.*
>
> *(5) State health insurance or contributory schemes and the Federal Capital Territory Scheme established under subsection (1) shall comply with the requirements under this Act, to ensure that any Health Maintenance Organization, Health Care Facility, Mutual Health Association or Third-Party Administrator employed in State health insurance schemes or the Federal Capital Territory Health Insurance Scheme are registered by the Authority in accordance with the provisions of this Act.*
>
> *(6) Every State and the Federal Capital Territory scheme shall establish an Information and Communication Technology (ICT) infrastructure for the management of data and such ICT infrastructure shall be integrated with and provide information in the requisite format to the ICT infrastructure of the Authority.*
>
> *(7) A State and the Federal Capital Territory shall provide coverage for vulnerable persons under the State health insurance and contributory scheme through the Basic Health Care Provision Fund and other sources and not require the payment of premiums for such coverage by vulnerable persons defined by this Act.*

(8) Every State which has established a state health insurance or contributory scheme and which complies with the requirements of this Act shall be eligible to participate in the Basic Health Care Provision Fund as established under the National Health Act and its guidelines.

Even though the word used in describing the obligation of states to set health insurance and contributory scheme is the discretionary "may" as against the mandatory "shall", a contextual reading of the section and indeed other relevant sections of the Act shows that it is rather compulsory if the state seeks to benefit from the Authority's gateway of the BHCPF.[21] The Basic Minimum Package of the National Health Act is treated as the minimum core content of the health services to be offered under the respective schemes. Subsections (3) and (4) retain the province of the Authority in managing the health accounts of federal public services employees. Subsection (7) reaffirms the need for public funding for the care of vulnerable persons.

(e) Participation in Health Insurance to be Compulsory: S.14. sets the ground rule.

(*1) Subject to the provisions of this Act, every person resident in Nigeria shall be required to obtain health insurance.*

(2) Residents under this Act include-

(a) all employers and employees in the public and private sectors with five staff and above;

(b) informal sector employees; and

(c) all other residents of Nigeria.

(3) Subject to subsection (2), nothing under this Act shall be construed to preclude a resident in Nigeria from obtaining private health insurance provided such a person participates in any State mandated health scheme.

(4) A person who obtains private health insurance shall not be eligible to receive free coverage as a vulnerable person as provided under section 13 (7) of this Act.

Health insurance is compulsory, through payment of requisite premiums, for all persons who are not vulnerable whilst the vulnerable will be taken care of by public intervention. Furthermore, any person who obtains a private health insurance will not be eligible to be counted as a vulnerable person and receive public care as such.

(f) Qualification for Operating a Private Health Insurance Scheme: This is detailed in s.15 of the Act.

15.*-(1) Without prejudice to the power of a State to establish a health scheme under section 13 of this Act, a person shall not qualify to apply to operate any form of health insurance scheme in the country unless the scheme is registered as a company limited by guarantee or a limited liability company and complies with the provisions of all relevant laws in Nigeria.*

[21] Subsections (1) and (8) of S.13 of the Act.

(2) A private health insurance scheme or plan shall cover interested individuals, employers or employees of organizations in the private sector who may want to buy the scheme for supplementary benefits.

(3) A body corporate registered as a limited liability company under the Companies and Allied Matters Act and accredited by the Authority as a Health Management Organization may operate a private health insurance scheme, subject to compliance with the provisions of law.

(4) A private health insurance scheme or plan shall be required as a condition for registration and licensing by the Authority to deposit with a bank accredited by the Authority an amount of money in an interest yielding account that the Authority shall prescribe as security for its members.

(5) The security referred to under subsection (4) shall be maintained throughout the period that the business of the private health insurance is carried on.

(6) The Authority may review the level of the security deposit.

(7) Where a private health insurance scheme or plan suffers a substantial loss, arising from liability to members and the loss cannot reasonably be met from its available resources, the Authority may, after ascertaining the nature of the claim, and on application made to it by the scheme, approve the withdrawal from the security deposit of the scheme of an amount sufficient to meet the liability, and an amount withdrawn shall be replaced by the scheme not later than 90 days after the date of the withdrawal.

(8) The security deposit is the asset of the private health insurance scheme or plan, but except as provided under subsection (7), it shall be available to the scheme only in the event of the closure or winding up of the health insurance business for the discharge of the liabilities arising out of policies transacted by the insurer and remaining un-discharged at the time of the closure or winding up of the insurance business.

(9) All private health insurance schemes or plans shall be regulated by the Authority.

This section details the qualifications for registering a private health insurance scheme including registration as a company limited by guarantee or a limited liability company. The Scheme shall be required by the Authority to make a deposit with a bank in an interest-yielding account as a security for its operation. The security deposit may be used, upon the approval of the Authority, to meet the liabilities of a scheme if it suffers a substantial loss, arising from liability to members, which cannot be met from its available resources. But such withdrawal from the security deposit shall be replaced by the scheme not later than 90 days after the date of withdrawal. Otherwise, the security deposit may only be available to the scheme upon closure or winding up of the health insurance business for the discharge of outstanding liabilities. Private health insurance is voluntary and shall be regulated by the Authority.

(g) Licensing and Accreditation, Revocation of License: Licensing and accreditation of a health insurance scheme shall be done by the Authority and may be subject to a fee as determined by the authority. However, this does not apply to a government health insurance

scheme.[22] The Authority may decline to register a scheme but the applicant may be given the opportunity to remedy a non-material defect in the application within six months of the Authority's refusal to register. The Authority may also revoke the license it has granted to a scheme if it is in breach of relevant provisions of the operational guidelines or failed to comply with provisions of the Act, regulations or any other enactment applicable to the scheme.[23]

(h) Implementation of the Basic Health Care Provision Fund: S.24 of the NHIAA states:

> *24.-(1) The Authority shall work in conjunction with the States to provide a basic minimum package of care to all residents of Nigeria.*
>
> *(2) For the purpose of subsection (1), the Authority shall implement the Basic Health Care Provision Fund as set out in the National Health Act and guidelines developed in that regard.*
>
> *(3) The Authority shall work in conjunction with the States to achieve the objectives of the Basic Health Care Provision Fund and to provide a basic minimum package of care as defined in the guidelines developed for the implementation of the Basic Health Care Provision Fund.*
>
> *(4) The Authority shall provide general guidance for the operation of the Basic Health Care Provision Fund and for that purpose-*
>
> > *(a) make regulations covering accreditation, quality of care and complaints handling;*
> >
> > *(b) collaborate with the State health schemes and State-owned institutions to accredit and empanel primary and secondary health care facilities using criteria as may be contained in relevant guidelines; and*
> >
> > *(c) provide for the administration of an Ombudsman to handle complaints of enrollees.*
>
> *(5) States health schemes shall be responsible for disbursements, management of the Basic Health Care Provision Fund, and monitoring and evaluation of the implementation of the Basic Health Care Provision Fund in the States in line with the relevant guidelines issued by the Authority.*
>
> *(6) Where a State has not yet established a State health scheme, it may contract a Third Party Administrator, as defined in this Act for a temporary period, prior to establishing a State health scheme*.

[22] Sections 16 and 17 of the Act.
[23] S.18 and 19 of the Act.

Essentially, the Authority is to work in partnership with State Health Insurance agencies for the implementation of the BHCPF's health insurance gateway (50% of the funds).[24]

(i) The Vulnerable Group Fund: S. 25 establishes the VGF to be funded inter alia from the BHCPF to the Authority, health insurance levy, special intervention fund allocated by the Government and appropriated to the VGF, money that accrues to the VGF from investments made by the Council; and grants, donations, gifts and any other voluntary contribution made to the VGF.

The Council is empowered through regulations to review the sources of funding to keep pace with developments in the health insurance industry. Vulnerable groups are defined to include children under five, pregnant women, the aged, physically and mentally challenged, and the indigent as may be defined from time to time.[25]

By S.26, the object of the VGF is to provide finance to subsidize the cost of provision of health care services to vulnerable persons in Nigeria. For the purpose of implementing the object, the money from the VGF shall be expended to provide subsidy for health insurance coverage of vulnerable persons as determined by the Council; and for the payment of health insurance premium for indigents.

S. 27 provides that the Council shall determine and submit to the Minister for approval, the criteria for disbursement of subsidies to be paid to State Health Insurance Schemes for health care of the vulnerable and indigents in Nigeria. Furthermore, the Council shall, in disbursing money from the VGF make specific provision towards the health needs of indigents and prescribe the methods for determining who is indigent in Nigeria.

S. 28 provides that the Council shall give directives to the Authority for the management of the VGF. The Council in the managing of the VGF shall formulate and implement policies towards achieving the objects of the VGF; approve methods for the collection of money lawfully due to the VGF; account for the money in the VGF; it will also provide formula for the disbursement of money from the VGF; approve any other expenditure charged on the fund under this Act or any other enactment; and perform any other function ancillary to the objects of the VGF.

Subject to the approval of Council, the Authority may invest a part of the VGF that it considers appropriate in securities and deposits.[26] The expenses attendant to the management of the VGF shall be charged to the VGF.[27]

(j) Contributions under Health Insurance Schemes: S.31 makes the following provisions:

[24] S.11 (3) (a) of the NHA: 50% of the Fund shall be used for the provision of basic minimum package of health services to citizens in eligible primary and secondary health facilities through the NHIS.
[25] See S.59, being the interpretation section.
[26] S.29 of the NHIAA.
[27] S.30 of the NHIAA

31. (1) Contributions under-

(a) formal sector shall be paid by the employers and employees at rates determined by the Councils of the various State health insurance schemes.

(b) informal sector shall be paid by individuals, groups and families at rates determined by the Councils of the various State health insurance schemes.

(2) The contributions for vulnerable persons, not otherwise covered by other schemes, shall be made on their behalf by one or a combination of the three levels of government, development partners or non-governmental organisations.

(3) Contributions from the Federal Government for vulnerable persons shall be made from the Basic Health Care Provision Fund.

(4) States shall be eligible to access these funds upon establishing their State health insurance schemes as required under this Act and other relevant provisions of the guidelines of the Authority.

(5) Individuals or employers may pay additional premiums for voluntary supplementary or complementary private health insurance plans.

The compulsory nature of health insurance is for the basic minimum healthcare package while individuals and groups are free to purchase additional supplementary private health insurance plans.

(k) Registration of Employers and Employees under the Scheme: S. 32 states:

(1) Subject to such guidelines and regulations as may be made under this Act, an employer shall register itself and its employees and pay into the account of States Social Health Scheme Funds, its contributions and the contributions in respect of its employees, at the time and in the manner as may be specified in the State health insurance scheme laws and guidelines issued thereunder.

(2) Subject to such guidelines and regulations as may be made under this Act, an individual or employer may register himself and the people under him under a private health insurer, pay into the designated accounts of such insurer the necessary premium in respect of himself and others under supplementary or private health insurance scheme.

By virtue of subsection (1), the State Health Insurance Scheme is to specify in the enabling law or its guidelines, the manner of registration and contribution to the scheme.

6. CRITICAL ISSUES ARISING FROM THE NHIAA AND CURRENT PRACTICE

(a) Governing Council Has Not Been Constituted: The Policy Council established in S.4 of the NIAA has not been constituted. The functions and powers of the Council are so critical and fundamental to the realization of the goals and objectives of the new regime established in the NHIAA. Indeed, any new policy framework approved by the authority when the Council is not in place will be of doubtful legal validity. This is notwithstanding the provisions of S.11 (7) that upon dissolution of Council and pending its reconstitution, the Minister shall exercise the powers and functions of the Council. But this ministerial power will kick in when there is a Council and it has been dissolved. It did not contemplate that there will be no Council at all. However, in accordance with S.58 of the NHIAA, it is acknowledged that the repeal of the NHIS Act did not affect the previous operation of the enactment or anything done or suffered under the enactment; any right, privilege, obligation or liability accrued or incurred under the enactment; any penalty, forfeiture or punishment incurred in respect of any offence committed under the enactment; or any investigation, legal proceedings or remedy in respect of any such right, privilege, obligation, liability, penalty, forfeiture or punishment, and any such investigation, legal proceeding or remedy in respect of any such right.

(b) Compulsory Health Insurance? A new regime of compulsory subscription to health insurance has been created for all by the NHIAA. But that is the law in the books and not the law in the streets. It is yet to be implemented. Furthermore, the provision of the NHIAA in this regard seems to be deficient within the context of the law being the command of the sovereign, to be disobeyed at the risk of sanction. Pray, what is the punishment for non-compliance? The NHIAA is silent on enforcement and sanctions to be meted to defaulters. Such a big provision should not be left to the regulations and guidelines of the NHIA.

(c) Enlightenment and Sensitisation: The regime of compulsory health insurance for all who do not fall into the category of vulnerable persons is known only to health insurance professionals, workers and relevant civil society organisations. Indeed, majority of the population, close to 90% of the population are unaware of this new regime. Therefore, enlightenment, sensitization, awareness creation, education, etc., are imperative and relevant to achieve the goals of the new regime and to increase health insurance penetration.

This is in line with the Communication and Marketing Priority Area of the NHIS Strategic Plan viz: Develop and implement strategic marketing and communication plan to increase public awareness. The major activities include conducting advocacy and sensitization meetings and public enlightenment campaigns on increasing public awareness of health insurance through multiple communication channels in all states and zones; facilitate development/review of advocacy kits, IEC materials, regular media dialogue and engagement of interest groups.[28]

(d) States with Health Insurance Schemes and Operationalization of the Schemes: The provisions of the NHIAA demands that states set up their Health Insurance and Contributory Schemes to be able to access funds under the NHIAA gateway of the BHCPF. It is not exactly clear how many states have set up their schemes. A 2021 report on the BHCPF indicates

[28] Pages 60 and 61 of the NHIS Strategic Plan.

that many states have enacted laws to establish health insurance and contributory schemes but have not operationalized the laws.

In this regard, most of the states are yet to commence deductions of percentages of their consolidated revenue funds and that of their local governments for their respective equity funds as dictated in the enabling laws. In some state laws, local governments were not mandated to contribute to the Equity Fund contrary to the need for the involvement of all tiers of government in health financing. In some other states, the governing board or council of the health insurance schemes have not been constituted.

(e) Vulnerable Group Fund: The VGF established by S.25 of the NHIAA has many sources of funding. The first is the resources accruing from the BHCPF which apparently has been activated before the enactment of the late. The second source of funding is the health insurance levy which has not been fixed or imposed. It is not clear, in view of the prevalent negative macroeconomic indicators, which sets of individuals, companies, or organisations that can afford to pay any extra levies. The third is the special intervention fund to be allocated by Government and appropriated to the Fund. This is not yet in place. However, it can be facilitated by stakeholder lobby and engagement of the federal government budgeting and prioritization system.

In accordance with the recommendations of the Nigeria Health Care Financing Policy and Strategy:[29]

> *Government shall earmark a percentage of the taxes on tobacco, alcohol, harmful environmental pollutants, and unhealthy foods as Sin Taxes to generate revenue for health as follows: 5% on Alcohol Tax; 20% on Tobacco Tax; 3 kobo/second on all phone calls; 0.5% of Companies Income Tax (CIT) and; 0.5% on all aviation air tickets.*

Furthermore, the justification for the imposition of a Sugar Tax on carbonated drinks is related to promoting good and healthy lifestyles. Excessive consumption of sweetened sugar beverages is associated with obesity and other non-communicable diseases such as type two diabetes, cardiovascular diseases, dental caries, liver disease, etc. It is therefore imperative that the sugar tax is converted to a dedicated tax for the health sector. It should not be a general pool tax that has nothing to do with the health mischief it was intended to provide a remedy for. All the foregoing could become part of the Health Insurance Levy proposed for the Vulnerable Group Fund.

(f) Database of Vulnerable Persons: Vulnerable groups are defined to include children under five, pregnant women, the aged, physically and mentally challenged, and the indigent as may be defined from time to time. To be able to reach this group, NHIAA and State Health Insurance Schemes need a census, a database of people who fall into this category and which has to be regularly updated on a yearly or any appropriate interval basis. Pregnancy is a category that will last about nine months and so needs to be regularly updated in terms of persons who recently became pregnant and pregnant women who have delivered.

[29] At page 32.

Also, under five category needs to admit new entrants and phase out older members on a yearly basis. Is there a national or state register of the aged and the mentally infirm? If the answer is positive, this register will be updated upon death or when a mentally infirm person regains his sanity. Is there a register of physically challenged Nigerians or people living with disability? The existing register used by the Humanitarian Affairs Ministry for payment of cash transfers can only identify the indigent and not the other categories.

(g) Lack of Contribution by Federal Employees: Federal employees not yet making their 5% contribution for their health insurance coverage but FGN is fully subsidising their enrolment. This is depriving the NHIAA of needed resources to improve the quality and effectiveness of service delivery for this category of workers. It is also reducing the funds that FGN should have committed to the VGF to attend to indigent, poor and vulnerable Nigerians. FGN needs to engage organize labour in dialogue to get their buy-in into the compulsory health insurance scheme through employer-employee contributions.

(h) Accountability and Transparency: Citizens are entitled to have access to health revenue, expenditure and health financing in general including health insurance income and expenditure.[30] Like the Universal Basic Education Fund, the NHIAA needs an electronic portal, accessible to all, where information on financial disbursements, retirements and state of financial play on a state to state basis arising from the obligations under the BHCPF should be displayed at all times. Such portal, in view of Health Insurance Under One Roof policy of the NHIAA should also contain all enabling laws, relevant policies and updates on health insurance and the VGF/Equity Funds across the Federation. Indeed, the portal should be a single internet portal that shall serve as a primary and definitive source of all information, containing and displaying all relevant (non-personal/sensitive) health insurance information at all times.

One of the key strategies of the "Good Governance and Accountability Pillar" of the NHIS Strategic Plan is to facilitate the creation of a Coalition of Health Insurance Advocacy Groups with bi-annual meetings and feedback forum; and to ensure full involvement of Independent Health Insurance Advocacy Groups and Watchdogs in NHIS operations. This pillar appears to be awaiting implementation.

(I) Funding The Basic Healthcare Provision Fund: Reviewing the funding of the BHCPF is imperative considering that it is to provide the bulk of the financial resources for the VGF. The Basic Health Care Provision Fund is by law a statutory transfer. However, it has been provided in the Federal budget under different headings. In 2019, it appeared as a Service Wide Vote; in 2020, it came as a statutory transfer; in 2021 and 2022, it was appropriated as a vote to the Ministry of Health. This practice should be changed and the BHCPF should be permanently appropriated as a statutory transfer.

Furthermore, it is not clear how the budget authorities calculate the BHCPF. The UBEC fund is by law a federal government block grant of not less than 2% of the Consolidated Revenue Fund[31] (CRF) while the BHCPF is by S.11 of the NHA, not less than 1% of the CRF.

[30] At page 43 of the NHFP&S.
[31] S11 (a) of the Compulsory, Free, Universal Basic Education Law of 2004.

Therefore, the BHCPF should ideally not be less than 50% of the UBEC allocation. Table 6 tells a different story.

Table 1: UBEC and BHCPF Allocations and the BHCPF Shortfalls

Year	UNIVERSAL BASIC EDUCATION (UBE) COMM	50% of UNIVERSAL BASIC EDUCATION (UBE) COMM	BASIC HEALTH CARE FUND	Shortfall
2019	121,924,903,544.00	60,962,451,772	51,219,751,964	9,742,699,808
2020	79,860,728,916.00	39,930,364,458	26,457,743,000	13,472,621,458
2021	94,460,399,261.00	47,230,199,631	35,025,926,586	12,204,273,045
2022	130,120,299,178.00	65,060,149,589	44,564,737,089	20,495,412,500

Source: Approved Budgets, Budget Office of the Federation

Table 6 shows that in 2019, there was a shortfall of N9.742billion; 2020 recorded N13,472billion shortfall; 2021 was N12.204billion while 2022 skyrocketed to N20.485billion. It is imperative to recall that what S.11 of the NHA provided is the minimum threshold and not the maximum. Therefore, the expectation is that FGN should appropriate more than the minimum instead of the present scenario of a shortfall. It appears that the appropriated sums are not fully released. N55.1billion was appropriated in 2018 and only 50% was released.

7. CONCLUSIONS

This memo establishes that a compulsory health insurance regime is imperative for Nigeria's journey toward UHC. Limited coverage of prepaid health services contributes largely to Nigeria's poor health indicators. A number of reasons justify making health insurance compulsory and they include financial risk protection, equity in financing healthcare, facilitating the implementation of the minimum core obligation of the state, reducing the financial burden of government and sustainability and credibility of health financing. Others are facilitating a whole-of-society approach to health, building block for a vibrant healthy population, a means of poverty rededication and to reduce inequality.

The NHIAA establishes the Authority and Governing Council with clearly designated functions and powers. It enjoins states to establish health insurance and contributory schemes to qualify to access funds from the NHIAA gateway of the BHCPF. Health insurance is compulsory for all citizens and residents who are not classified under the vulnerable person umbrella. The Act provides the criteria for registering private health insurance schemes and the general framework for the implementation of the BHCPF. Furthermore, it establishes the VGF, defines who is eligible for support under it and the source of its funding. It provides for contributions to the scheme and the registration of employers and employees under the scheme.

The memo found that the Governing Council of the Authority is yet to be established; the regime of compulsory health insurance appears inchoate because there is no sanction for an eligible person who fails to comply with this provision. There is a need for increased

sensitization, awareness creation and enlightenment on the benefits of health insurance while states that have enacted health insurance and contributory schemes need to fully operationalize the laws. The VGF is established in the Act but some of its sources of financing have not been operationalized and there is the challenge of identifying vulnerable persons as defined in the Act. There are also challenges to accountability and transparency as well as the fact that only FGN (employer) contributes to the health insurance of its employees while the employees do not contribute to their enrolment and access to services. the appropriation of the statutory 1% of the federal CRF to the BHCPF seems to be more obeyed in the breach.

8. STRATEGIES AND RECOMMENDATIONS FOR IMPROVING HEALTH INSURANCE COVERAGE

Against the background of the foregoing, this memo makes the following recommendations on strategies to improve health insurance penetration, quality and efficient health services.

(a) Constitute the Governing Council: In accordance with S.4 (5) of the NHIAA, the Minister of Health should make recommendations to the President for the constitution of the Council. New policy frameworks are needed for the full implementation of the Act and policy or guideline made without approval of the Council will be ultra vires the powers of the Authority and will be null and void.

(b) Compulsory Health Insurance Regime: The authority should consider an executive bill for the amendment of the NHIAA to include punishment and sanctions for failure to comply with the compulsory health insurance regime. The Council when established should consider imposing administrative sanctions for non-compliance with the compulsory health insurance regime.

(c) Massive Enlightenment and Sensitisation: To deepen health insurance coverage, the Authority should actively engage in public awareness and education on the establishment and benefits of the new health insurance regime. Scaling up citizens' sensitization on the benefits of health insurance is an approach that possesses the potential of improving health insurance coverage across the Federation. This would in turn edge Nigeria closer to attaining UHC. Key stakeholders to be engage will include professional associations, organized private sector, civil society organisations, faith based groups, women's groups, youth groups, market and artisanal associations, cooperatives, etc. Various media platforms including print, electronic, social and digital media should be used for this purpose. Physical and online meetings, workshops, town halls, etc., should be used.

(d) Operationalize State Health Insurance and Contributory Schemes: The Authority should use its good office at the national forum of health insurance schemes to urge states to operationalize their schemes. Key issues for operationalization include the est5ablishment of council or management boards of the health insurance agencies; commencement of contributions by formal sector employers and employees; informal sector schemes, etc. This advocacy can also be done at the Nigeria Governor's Forum and through the National Council on Health comprising the Minister of Health and all state Commissioners for Health. The Authority should consider the establishment of a benchmarking mechanism that will annually

assess the performance of state health insurance schemes and rank them in accordance with their performance. This will improve the efficiency and effectiveness of their operations.

(e) Operationalize the Vulnerable Group Fund: In accordance with S.25 of the NHIAA, the health insurance levy, being a component of the VGF, should be imposed. FGN should earmark a percentage of the taxes on tobacco, alcohol, harmful environmental pollutants, and unhealthy foods as Sin Taxes to generate revenue for health as follows: 5% on Alcohol Tax; 20% on Tobacco Tax; 3 kobo/second on all phone calls; 0.5% of Companies Income Tax (CIT). The Sugar Tax should also be dedicated to the health sector. This can be achieved through the Finance Act of 2022. Provision should also be made for the special intervention fund in the 2023 Appropriation Act.

(f) Establish and Continually Update a Database of Vulnerable Persons: The Authority, in collaboration with the states and relevant federal agencies (including National Population Commission, National Bureau of Statistics, Ministry of Humanitarian Affairs, Ministry of Health,[32] etc.) should maintain a database of vulnerable persons. This database should be continually updated by including new entrants and expunging listed persons who have exited the category.

(g) Contributions by Federal Employees: The formal sector health insurance schemes are designed as contributory schemes involving percentage contributions by employers and employees. The Authority and relevant institutions including the Ministry of Labour should engage organized labour in dialogue to reach a settlement on the exact percentage contribution by workers while FGN continues its contributions as the employer. This will increase the fund available to the scheme and facilitate the improvement of the quality of service delivery.

(h) Improve Accountability and Transparency: NHIAA should host a single internet portal that shall serve as a primary and definitive source of all information, containing and displaying all relevant (financial, governance, etc.) health insurance information at all times. It should also facilitate the creation of a Coalition of Health Insurance Advocacy Groups and ensure full involvement of Independent Health Insurance Advocacy Groups and Watchdogs in their operations.

(i) Funding the Basic Health Care Provision Fund: FGN should ensure that the funding of the BHCPF meets the statutory provision of not less than 1% of the CRF and this should be provided as a statutory transfer, instead of being a service-wide vote or just a mere vote under the Ministry of Health. The BHCPF is a ring-fenced fund that should be fully released and utilized and if for any reason, it is not fully utilized in any given year, the unutilized remainder should be rolled over and combined with the next year's appropriation. The votes in the BHCPF cannot lapse by effluxion of time considering that the health challenges it is meant to address still subsist. MDA bureaucracy and absorptive capacity deficits should not deny citizens of their right to access health care services.

[32] Through the Health Information Management System.