# HEALTH SECTOR REFORM AGENDA FOR THE BOLA AHMED TINUBU ADMINISTRATION

## (Proposed by Centre for Social Justice)

CSJ

Centre for Social Justice

# Table of Contents

## Abbreviations

| | |
|---|---|
| BHCPF | Basic Health Care Provisions Fund |
| CRF | Consolidated Revenue Fund |
| FGN | Federal Government of Nigeria |
| HMOs | Health Maintenance Organisations |
| NEITI | Nigeria Extractive Industries Transparency Initiative |
| NHA | National Health Act |
| NHIA | National Health Insurance Authority |
| NHIAA | National Health Insurance Authority Act |
| NPHCDA | National Primary Health Care Development Agency |
| NSR | National Social Register |
| PMS | Premium Motor Spirit |
| S. | Section |
| SHI | Social Health Insurance |
| UHC | Universal Health Coverage |
| USD | United States Dollar |
| VAT | Value Added Tax |
| WHO | World Health Organisation |

# 1. CRITICAL CHALLENGES

## 1.1 Rising Inflation

High inflation driven inter alia by high levels of ways and means financing, insecurity preventing farmers from working on their farms, increase in energy prices in PMS and electricity, previous multiple exchange rates and exchange rate depreciation. This has definitely impacted negatively on the health sector. What are the demands of the sector to ensure that resources available to it keep pace with the inflationary spiral?

## 1.2 Fuel Subsidy Removal

FGN has removed fuel subsidy and it is projected that N3.9trillion will be saved in 2023 and over N21trillion between 2023 and 2025.[1] The Nigeria Extractive Industries Transparency Initiative (NEITI) reports that N13.7trillion has been spent on fuel subsidy in the last 15 years. The reform comes with its downsides and upsides. The World Bank states that over 4million Nigerians were forced into poverty from January to June and about 7million more will descend into poverty if nothing is done to hedge the free fall.

The price of PMS touches virtually everything including transportation, food, education, health, artisanal services, etc.

There is a presidential request, which has now been approved by the National Assembly for the sum of N500billion for palliatives. The details of the proposed expenditure are not yet in the public domain. So, what should the health sector ask for or should we watch and be excluded or take whatever crumbs is thrown at us?

## 1.3 Exchange Rate Unification

FGN has unified the exchange rate and this has positives and downsides. In the positives, more money will be available for sharing by the three tiers of government from foreign currency proceeds like the sale of crude oil. Nigerian exporters will earn more and will be encouraged to repatriate their proceeds and this will boost export proceeds. Foreign direct investment as well as portfolio investment will receive a boost considering that investors can now more easily repatriate their profits. On the downside will be increase in the naira value of foreign debts which will require more public funds for servicing and repayment. Considering that we are an import dependent economy, inflation will increase from the price of goods and services imported into the country. There will be an immediate increased demand for foreign exchange supply considering the backlog of unmet foreign exchange demands and associated obligations as well as estimates of future foreign exchange demand for the years ahead. Therefore, there is the danger of the market facilitating a free fall of the naira, that will depreciate the currency to unexpected levels, fuel aggravated price instability, inflation and uncertainty in the economy. In the interim, the naira has

[1] Nigeria Development Update of the World Bank, June 2023 at page 31.

suffered a devaluation of over 40 percent following the unification. The official rate has moved from about N450 to N770 to the USD

The challenge is to take steps to increase the positives while minimizing the downside effects on the health sector. Thus, how should the health sector respond to the downsides of the unification and how can we take advantage of the upsides of the unification? For instance:

- Drugs, medicines and the cost of human resources for health have become more expensive, how do we ensure that the poorest of the poor who access health services through out of pocket expenditure access services?

- It will now be more costly for naira earners to buy tickets denominated in foreign currency and pay bills for medical tourism. What alternatives in terms of good, quality, efficient and effective medical services are we making available to this crop of Nigerians?

**1.4 Poor Funding of the Sector**

The poor public funding of the health sector, population increase that outpaces economic growth, and the fiscal crisis have all combined to guarantee poor health indicators and out-of-pocket health expenditure of 70.52%, the highest in Sub Saharan Africa. However, in this scenario, the Federal Ministry of Health is still saddled with poor absorptive capacity, unable to fully utilize its meagre budgetary allocations (of about 4.982% of the federal budget in the last five years) and experiencing procurement challenges leading to a point where its procurement function was transferred to the Federal Ministry of Agriculture.

Considering the critical nature of the sector, it should attract non budgetary funds through incentives to the private sector to provide additional resources to the sector. Furthermore, there are other public resources that can be tapped to increase the funding of the sector such as constituency project funds of legislators.

**1.5 National Health Insurance Authority Act**

Full implementation of the National Health Insurance Authority Act 2022 (NHIAA) to reduce the high-level out-of-pocket health expenditure in Nigeria while moving towards Universal Health Coverage (UHC) is imperative. The high out-of-pocket expenditure (in a country with 63% of the population in multi-dimensional poverty) has hindered the attainment of the goals of UHC - to ensure that all people have access to 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.

The NHIAA has made health insurance mandatory for every resident of Nigeria and seeks to pool funds for the realization of UHC. It also provides for social health

insurance (SHI) including the Vulnerable Group Fund (VGF). Implementing the NHIA Act will create a large pool of funds for the realization of the right to the highest attainable standard of physical and mental health. Nigeria has produced a National Social Register documenting the poor and vulnerable households. All persons on this register should access SHI medical access not linked to payment of premiums. The NHIA acts as a Health Maintenance Organisation (HMO) for the federal civil service thereby making the NHIA both a regulator and a player in the same industry.

### 1.6 Basic Health Care Provision Fund

By the current BHCPF under the National Health Act, 45% of the fund goes for primary healthcare through the National Primary Health Care Development Agency (NPHCDA) via the "NPHCDA Gateway".[2] And the NHIAA collaborating with state health insurance/contributory health agencies has started implementing the SHI programme across the states of the Federation. Furthermore, the implementation of the entire BHCPF is shrouded in secrecy without publication of allocations to states (unlike the Universal Basic Education scheme) and public audits of showing how funds have been disbursed and managed.

### 1.7 Accountability

Overall, the public accountability and engagement mechanisms in the health sector have not been fully engaged. S.2 (2) (d) of the NHA mandates the minister to ensure the preparation and presentation of an annual report on the state of health of Nigerians and the National Health System to the President and National Assembly. Simply put, this is a report to Nigerians which should be in the public domain and vigorously discussed and interrogated.

Furthermore, unlike the public finance management space where there are peer review and benchmarking exercises, the health sector has none. This has impeded the meeting of strategic targets.

### 1.8 Health Infrastructure

Health infrastructure funding and upgrades are suboptimal and Nigeria is reported to lose up to $1billion annually in health tourism to advanced counties. Considering that Nigeria is exporting health professions, health tourism is facilitated by inadequate domestic health equipment, facilities and infrastructure. There have been recommendations for public private partnerships, viability gap funding, interventions by Nigerian Sovereign Investment Authority, Bank of Industry, Development Bank of Nigeria, etc. While these are good as interim measures, they may not provide long term solutions to the equipment and infrastructure crisis in the sector.

[2] This is for the provision of essential drugs, vaccines and consumables for eligible primary health care facilities (20%), the provision and maintenance of facilities, laboratory, equipment and transport for eligible primary health care facilities (15%) and the development of Human Resources for Primary Health Care (10%).

**1.9 Human Resources for Health: Sectoral Brain Drain:** Nigeria's health professionals (doctors, pharmacists, nurses and other allied professionals) to patient ratio is low and has contributed significantly to the low-quality health services delivered in the country. For instance, Nigeria requires additional 149,700 doctors to achieve the 1 doctor to 1000 patients' ratio. The total approved training capacity for 42 medical schools is 3,650. The human resources challenge is compounded by high emigration levels as high numbers of health workers migrate abroad seeking better conditions of work and remuneration.

## 2.. RECOMMENDATIONS

### 2.1 Palliative Measures for the Sector

**(a)** As a palliative measure from fuel subsidy savings, increase resources to social health insurance to ensure that all persons on the National Social Register (15.7million households and over 60million individuals) have access to healthcare not anchored on payment of premium.

**(b)** To enhance process transparency, the NSR should be continually updated and cleaned to take out deceased persons, previously poor but who have now left that category and include new persons who have recently fallen into the category. The criteria for enrolling persons unto the Register should be made public.

### 2.2 Improve Resources for the BHCPF

**(a)** To further provide funds for SHI to cover all on the National Social Register, two options are (1) increase the BHCPF to 2 percent of the Consolidated Revenue Fund of the Federal Government and (2) to set aside 2% of Federation Account revenues for social health insurance. The first option puts more pressure on the fiscal resources of FGN while the second is preferred because the current BHCPF is a grant from FGN to the states. It is therefore important that befitting states join FGN and begin to make contributions to the health security of their people. This second option will guarantee greater funding for SHI schemes because most states who have provided for 1% (or more) of their CRF for SHI have not been releasing the funds as required by their respective laws. Essentially, the continuation of one percent from the federal CRF and one percent of Federation Account is proposed.

**(b)** FGN should immediately activate the Vulnerable Group Fund to be combined with other revenue sources to finance access to health care to all persons on the National Social Register through the social health insurance programme.

**(c)** Legislators at the federal and state levels should be encouraged to invest their constituency projects funds in purchasing health insurance for their vulnerable constituents.

**(d)** Provide tax concessions and or make contributions by private sector companies to the BHCPF tax deductible.

**(e)** Considering that the increased taxes on Cigarettes, Tobacco and Alcoholic beverages and the Sugar tax are justified by reference to the health dangers of (over) consumption, it is pertinent that the accruing revenue be targeted to the health sector especially, the Vulnerable Group Fund to be used in paying the premiums of the poorest of the poor and vulnerable.

**(f)** It is imperative over the medium term to increase taxes on alcohol and tobacco to the West African average of 50%. It is projected that alcohol, tobacco and sugar taxes can yield up to 1% of the GDP to be dedicated to the health sector.[3]

### 2.3 Optimise Service Delivery under the BHCPF

Amend the National Health Act and reform the Guidelines for the utilization of the Basic Health Care Provision Fund so that not less than 90% is dedicated to service delivery on basic minimum package for the poorest of the poor.

### 2.4 Functionalize the NHIAA and the Compulsory Health Insurance Regime

**(a)** The President should constitute the Governing Council of the Board of National Health Insurance Authority.

**(b)** The Governing Council should take policy steps to ensure that the mandatory health insurance scheme is activated viz, policy frameworks, implementation strategies, sensitization, education, awareness creation and sanctions.

**(c)** The NHIA Act should be amended to provide sanctions for no compliance. In the interim, the Governing Council should enact subsidiary legislation to impose penalties for non-compliance.

**(d)** NHIA and State Health Insurance/Contributory Health schemes should liaise with the relevant stakeholders including tax and licensing authorities to devise and activate enforcement mechanisms at the next stage of the campaign for universal health insurance coverage. The yearly premiums could be collected as a tax from formal sector workers while strategies are devised for engaging the informal sector. A regime of fully implemented compulsory health insurance would raise not less than N1.169trillion in additional premium revenue for the health sector.[4]

**(e)** VAT should be removed from health insurance premia for affordability of payment by enrollees.

---

[3] Report of the Presidential Heath Reform Committee at page 27.

[4] The National Bureau of Statistics puts the 2020 Q2 working population at 116,871,186. With current employment rate at 66.7%; 66.7% of 116,871,186= 77,953,081 vis unemployment rate at 33.3%. A minimum premium of N15,000 per person per year of the working population will generate this sum.

(f) NHIA should focus on its core role of regulating the sector and the federal civil service should set up its own HMO or in the alternative use the services of existing private sector HMOs.

**2.5 Budget and Procurement Reform: Improving Absorptive Capacity, Value for Money, etc.**

**(a)** Adopt a performance-based budgeting approach for the sector focusing on targets set in the Sustainable Development Goals, National Health Policy, National Strategic Health Development Plan, National Health Act, etc.[5]

**(b)** Ensure the preparation of medium-term sector strategies by a sector team including the health ministry and its agencies, private sector, civil society, professionals and organized labour.

**(c)** Harmonise the budgets and procurement activities of the FMOH with that of development partners and donors to avoid waste, duplication and poor implementation of capital components of federal and state budgets. Governments should no longer make provisions for services already paid for by donors.

**(d)** Public procurement capacity building for the Federal Ministry of Health to ensure improvements in absorptive capacity of the Ministry to fully utilize all released funds through the procurement process. Apply administrative and criminal sanctions where clear cases of deliberate default/mischief are established.

**2.6 Transparency and Accountability**

**(a)** Ensure that the Minister of Health prepares and presents the Annual Report on the State of Health of Nigerians and the National Health System to the President and National Assembly.

**(b)** Introduce transparency into the management of the BHCPF through regular publications and public access to information on approved institutions rendering service, disbursements, expenditure, outputs and results and public audit of the fund at the federal and state levels.

**(c)** A peer review and benchmarking exercise focused on strategic targets should be introduced in the sector through collaboration between the National Council on Health, Governors Forum, National Planning Commission, civil society and donors.

**2.7 Health Infrastructure: Establish a Health Development Bank of Nigeria**

Establish a Health Development Bank of Nigeria with a clear mandate of health infrastructure and equipment funding at single digit interest medium- and long-term funding. The critical areas of intervention from the Health Bank shall include support for: (a) state of the art reference hospitals and highly efficient mono-specialty hospitals; (b) facilities upgrade, health supporting infrastructure such as power, clean

[5] Numeric quantifiable targets should be used and incentives for agencies/staff for good performance.

water and sanitation; (c) laboratories, diagnostics equipment, maintenance and infrastructure; (d) information and communications technology connectivity that supports improved health information systems, mobile services and digital health solutions; (e) emerging technologies, and innovative approaches to healthcare delivery including use of drones to supply blood and other health inputs, virtual outpatient platforms, etc; (f) equitable provider payment mechanisms and systems to promote access to health care by creating incentives to improve health service delivery, quality and efficiency; (g) manufacture and production of vaccines and other pharmaceuticals especially to improve upstream research and production, production of intermediaries and active pharmaceutical ingredients and excipients; (h) local manufacturing of health commodities; (i) outsourcing of specialised services and public private partnerships including service level agreements guaranteeing drugs and commodities in a universal health coverage environment (j) promoting low carbon health service delivery infrastructure and climate resilient health facilities leveraging technology and innovation; (k) training and development of critical but unavailable human resource competencies in health including biomedical sciences and engineering; (i) developing health financing advisory services to enhance equity, value for money and fitness of purpose in the health sector. These critical areas of intervention shall include green field and brown field investments provided they are financially viable.

**2.8 Improve the Availability of Human Resources for Health**

**(a)** Increase government investments in medical human resource development to improve the carrying capacity of existing medical and allied training institutions.

**(b)** Consider negotiations and agreements with destination countries of health sector brain drain to invest in health workforce development in Nigeria while streamlining the Health Migration Policy in line with the WHO Code of Practice for International Recruitment of Health Workers.