IMPROVING THE IMPLEMENTATION OF THE SOKOTO STATE HEALTH INSURANCE SCHEME

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ABBREVIATIONS

BHCPF	Basic Health Care Provision Fund
CRF	Consolidated Revenue Fund
EHP	Equity Health Plan
EPO	Exclusive Provider Organization
MHA	Mutual Health Associations
NHA	National Health Act
HMO	Health Maintenance Organization
NHIA	National Health Insurance Authority
NHIS	National Health Insurance Scheme
PHC	Primary Healthcare
PPO	Preferred Provider Organization
POF	Point of Service
SDG	Sustainable Development Goals
SOCHEMA	Sokoto Contributory Health Management Scheme
SPHCDA	Sokoto Primary Health Care Development Agency
TPA	Third Party Administrator
UHC	Universal Health Coverage

EXECUTIVE SUMMARY

This Policy Brief engaged the Sokoto State Health Insurance 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 SOCHEMA and section 6 analyzed the linkage between the new National Health Insurance Authority Act (NHIA) and the law setting up SOCHEMA. Section 7 reviewed the performance of the State in accessing the Basic Health Care Provision Fund (BHCPF) while section 8 reviewed the funding of SOCHEMA. In the penultimate section, it draws conclusions from the earlier sections. The tenth section is the strategies and recommendations for improving health insurance coverage in Sokoto which are summarized as follows.

- **Effective Implementation of Compulsory Health Insurance Coverage** **(a)** The political leadership should activate the Scheme by commencing the remittance of 10 percent of their monthly basic salary as required by Law; **(b)** Negotiate with Organized Labor and commence the remittance of the 15 percent of worker's basic salaries (10 percent by Employer and 5 percent by Employee) as required by Law; **(c)** Start budgeting and fully releasing to SOCHEMA the one percent of Consolidated Revenue Fund of the State and Local Governments as required by Law and; **(d)** The Scheme should set realistic and realizable targets and timelines for its full implementation.

- **Take steps to Implement the Recommendations to Sokoto 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 Sokoto State (see page 159 of the report), they include (but not limited to): **(a)** Completing all required trainings, establishing the health facility management committees, and regularizing the primary health facility bank accounts in all wards so that facilities can commence accessing BHCPF; **(b)** Provision of equity funds for the NHIS gateway of the BHCPF; conduct the quarterly gateway forum meetings of the SPHCDA and the SOCHEMA to strengthen the BHCPF implementation.

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

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

- **Reduce the Bottlenecks of Registering and enrolling under the Scheme.**
- **Improve and Optimize the Expected Benefits of Health Insurance Coverage to retain enrollees.**
- **Ensure Transparency and Accountability in the Scheme.**
- **Deploy the Best Human Resources in the Management of SOCHEMA.**
- **Provide Incentives for Compliance by Enrollees and other Stakeholders.**
- **Reduce Extreme Poverty and Restructure the Economy for Productivity and Value Addition.**

1. INTRODUCTION

1.1 What is Health Insurance?

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

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

It is imperative to distinguish between health insurance and publicly funded healthcare system which provides coverage for every citizen or resident under a free healthcare program. For instance, healthcare services available to indigent and poor persons under the Basic Health Care Provision Fund (BHCPF) under S.11 of the National Health Act (NHA) are not based on any premiums paid by the beneficiary, but are funded through the statutory 1 percent of the

[1] https://en.wikipedia.org/wiki/Health_insurance
[2] Supra.
[3] See https://www.britannica.com/topic/health-insurance

Consolidated Revenue Fund of the Federal Government.[4] This is also the status of the Equity Fund created by S.19 (1) (e) of the Sokoto State Contributory Health Care Management Agency (SOCHEMA) 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 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

[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/

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.

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 broadens the horizon for improvement of health outcomes thereby edging a nation closer to attaining UHC. There are three interrelated components of UHC[7]: The relate to comprehensiveness, quality and affordability.

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

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

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

The foregoing components are linked to the cardinal parameters necessary for the enjoyment of the right to the highest attainable standard of physical and mental care. These parameters are availability of functional health care facilities, services and goods; accessibility which

[6] See WHO website https://www.who.int/health-topics/universal-health-coverage#tab=tab_1
[7] See https://elibrary.worldbank.org/doi/10.1596/978-1-4648-0297-3_ch1 ; see also https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4541093/

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 coverage[9] :

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

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

4. REASONS FOR MAKING HEALTH INSURANCE UNIVERSAL AND COMPULSORY

Already, two relevant legislation vis the National Health Insurance Authority Act (S.14) and SOCHEMA Law (S.10) 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.

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[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

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

(a) To Achieve Universal Health Coverage: UHC connotes availability of health care services for all, especially the poorest segment of the society. Its goal, as laid out by the United Nations General Assembly (UNGA), is "*to promote physical and mental health and well-being and to extend life expectancy for everyone … thus leaving no one behind".*[11] Making health insurance universal and mandatory for everyone ensures that this goal is achieved.

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 is another key objective of making health care universal. It is one of the critical hallmarks of health accessibility. Health financing policy impacts financial protection directly. Financial protection works by ensuring that payments made to obtain health care services do not expose people to financial difficulty and do not threaten living standards. Necessary for this to work is the collection of premium payments so as to pool funds for health care provision instead of relying on out-of-pocket payments for health care services at the time of use. Nigeria's out of pocket expenditure on health is one of the highest in the world and has been stated by the World Bank at 70.52 percent. This is in contrast to the Sub-Saharan Africa average of 29.98 percent[12].

(c) Equity in Financing Health Care: 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 Sokoto 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 goods and the less privileged.

(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

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

government or citizens. Healthy insurance expands the pool of available resources and walks the talk of domestic resource mobilization.

(e) To Reduce the Financial Burden on the Government: 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.

(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 15percent of budget target as required in the Abuja Declaration. Furthermore, the appropriated votes are not fully released and the released sums sometimes do not get fully utilized. Thus, the budget figures do not provide credible evidence of expenditure. Oftentimes, this is based on poor revenue forecasting. Health insurance funds on the other hand are predictable and promises of services will not be bugged down by claims of lack of resources. Policy implementation can proceed as planned and sustainability will be built into the system.

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

(h) Building Block for a Vibrant and Healthy Population: Health care coverage ensures that everyone gets the health care needs they require and at the time they require it thereby improving the overall health of a people. This is an advantage of pursuing UHC as opposed to leaving health expenditure to out-of-pocket payments by citizens.

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

(j) To Reduce Inequality and Uplift the Low Strata of the Society: Health insurance provides a veritable tool for reduction of inequality as it offers affordable health care services to every class of the society in so far as they are able to pay the premium. Access to decent

health care is made available to the lower class of the society given their enrolment into the system. 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 SOKOTO STATE CONTRIBUTORY HEALTH CARE MANAGEMENT AGENCY (SOCHEMA) LAW

This section highlights the salient provisions in the law that provided for the establishment of SOCHEMA. S. 3 of the Law established the SOCHEMA as a corporate body with perpetual succession and a common seal. Section 4 provides for the establishment of SOCHEMA's Governing Board to be appointed by the Governor of the state to manage the affairs of the Agency. Board members' tenure 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: approve standards, rules and guidelines for the management of Contributory Health Care Scheme under the Law; approve for the Agency all the paid schemes and private health plans of Health Maintenance Organizations (HMOs) and Third Party Administrators (TPAs).

S.10 establishes the Sokoto State Contributory Healthcare Management Scheme which is mandatory for all residents of the state covering all employees in the public, private and informal sectors whose monthly income is not less than the national minimum wage and Who are not covered by the National Health Insurance Scheme.

S.11 Components of the Scheme provides as follows:

(1) The Scheme shall comprise initially of 5 components:

(a) The Sokoto State Health Plan (SKSHP) - The plan shall consist of a basic, defined Minimum Benefit Package of healthcare services for Primary Care as well as an affordable Supplementary Benefit Package of healthcare services for Secondary and Tertiary Care and will be accessible from both Public and Private Primary Health Care Facilities who shall refer if necessary to designated secondary and tertiary health facilities.

(b) The Formal Health Plan - This shall be a contributory plan for all Students of educational institutions, public and private formal sector employees wherein the employer and employees shall make contributions as determined by the Board;

(c) The Informal Health Plan (IHP)- This shall be an affordable program providing access to health services at uniform contribution accessible at grassroots;

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

(e) The Equity Health Plan - This shall be a package providing health care services for the vulnerable groups and shall be funded from the Equity Fund; and

(f) any other component as maybe developed by the Agency with the approval of the Board.

(2) All residents in the formal or informal sector must possess evidence of being covered by the Scheme.

Component 2 of the scheme makes a weighty provision as it mandates all citizens and inhabitants of the state to have health care coverage. Implementation of this provision is critical for UHC. Also, the implementation of the Equity Health Plan for vulnerable groups who cannot afford to pay premium is imperative to cover the poorest of the poor.

S.12: Objectives of the Scheme

The objectives of the Scheme are to:

a) *ensure that every resident of Sokoto State has quality health care services;*
b) *ensure that all residents of Sokoto State have access to effective, quality and affordable services;*
c) *protect families from the financial hardship of huge medical bills;*
d) *limit the inflationary rise in the cost of healthcare services;*
e) *ensure equitable distribution of health care costs across different income groups;*
f) *maintain high standard of health care delivery services within the Health Sector;*
g) *improve and harness private sector participation in the provision of health care services;*
h) *ensure adequate distribution of health facilities within the State;*
i) *ensure appropriate patronage at all levels of the health care delivery system; and*
j) *ensure the availability of alternate sources of funding to the health sector for improved services.*

Sections 13 and 14 provides for the functions and power of the SOCHEMA respectively, in the administration health insurance in the State. The functions include but not limited to: effective implementation of policies and procedures of the Scheme; registering NHIS

accredited HMOs, TPAs, MHA and healthcare facilities; awareness creation; establishing quality assurance; definition of benefit packages; approval of contracts; collection, collation, analysis and reporting on monthly and quarterly returns from the HMOs, TPAs and the Mutual Health Associations (MHAs).

The broad powers include regulation, implementation and issuance of guidelines for registration of employers and employees liable to contribute under the Law; the registration of dependent or employees covered by the Agency; the nature, amount of capitation, fee for service and other payment options under the Scheme; negotiation of fees and charges payable for services under the scheme, procedure and method of assessment and receiving of contributions, etc.

S.19 provides for the establishment of the Fund:

> *There is created the Sokoto State Health Fund (SKSHF) (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 Sokoto State Government;*
>
> *(b) Formal Sector Fund; comprising of contributions from students, public and private sector employers who shall contribute 10% and employees shall contribute not more than 5% of the monthly basic salary;*
>
> *(c) contributions of not more than 10% of monthly basic salaries of all elected and political office holders in the State; (d) contributions from the informal sector;*
>
> *(e) Equity Fund; comprising of contributions of not less than 2% of Consolidated Revenue Fund of the Sokoto State Government, 1% of Consolidated Revenue Fund of not less than 1% of the Local Government Councils, funds from NHIS for pregnant women, children under-five (5) years and other relevant programs; funds from NHIS and National Primary Health Care Development Agency (NPHCDA) for guaranteeing a minimum health package, donations or Grants-in-Aid from private Organisations, philanthropists, Zakat and Waqf, International Donor Organizations and Non-Governmental Organizations from time to time;*
>
> *(f) such money as may be due from HMOs; and subsidy remitted from Private Health Plan; (g) fines and commissions charged by the Agency; (h) other appropriations earmarked by the Federal, State and Local Governments purposely for the implementation of the Scheme;*
>
> *(i) funds as may be approved from the Sokoto State Primary Health Care Development Agency (SPHCDA), from the National Primary Healthcare Development Agency (NPHCDA) for the Community Based Health Plan (CBHP) and other relevant programs;*

(j) dividends on investments and stocks; (k) contribution of 1% levy of State and Local Governments capital projects; and (l) all other monies which may, from time to time, accrue to the Agency.

The inclusion of students in (2) (b) above seems to be hanging as they are not in the same category with public and private sector employers and employees. This needs to be expunged. The provision in (2) (e) on the percentage of Consolidated Revenue Fund contribution by the State and Local Governments is not clear. It appears to be 2 percent by the State Government and 1 percent by Local Governments. This needs to be clarified.

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

The NHIA was enacted in 2021, to repeal the National Health Insurance Scheme Act (2004), to ensure an effective implementation of the National Health Insurance Policy that would ensure the attainment of UHC in Nigeria. S. 1 establishes the National Health Insurance Authority 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 residents;
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.

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. On the other hand, S. 10 and S.11 (2) of the SOCHEMA Law 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 Sokoto State. What needs to be done is the full implementation of the provisions of the NHIA Act at the federal level and the SOCHEMA Law in Sokoto 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. The Sokoto State Health Plan (SKSHP), one of the components of the State Health Insurance Scheme under S. 11 (a) of the SOCHEMA Law, defined the State's Minimum Benefit Package of health care for Primary Care and an "affordable" supplementary benefit package of health care for both Secondary and Tertiary health facilities. This shows a concordance in both legislations as to there being a need for a defined basic minimum health package for citizens.

Regarding the governing body, S. 4 of the NHIA Act provides for the establishment of a Governing Council to guide the operations of the Authority. Members have an initial tenure of four (4) years which can be renewed making a maximum of two (2) tenures of service. S. 4 of the SOCHEMA law provides for a Governing board to run the affairs of the Scheme with exact same tenure of service as in the NHIA Act.

S. 13 (2) of the NHIA provides for the implementation of the basic minimum package of healthcare under the NHA across the Federation while S.13 (8) enjoins states to access the BHCPF through their health insurance and contributory schemes. 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.[15] The BHCPF is to be funded via: 1% of the Consolidated Revenue Fund of the Federal Government; grants by international donor partners; and lastly, other funding sources. S. 13 (q and r) of the SOCHEMA Law in providing for the functions of Agency[16] gives the responsibility of implementing the minimum packages of health services to be provided to the SOCHEMA.

7. STATUS UPDATE ON PRIMARY HEALTH CARE (PHC) SERVICE DELIVERY AND THE BASIC HEALTH CARE PROVISION FUND

PHC is the first point of contact of the 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 findings of the assessment for Sokoto State are given below:

> *"Sokoto State has attained full capacity to utilise BHCPF disbursements from the NPHCDA and NHIS gateways. All eligible PHCs are however not receiving and retiring funds for the NPHCDA gateway, and the state has failed to provide either its counterpart or its equity funding for the NHIS gateway. The state has not sent reports*

[15] See https://www.globalfinancingfacility.org/sites/gff_new/GFF-Annual-report/nigeria.html
[16] That is SOCHEMA
[17] The report was published by One Campaign, in partnership with National Advocates for Health (N4H), Nigeria Health Watch, Public and Private Development Centre (PPDC) and Corona Management Systems (CMS), with technical support from the World Bank/International Finance Corporation (IFC) and the United Kingdom (UK) Foreign, Commonwealth, and Development Office (FCDO). The Presidential Reform Committee on Basic Health Care Provision Fund (BHCPF) led by the Bureau for Public Sector Reforms (BPSR) also provided steering leadership on the specific aspects of the assessment.
[18] You can access the report via www.sphcn.ng; see pages 8 and 9.

of any gateway forum and SOC meetings from Q4 2021 to NHIS and the State does not have a formal sector health insurance scheme".

The study also presented details of its findings on the various indicators. For instance, it reported that the State has laws and policies on health insurance and other laws for the implementation of the NHA. Also, it presented findings on the various health indicators and state of PHC facilities in the State. It is noteworthy that the State scored 41/100 and the assessment made recommendations on what needs to be done for improvement on the implementation status of the BHCPF. The key recommendations from the study for Sokoto State include the following:

- Completing all required trainings, establishing the health facility management committees and regularizing the primary health facility bank accounts in all wards so that facilities can start accessing BHCPF;

- Provision of equity funds for the NHIS gateway of the BHCPF;

- Conduct the quarterly gateway forum meetings of the SPHCDA and the SOCHEMA to strengthen the BHCPF implementation.

8. FUNDING OF SOCHEMA

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

Table 1: Budgeted Expenditure of the Sokoto State Contributory Healthcare Management Agency

Year	Personnel	Overhead	Total Recurrent	Capital	Total Expenditure
2022	9,750,245.00	15,600,000.00	25,350,245.00	400,000,000.00	425,350,245.00
2021	14,750,245.00	18,000,000.00	32,750,245.00	100,000,000.00	132,750,245.00
2020	14,750,245.00	20,000,000.00	34,750,245.00	20,000,000.00	54,750,245.00
2019	49,750,245.00	20,000,000.00	69,750,245.00	200,000,000.00	269,750,245.00
2018	49,750,245.00	15,000,000.00	64,750,245.00	200,000,000.00	264,750,245.00
TOTAL	138,751,225.00	88,600,000.00	227,351,225.00	920,000,000.00	1,147,351,225.00

Source: Sokoto State Budgets

Table 1 shows a total vote of N1.147billion over the five years. The highest vote was in the year 2022 while the least vote was allocated in the year 2020. Capital votes constitute the bulk of the appropriation, being 80.1% of the votes. The basis of these budget votes is not clear considering that S.19 (2) (e) of SOCHEMA Law requires inter alia, an Equity Fund comprising of contributions of not less than 2 percent of the Consolidated Revenue Fund of Sokoto State Government and 1 percent of the Consolidated Revenue Fund of Local Government Councils, etc. By S.19 (2) (k), the Sokoto State Health Fund includes a further component of 1 percent levy of State and Local Government capital projects. It

is not clear whether the appropriated sums constitute 1% of the CRF of the State and Local Governments 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 SOCHEMA, the Sokoto State Health Fund also consists of initial take off grant from the State Government, formal sector funds consisting of contributions from public and private sector employees and employers, contributions of not more than 10% of monthly basic salaries of all elected and political office holders in the state. It is not yet clear which of these different funds has become functional through the budget.

Table 2: Actual Expenditure of the Sokoto State Contributory Health Care Management Agency

Year	Personnel	Overhead	Total Recurrent	Capital	Total Expenditure
2021	0.00	2,085,800.00	2,085,800.00	0.00	2,085,800.00
2020	14,750,245.00	20,000,000.00	34,750,245.00	0.00	34,750,245.00
2019	0.00	0.00	0.00	100,000,000.00	100,000,000.00
2018	0.00	0.00	0.00	0.00	
TOTAL	14,750,245.00	22,085,800.00	36,836,045.00	100,000,000.00	136,836,045.00

Source: Sokoto State Budgets

*2021 figure is for the actuals from January – June
*2019 figure is for the actuals from January – September

From Table 2, no funds were released in 2018. 2019 got 37% releases. In 2020, 63.47% of budgeted sums were released. In 2021, it came down to 1.57% while the releases for 2022 are not yet available. Evidently, the appropriation and releases need more credibility. SOCHEMA needs more funds to meet its goals 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 Sokoto 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.[19] Reducing Nigeria's and Sokoto 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 SOCHEMA law will be a major first step towards improving health insurance coverage.

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

- The 15 percent of monthly basic salary contribution from public and private sector employers and employees has commenced.
- Elected and political office holders have started remitting 10 percent of their monthly basic salary to the Scheme.
- Contributions from the informal sector has commenced.
- 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[20]. 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 rural residents to the urban resident. 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 Sokoto State:

10.1 Effective Implementation of Compulsory Health Insurance Coverage

It is commendable that Nigeria has made health insurance coverage mandatory for all. S. 11 (2) of the SOCHEMA Law made the same provision. One of the key factors required for

[19] 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

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

SOCHEMA to yield the desired result is political will and the resolve to make the system work on the part of stakeholders.

(a) The political leadership should activate the Scheme by commencing the remittance of 10 percent of their monthly basic salary as required by Law.

(b) Negotiate with Organized Labor and commence the remittance of the 15 percent of worker's basic salaries (10 percent by Employer and 5 percent by Employee) as required by Law.

(c) Start budgeting and fully releasing to SOCHEMA the 1 percent of Consolidated Revenue Fund of the State and Local Governments and the contribution of 1 percent levy of State and Local Government capital projects as required by Law.

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

10.2 Take steps to Implement the Recommendations to Sokoto 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 Sokoto State (see page 159 of the report), they include (but not limited to):

(a) Completing all required trainings, establishing the health facility management committees, and regularizing the primary health facility bank accounts in all wards so that facilities can commence accessing BHCPF.

(b) Provision of equity funds for the NHIS gateway of the BHCPF; conduct the quarterly gateway forum meetings of the SPHCDA and the SOCHEMA to strengthen the BHCPF implementation.

10.3 Sensitization on the Benefits of Health Coverage

To deepen health insurance coverage, SOCHEMA has to actively engage in carrying out public awareness and education on the establishment and management of the Scheme as provided in S.13 (f) of the Law. Scaling up citizens' sensitization on the benefits of health care coverage is an approach that possesses the potential of improving health insurance coverage in Sokoto 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 Sokoto State closer to attaining UHC.

10.4 Simplify the Cost-Benefit Analysis of Health Insurance Plans

Further to the last recommendation and for ease of comparison by prospective enrollees, simplifying the comparison of the costs and benefits of health insurance plans can help

citizens to understand better which plan to go for.[21] 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.

10.5 Reduce the Bottlenecks of Registering under the Scheme

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

10.6 Improve and Optimize the Expected Benefits of Health Insurance Coverage

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[22] 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 SOCHEMA.

10.7 Ensure Transparency and Accountability

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

10.8 Deploy the Best Human Resources in the Management of SOCHEMA

SOCHEMA 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.

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

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

10.9 Provide Incentives for Compliance

The regulations and guidelines to be enacted by SOCHEMA should boost enrolment and participation in the Scheme through incentives. The incentives may be financial for early enrolment and payment pf premiums or recognitions for good performance across communities and social groups.

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

The World Bank estimates that 95.1million Nigerians would be below the poverty line by the end of 2022, from the current value of over 80 million people.[23] 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 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.

[23] 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

ORGANISATIONS THAT VALIDATED THE MEMORANDUM