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NASARAWA STATE 2023 PRE-BUDGET RIGHT TO HEALTH MEMORANDUM

SCALE
STRENGTHENING CIVIC ADVOCACY AND LOCAL ENGAGEMENT

CSJ
Centre for Social Justice

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By

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ACRONYM

AIDS	Acquired Immunodeficiency Syndrome
BCG	bacille Calmette-Guérin Vaccine
BHCPF	Basic Health Care Provision Fund
CSJ	Centre for Social Justice
CSOs	Civil Society Organizations
EHP	Equity Health Plan
FRL	Fiscal Responsibility Law
HBV	Hepatitis B
HCV	Hepatitis C
HIV	Human Immunodeficiency Virus
ITN	Insecticide Treated Net
MSP	Minimum Service package
MSPAN	Multi-Sectoral Plan of Action on Nutrition
MTEF	Medium Term Expenditure Framework
MTSS	Medium Term Sector Strategy
NEDS	Nasarawa Economic Development Strategy
NGN	Nigeria Naira
NHA	National Health Act
NHIA	National Health Insurance Authority Act
NHIS	National Health Insurance Scheme
NHP	National Health Policy 2016
NPHCDA	National Primary Health Care Development Agency
NSHIS	Nasarawa State Health Insurance Scheme
NSPHCDA	Nasarawa State Primary Health Care Development Agency
PHC	Primary Health Care
SDGs	Sustainable Development Goals
SMOH	State Ministry of Health
TB	Tuberculosis
TIHP	Tertiary Institution Health Plan
UHC	Universal Health Coverage
USD	United State Dollars

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EXECUTIVE SUMMARY

This Memorandum is divided into seven sections. Section 1 is the background, provides the rationale for the exercise and reviews key sectoral goals, objectives, targets and strategies. Section 2 reviews Nasarawa State specific health indicators and their implications. Section 3 reviews the health budget commitments of the State including the actuals and their compliance with the Abuja 15% Declaration. It also reviews whether the State has set and costed a Minimum Service Package for PHC and the whole of government and health in all policies approach. Section 4 is on the implementation of the Basic Health Care Provision Fund (BHCPF) in the State while Section 5 reviews the sustainability of the current health care financing model. Section 6 is on the operation of health insurance in Nasarawa State while Section 7 is on recommendations.

The following recommendations for Nasarawa State flow from the review and analysis in this Memorandum.

- Prepare a New Strategic Health Development Plan 2023-2027.
- Prepare a Health MTSS.
- Mainstream the Plan, Policy and Budget Continuum in Health.
- Adopt a Whole-of-Government, Health-in-all Policies Approach.
- Ensure Stakeholder Engagement and Popular Participation in Preparation of MTSS and Annual Budget.
- Adopt a Whole of Society Approach to Health.
- Update and Implement the Minimum Service Package for Primary Health Care.
- Increase Funding to the Sector and Invest in Value for Money.
- Moratorium on New Capital Projects.
- Invest in Transparency and Accountability.
- Prepare and present Annual State of Health Report.
- Ensure Maximum Benefits from BHCPF.
- Full Implementation of NSHIS Law and the National Health Authority Act in the State.

SECTION ONE: INTRODUCTION

1.1 Background

The Nasarawa State Fiscal Responsibility Law (FRL) requires the State Government to prepare the Medium Term Expenditure Framework (MTEF) every year. This is a three year rolling plan containing the macroeconomic framework, fiscal strategy paper, expenditure and revenue framework, consolidated debt statement and statement describing the nature and fiscal significance of contingent liabilities. However, after preparing the MTEF, every Ministry, Department and Agency of the State Government (MDA) is expected to submit its Medium Term Sector Strategy (MTSS), which should focus on the medium term goals of their sectors and will feed into the broad goals of the MTEF. Where the state neither prepares the MTEF nor the MTSS, it still has a constitutional obligation to prepare an annual budget.

Adapting the provisions of the National Health Act (NHA) to Nasarawa State, the State Ministry of Health (SMOH) shall prepare strategic, medium-term health and human resource plan annually for the exercise of its powers and performance of its duties and ensure that this plan shall be the basis of the annual budget estimates for health.[1]

In the Nigerian context, the Centre for Social Justice (CSJ) articulates the principles of good health budgeting as follows:

- Pursue spending policies that are consistent with strategic and high-level health plans and policies and which assures a reasonable degree of stability and predictability;
- Hinge health spending on a whole of government, whole of society, health in all policies approach;
- Mainstream primary health care which is the foundation for secondary and tertiary care;
- Provide an enabling environment and motivate domestic resource mobilization as a step towards Universal Health Coverage (UHC);
- Pursue spending within a definitive macro-economic framework with, at a minimum, medium term horizon and which assures a prudent balance between available resources and planned spending;
- Ensure that the scale and focus of health spending address the prevalent disease

[1] S.2 (2) of the NHA 2014.

conditions found in epidemiological analysis in the State;

- Ensure optimal value for all Government health spending combining the realisation of improved (more) health from already available resources while pushing for more money for health;
- Maintain the integrity of the Health Information Management System;
- Provide full, accurate and timely disclosure of financial information relating to the health activities of the Government and its agencies, that is, ensuring transparency and accountability; and
- Manage health risks faced by the State prudently, having regard to economic, social and other circumstances.

The Health Sector Budget is to be prepared with the Health Sector Envelope contained in the MTEF. It is expected to incorporate the following:

- ❖ Key programs and projects that the Nasarawa State Government will embark upon within the financial year in order to achieve the health goals and objectives as detailed in high level subnational, national and international standards including the National Health Policy, National Strategic Health Development Plan, Sustainable Development Goals (SDGs 3, etc.) and ratified treaties and standards, etc.;
- ❖ Cost and prioritize the identified key programs and projects in a clear and transparent manner;
- ❖ Definite and measurable outcomes of each of the identified programs and projects;

Accordingly, priority programs and projects are to be ranked in accordance with their contribution to the major health thrust of the Nasarawa Economic Development Strategy (NEDS) which is to improve access to quality healthcare and improve the efficiency of the healthcare delivery system, while also delivering a robust disease management system. Furthermore, it should contribute to the National Health Policy's theme of "promoting the health of Nigerians to accelerate socioeconomic development".

1.2 Rationale for the Exercise

The SMOH is required to consult with relevant stakeholders including Civil Society Organizations (CSOs) that work in the Health Sector during the preparation of the annual budget. Therefore, this Memorandum presents the key inputs of CSOs into the 2023 State

Government budget for the health sector. The primary focus is on Primary Health Care (PHC) as an entry point for Universal Health Coverage (UHC).

For Budgets to be effective, they must be based on empirical evidence and in tandem with the plan, policy and budget continuum. Therefore, this exercise provides the opportunity to use evidence garnered by CSJ and other CSO actors and aligned with the minimum core content of the right to health in a bid to implement the minimum core obligations of the state for the progressive realization of the right to health within the ambit of available resources. These state obligations reflected as activities, projects and programs should ensure the respect, protection, facilitation and to a great extent, the fulfillment of the right to health and as such, should prioritize PHC including maternal, new born and child health, preventive care, water, sanitation and hygiene, promotional activities and respect the forward ever obligation in health provisioning - backward steps are not acceptable. The Budget should also be based on a plan for increased domestic resource mobilization and the optimum utilization of all available resources in a more health for money approach.

1.3 Sectoral Goals, Objectives, Targets and Strategies

Health Sector goals and objectives are clearly identified in key high level policy documents such as the National Health Policy 2016 (NHP), SDGs[2], NHA, etc. The National Health Policy 2016 is made with a vision of UHC for all Nigerians and specifically states that its goal is to strengthen Nigeria's Health System, particularly the primary health care sub-system so as to deliver quality, effective, efficient, equitable, accessible, affordable, acceptable and comprehensive health care services to all Nigerians. Nasarawa State has established a Health Insurance Scheme with a key objective of ensuring that every resident of the State has access to good and quality health care.

The NHA establishes a National Health System which is mandated inter alia to provide for persons living in Nigeria the best possible health services within the limits of available resources and to protect, promote and fulfill the right of the people of Nigeria to have access to health care services[3]. It entitles all Nigerians to a basic minimum package of

[2] Targets include: By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births: End preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births: By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases: By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being. They further include: By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programs: Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all: Substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination, etc.
[3] Section 1 (1) (c) and (e) of the NHA.

health services[4]. The NHA further provides in S.11 for the Basic Health Care Provision Fund (BHCPF) with a government annual grant of not less than one percent of the Consolidated Revenue Fund.

The foregoing goals, objectives, targets and strategies reinforce the core values and principles of the NEDS in the field of health. Two key strategies of NEDS are the establishment and refinement of primary healthcare centres and development of framework and policies for healthcare advancement. The major activities are to explore the development of specialised health care centres (such as centres for cardiology, orthopedic, renal dialysis, and cancer issues) with the private sector; to attract medical tourism and position Nasarawa as a hub of healthcare services for the North Central region; systematic renovation of healthcare centres across the state (one per senatorial district, then one per LGA and then wards etc.), with possible public private partnership elements; ensure constant supply of drugs to PHCs and development and operationalization of a comprehensive advocacy plan for health and HIV/AIDS. Others are deployment of a robust monitoring and evaluation framework for the health sector; equitably distribute cost of healthcare amongst different income groups, which would protect families from hardships of huge medical bills; reduce the incidence of diseases through promoting environmental and preventive healthcare (such as sanitation, good nutrition and Immunization), etc.

The Nasarawa State Primary HealthCare Development Agency (NSPHCDA) is established by law with objectives inter alia to fast tract the development of PHC in the State; to ensure easy access to health care services by people in the State at the grassroots level, etc.

SECTION TWO: HEALTH SECTOR INDICATORS AND MAJOR CHALLENGES IN NASARAWA RELATED TO THE MINIMUM CORE OBLIGATION OF THE STATE AND PRIMARY HEALTH CARE

2.1 Health Indicators

The Nasarawa State Health Sector is faced with a number of challenges. Some of the challenges include the poor health indicators in the midst of dwindling financial resources. The National Bureau of Statistics puts Nasarawa State's population at 2.523milion as at 2016.[5] It is estimated that the population comprises of 50.5% male and 49.5% female, the majority of which are between the ages of 15 and 64, which is a relatively young

[4] Section 3 (3) of the NHA.
[5] https://nigerianstat.gov.ng/elibrary/read/474

population.[6] This figure increasing by 2.5% a year would have added not less than half a million persons over the last six years.

The implication of the population figure is that there is increasing pressure on available health facilities in the State. PHC has been identified as a critical part of the minimum core obligation of the state on the right to health.[7] NEDS affirms that:[8]

> *In the health sector, the key challenges include high prevalence of diseases and poor access to quality primary healthcare. The prevalence of HIV/AIDS is at 7.5% in the State compared to the 4.1% national average. Hepatitis B (HBV) and Hepatitis C (HCV) infections are also very high. Results from a recent rapid assessment conducted by the Nasarawa State Ministry of Health observed HCV sero positivity as high as 13.2% suggesting over 200,000 individuals are chronically infected with HCV. Tuberculosis, on the other (hand), was recorded at 12,000 cases between 2012 and 2017 and out of those, only 800 cases were treated and certified TB free. Meanwhile, Malaria was reported to be responsible for 61% of the under-five mortality in the State in 2016. These challenges in the sector can be attributed to a variety of issues such as high cost of healthcare services, poor medical infrastructure, poor level of education and awareness of certain health issues, inaccessibility of services among other factors. Majority of the State residents also live in rural Nasarawa State where there is poor access to adequate primary healthcare centres, as well as qualified medical personnel.*

Table 1 documents major health indicators relating to PHC and other tiers of health in Nasarawa State. This will facilitate a proper understanding of the health challenges in the State within the context of programming available public resources towards their resolution.

Table 1: Health Indicators – National Average vs Nasarawa State

S/N	Health Indicator	National Average	Nasarawa State
	Maternal and Child Health		
1	Neonatal Mortality*	39 per 1,000 live births	36 per 1,000 live births
2	Post-neonatal Mortality*	28 per 1,000 live births	28 per 1,000 live births
3	Infant mortality*	67 per 1,000 live births	64 per 1,000 live births
4	Child mortality*	69 per 1,000 live births	60 per 1,000 live births
5	Under-5 Mortality*	132 per 1,000 live births	120 per 1,000 live births

[6] Page 63 of the Nasarawa Economic Development Strategy.
[7] United Nations Committee on Economic, Social and Cultural Rights, General Comment No. 3 (Fifth Session, 1990) on the nature of State Parties obligations under article 2 (1) of the International Covenant on Economic, Social and Cultural Rights. Nigeria is a State Party to the ICESCR.
[8] Page 63 of NEDS.

6	Adolescent birth rate**	120 per 1,000 population (15 – 19 years)	101 per 1,000 population (15 – 19 years)
7	Percentage of women with unmet need for contraception (spacing)**	18.5%	18.2%
8	Percentage of women without antenatal care**	31.6%	30.7%
9	Percentage of women who deliver at home**	60.2%	55.1%
10	Percentage of women with postnatal checks for their newborns (in a facility or at home)**	32.8%	38.4%
	Immunization		
11	Percentage of children (1-2 yrs) who receive BCG Vaccine**	53.5%	63.8%
12	Percentage of children (1-2 yrs) who receive Hepatitis B Vaccine at birth**	30.2%	33.7%
13	Percentage of children (1-2 yrs) who receive Polio Vaccine at birth**	47.4%	59.6%
14	Percentage of children (1-2 yrs) who receive Yellow Fever Vaccine**	38.8%	46.5%
15	Percentage of children (1-2 yrs) who receive Measles Vaccine (MCV 1)**	41.7%	49.7%
	Adequate Supply of Potable Water		
16	Unimproved Source*	34.7%	25.2%
17	Improved Source*	65.3%	74.8%
	Sanitation		
18	Improved facility usage*	53.4%	65.7%
19	Unimproved facility usage*	23.7%	12.3%
20	Open defecation*	22.9%	22.0%
	Others		
21	HIV/AIDS prevention knowledge* (a) Men: Using condoms and limiting sexual intercourse to one uninfected partner can reduce risk	88.3%	96.2%

	(b) Women: Using condoms and limiting sexual intercourse to one uninfected partner can reduce risk	74.1%	66.8%
22	Malaria* (a) Percentage who slept under any mosquito net last night (b) Percentage who slept under ITN by persons in the household the previous night (c) Percentage of pregnant women who slept under an ITN last night (d) Prevalence, diagnosis and prompt treatment of children with fever	43.9% 43.2% 58.0% 24.2%	51.4% 51.2% 59.6% 10.3%

*Source: * Indicates NDHS 2018: ** Indicates MICS (2016 – 2017)*

Table 1 makes very interesting findings. In maternal, new born and child health, the State's indicators were generally better than the national average in neonatal mortality, infant mortality, child mortality and under-5 mortality. But the national and Nasarawa state figures are very poor compared to the demands of the SDG 3 Target 2 which requires that by 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births.

Again, the state slightly performed better than the national average in adolescent birth rate, percentage of women without antenatal care, percentage of women with unmet need for contraception, percentage of women who deliver at home, percentage of women with postnatal checks for their newborns. It also performed slightly better in child immunization. But these performances are just average, about 50% performance and as such still leaves a long way to attaining the SDG 3. The state performed better than the national average in water and sanitation but has a poorer record in HIV/AIDS prevention and knowledge. The state did better in the use of insecticide treated nets but was poorer in the prevalence, diagnosis and prompt treatment of children with fever.

It is pertinent to state that these performance indicators from the State, even where they are better than the national average are generally below the targets set in the SDGs, National Health Policy and other relevant policies.

2.2 Implications of the Indicators

The first major implication of the indicators listed in Table 1 is the urgency of taking deliberate and targeted steps within the context of available resources to begin to reverse the negative trend as well as sustaining and improving on the relatively positive trends.

The second implication is the need to increase the resource outlay through domestic resource mobilization for the task of promoting improvements in health indicators and the third is the need to improve value for money and resource optimization in the deployment and expenditure of the available resources.

Improving the standard of health in the State in a constrained fiscal environment will require the mainstreaming of health in governance through the whole of government and health in all policies approach to the realization of the right to the highest attainable standard of physical and mental health using PHC as the entry point towards UHC.

SECTION THREE: REVIEW OF EXISTING BUDGET COMMITMENTS AND EMERGING ISSUES

There is a state obligation to take concrete and targeted steps and to use the maximum of available resources for the progressive realization of the right to health including PHC.[9] This is to be done with a view to the realization of UHC. Resources include financial resources appropriated through the budget and other finances leveraged through collaboration with state and non-state actors. Resources also include information, environment, technology and human resources. To set the context for the state health budget review, the overall Nasarawa State Budget per capita was N44,792.75, N32,203.66, N38,730.29, N41,329.58 and N39,589.27 respectively for the years 2018, 2019, 2020, 2021 and 2022.

There are standards used to benchmark state financial resources dedicated to health. Two of the standards vis, the Abuja Declaration and the utilization of appropriated funds will be used to benchmark Nasarawa State's health budget allocations in recent years.

3.1 Abuja Declaration

Under the Abuja Declaration, Nigeria (and this is binding on Nasarawa State being a component of the Federation of Nigeria) made a commitment to dedicate not less than 15% of its overall budget to fund the health sector. From Table 2 below and a projected population of 2.8million persons in Nasarawa, the health budget per capita for 2018, 2019, 2020, 2021 and 2022 was N3,394.84, N3,439.09, N3,931.30, N4,304.71 and N4,247.21 respectively. Table 2 shows the trend of Nasarawa State Allocation to Health Sector as a percentage of total State budget over a five-year period of 2018 – 2022.

[9] Article 2 (1) of the ICESCR ratified and binding on Nigeria.

Table 2: Trend of Nasarawa State Allocation to Health Sector as % of Total State Budget (2018 - 2022)

TREND OF NASARAWA STATE ALLOCATION TO HEALTH SECTOR AS % OF FG TOTAL BUDGET (2018 - 2022)					
Years	**Total Budget (NGN)**	**Health Budget (NGN)**	**% of Health Budget to Total Budget**	**15% of Total Budget (NGN; Benchmark)**	**Variance from 15% Benchmark (NGN)**
2018	125,419,687,484.00	9,505,562,691.00	7.6%	18,812,953,122.60	9,307,390,431.60
2019	90,170,246,464.00	9,629,454,978.00	10.7%	13,525,536,969.60	3,896,081,991.60
2020	108,444,805,613.72	11,007,633,929.00	10.2%	16,266,720,842.06	5,259,086,913.06
2021	115,722,814,543.00	12,053,199,520.45	10.4%	17,358,422,181.45	5,305,222,661.00
2022	110,849,954,879.49	11,892,190,345.06	10.7%	16,627,493,231.92	4,735,302,886.86
Total	**550,607,508,984.21**	**54,088,041,463.51**	**9.9%**	**82,591,126,347.63**	**28,503,084,884.12**

Source: Nasarawa state Approved Budgets and Author's Calculation

From Table 2 above, the year 2018 had a 7.6% vote and it appreciated to 10.7% in 2019, came down to 10.2% in 2020; it moved up to 10.4% in 2021 and 10.7% in 2022 The highest vote of 10.7% as recorded in 2019 and 2022 while the lowest vote of 7.6% was recorded in 2018. However, the average vote over the five years was 9.9% - being 66% of the Abuja Declaration. The variance in terms of shortfall between the expected 15% in the Abuja Declaration and allocated resources amounts to N25.503 billion. The implication of Table 2 is that the State has not met the demand and commitment of the Abuja Declaration. However, 66% compliance is a good and encouraging start towards meeting the target.

In Table 3, the disaggregation between appropriated capital and recurrent expenditure over the five years period is shown.

Table 3: Trend Analysis of Nasarawa State Health Budget (2018 - 2022): Recurrent and Capital Expenditure

TREND ANALYSIS OF NASARAWA STATE HEALTH BUDGET (2018 - 2022)					
Year	**Health Budget (NGN)**	**Capital Expenditure (NGN)**	**Recurrent Expenditure (NGN)**	**% of Capital Exp to Total Heath Budget**	**% of Recurrent Exp to Total Heath Budget**
2018	9,505,562,691.00	1,976,000,000.00	7,529,562,691.00	20.8%	79.2%
2019	9,629,454,978.00	1,101,600,000.00	8,527,854,978.00	11.4%	88.6%
2020	11,007,633,929.00	5,281,106,144.00	5,726,527,785.00	48.0%	52.0%
2021	12,053,199,520.45	2,051,681,792.00	10,001,517,728.45	17.0%	83.0%
2022	11,892,190,345.06	2,022,408,020.00	9,869,782,325.06	17.0%	83.0%

Source: Nasarawa State Budgets and Author's Calculation

Table 3 clearly shows that recurrent expenditure received more votes than capital expenditure. The highest capital vote was in 2020 while the lowest was in 2019. Capital expenditure over the five years averaged 22.84% while recurrent expenditure averaged 77.16%.

It is imperative to present information on the actual expenditure especially where there are variances between appropriation and actual releases and implementation. Tables 4A and 4B show the actual expenditure between the years 2020-2021 being the years in which implementation reports are available.

Table 4A: Trend Analysis of Approved and Actual Nasarawa State Health Sector Budget 2020-2021

Trend Analysis of Approved and Actual Nasarawa State Health Sector Budget (2020-2021)			
Year	**Approved/Revised Health Budget (NGN)**	**Actual Health Budget (NGN)**	**% of Actual Health Budget to Approved Heath Budget**
2020	11,007,633,929.00	5,769,269,006.37	52.41%
2021	12,053,199,520.45	6,990,643,199.93	58.00%

Source: Nasarawa State Budget Implementation Reports

Table 4A shows that 52.14% and 58% respectively were released and utilised in the years 2020 and 2021. This is an average budget utilization of 55.2% over the two years. This shows that the Nasarawa State health budget requires more credibility to reduce the gap between appropriation, releases ad utilized budgets sum.

Table 4B below shows the breakdown of the ratios between recurrent and capital expenditure in 2020 - 2021.

Table 4B: Trend of Actual Health Expenditure - Capital and Recurrent 2020-2021

Trend of Actual Health Expenditure - Capital & Recurrent Budget (2020-2021)					
Year	**Actual Health Budget (NGN)**	**Actual Recurrent Expenditure (NGN)**	**Actual Capital Expenditure (NGN)**	**% of Recurrent Exp to Total Heath Budget**	**% of Capital Exp to Total Heath Budget**
2020	5,769,269,006.37	5,413,820,773.79	355,448,232.58	93.8%	6.2%
2021	6,990,643,199.93	6,765,253,891.98	225,389,307.95	96.8%	3.2%

Source: Nasarawa State Budget Implementation Reports

From Table 4B, in 2020, the ratio of recurrent to capital expenditure was 93.8% to 6.2% and 2020 was 96.8% to 3.2%. The implication of this development is that there was very little capital budget implementation. On a very large scale, recurrent expenditure trumped capital expenditure.

3.2 Forward Ever, Backward Never Commitment

The right to health, which is to be realized progressively, under the jurisprudence of economic, social and cultural rights is a "forward ever, backward never" right. Deliberate retrogressive measures are not permitted and if any such measure is to be undertaken by the State, it requires the most careful consideration and justification by reference to other compelling rights and in the context of the full use of the maximum of available resources.[10]

Considering that the Naira has been depreciating over the years, the health allocations have been converted to a more stable international currency being the United States Dollar to bring out the real value of the votes and overall budget over the years. Table 5 tells the story.

Table 5: Trends of Nasarawa State Allocation to Health Sector in USSD as % of State's Total Budget (2018 - 2022)

CONVERSION OF NASARAWA STATE TOTAL BUDGET AND HEALTH BUDGET TO USD (2018 - 2022)					
Years	**Total Budget (NGN)**	**Health Budget (NGN)**	**Exchange Rate (1$=NGN)**	**Total Budget (USD)**	**Health Budget (USD)**
2018	125,419,687,484.00	9,505,562,691.00	307	408,533,183.99	30,962,744.92
2019	90,170,246,464.00	9,629,454,978.00	307	293,714,157.86	31,366,302.86
2020	108,444,805,613.72	11,007,633,929.00	380	285,381,067.40	28,967,457.71
2021	115,722,814,543.00	12,053,199,520.45	413.49	279,868,472.13	29,149,917.82
2022	110,849,954,879.49	11,892,190,345.06	415.63	266,703,449.89	28,612,444.59
TOTAL	**550,607,508,984.21**	**54,088,041,463.51**		**1,534,200,331.28**	**149,058,867.90**

Source: Nasarawa State Budgets, Central Bank of Nigeria Website https://www.cbn.gov.ng/rates/exchratebycurrency.asp and Author's Calculations

The overall available resources being the total budget figures have been decreasing in real terms between 2018 and 2022. However, it initially increased between 2018 and 2019 (from $30.962million to $31.366million); decreased to $28.967 million in 2020 and rose again to $29.147 million in 2021 and decreased to $28.612 in 2022. Essentially, the resources available to the health sector has been decreasing. However, it must be acknowledged that the overall resources available to the state have also been decreasing.

3.3 Minimum Service Package

The Nasarawa State Primary Health Care Development Agency is required to develop a Minimum Service package (MSP) for PHC through the Ward Health System Service

[10] General Comment No.3 (Fifth Session, 1990) on the nature of State Parties obligations under the ICESCR, paragraph 9.

Package. The MSP is the minimum core content of PHC, being the minimum package of health services to be delivered at the primary and secondary levels of care funded by the state. This is to ensure the best health/value for money in government expenditure so that scarce resources are deployed to the areas of greatest need and impact. This will ensure the provision of the best possible health services to citizens within the limits of available resources.

It is reported that Nasarawa State has developed the MSP for PHC facilities identified for the one PHC per political ward strategy, which is fully costed. However, this is not complimented with an Investment Plan that is guided by a Fiscal Space Analysis.[11]

3.4 Whole-of-Government and Health-in-all-Policies Approach

Although there are indications of collaboration across Ministries, Departments and Agencies of Government in the State, there is no policy mandating the whole of government and health in all policies approach. For example, there is little in the budget to show the involvement of the ministry in charge of information in the critical task of information dissemination as a resource for preventive and promotive health interventions.

The whole-of-government approach is an understanding that securing the health of the population cannot be achieved by the Ministry of Health and its departments and agencies alone. It requires inter-ministerial/agency collaboration and mainstreaming health in other sectors. Health is made an explicit objective of every policy decision. Health in all policies approach is a collaborative approach that integrates and articulates health considerations into policy making across sectors to improve the health of all communities and people.

SECTION FOUR: THE BASIC HEALTH CARE PROVISION FUND

According to the State of Primary Health Care Delivery in Nigeria, 2019-2021;[12]

> *Nasarawa State has attained full capacity to utilise BHCPF disbursements from the NPHCDA and NHIS Gateways. The State has released equity funds for at least one round of disbursements from the NHIS, but has failed to provide its counterpart funding for the NHIS Gateway. The State also has an active oversight committee. The State does not have a formal sector health insurance scheme to support risk and financial pooling.*

According to the summary of key steps to improvement, the following is recommended:[13]

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

[11] State of Primary Health Care Delivery in Nigeria by ONE Campaign, Et al.
[12] State of Primary Health Care Delivery in Nigeria, supra.
[13] State of Primary Health Care delivery in Nigeria, supra.

- Develop an Electronic Workforce Registry in the State to support management of human resources for health;

- Commission and develop a State Human Resources for Health Strategic Plan that models HRH needs and provides a pathway for training, recruitment, retention, career development and replacement.

- Commission a legal assessment and provide political leadership for the drafting and passage of a Comprehensive State Health Law;

- Develop a Health System Wide Accountability and Performance Management Framework, and engage technical assistance to support its implementation;

- Create a pipeline for private sector involvement in overcoming the health infrastructure deficit in the State, by aligning with the new national drive to adopt a PHC building on its strong Diaspora community.

- Develop a State MSPAN and an investment plan to accompany the fully costed MSP, and ensure that both plans fit into the State Strategic Health and Development Plan III and forms the basis of state budgeting for health;

- Invest in an integrated logistics and supply chain management system, to leverage gains and experience from ensuring last mile availability of vaccines and TB control health products, and ensure that family planning, malaria and HIV control commodities are also available at service provision points.

From available information, the State is on the right path in terms of accessing resources from the BHCPF but needs to deepen the engagement with the Fund by paying its counterpart and equity funds, full enrolment of the poorest of the poor and vulnerable groups into a social insurance scheme; and enhancing transparency, accountability, value for money and citizens' engagement.

SECTION FIVE: SUSTAINABILITY OF CURRENT HEALTHCARE FINANCING MODEL IN NASARAWA STATE

The sustainability of healthcare services is to a great extent dependent on the quantum and sources of healthcare financing. From section 3 on the review of existing budget commitments, it is clear that the State's public budget allocations do not meet the requirement of the funding needed to achieve UHC. This is compounded by the dwindling fiscal resources and fiscal space available to the State Government. Also, the complimentary funding from the BHCPF is not sufficient to fill the funding gap while the

contributions expected from donors, the private sector and other non-state actors have been unable to fill the funding gap.

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.[14] Nasarawa State, as a part of the Nigerian Federation falls under this umbrella of high out of pocket health expenditure. Out of pocket health expenditure is a reference to direct expenses on health care which is not covered by any prepayments for health services. It is paid from an individual's cash reserves. It forces people, especially the poor to make unnecessary choices between their health and expenditure on other basic rights such as food, housing and education.

To fulfil the vision of UHC where all Nasarawa residents can have access to the health care services they need at any time without being constrained by the depth of their pocket and personally available resources, will require optimum health financing from a plethora of sources which minimizes the need for out-of-pocket health expenditure. The current Nasarawa State Health Financing Model is not sustainable and needs to be improved upon.

SECTION SIX: HEALTH INSURANCE TO THE RESCUE

The enrolment numbers into the various plans of the National Health Insurance Scheme (NHIS) and various private health insurance schemes across the Federation is reported at 10million, about 5% of the population.[15] However, there is no disaggregation of this overall national figure according to States. On the other hand, the Nasarawa State Contributory Health Insurance Scheme is relatively new and may not have covered majority of the population. The Executive Secretary of the Nasarawa State Health Insurance Agency, Gaza Gwamna, indicated that the Scheme has registered 50,000 enrollees in the informal sector and discussions were ongoing with civil servants to commence the formal sector enrolment.[16] Generally, the contribution of health insurance to overall healthcare financing is still very low. The majority of health insurance enrollees

[14] https://data.worldbank.org/indicator/SH.XPD.OOPC.CH.ZS?locations=NG, 2019.
[15] 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 quoting Head, Media and Public Relations of NHIS, Mr. Ayo Osinlu who stated: "There are over 10 million Nigerians currently covered by health insurance under various programs by NHIS, State health insurance agencies and private plans by HMOs". It also cited with approval a study published in The Lancet, a medical journal, where it was noted that more than ''90 per cent of the Nigerian population were uninsured, despite the NHIS that was established in 2006. Less than five per cent of Nigerians in the formal sector are covered by the NHIS. Only three per cent of people in the informal sector are covered by voluntary private health insurance. Uninsured patients are at the mercy of a non-performing health system."
[16] 50,000 Residents Enroll in Nasarawa Health Insurance Scheme – THISDAYLIVE; 25/11/2021.

seem to be in the NHIS schemes which have been generally rated not to be very impactful. A health scholar has posited of the low enrolment numbers as follows:[17]

> *A number of reasons could be attributed to the small proportion of this veritable source of healthcare financing. One of the major reasons is the administrative bottlenecks within the National Health Insurance Scheme in Nigeria. Another important reason is the non-comprehensiveness and non-inclusiveness of the Scheme. A number of those that have NHIS accounts are deprived of some services with the flimsy reason that the Scheme does not provide all the healthcare services they may have need of. Certain healthcare services have been deliberately excluded under the scheme. This does not encourage more take-up of the Scheme. This is compounded by the fact that the Scheme has not been marketed to non-government workers. An all-inclusive Scheme will do Nigeria a greater and better deal than the current state of the National Health Insurance Scheme.*

Considering the beautiful provisions of the Nasarawa State Health Insurance Scheme Law of 2018 (NSHIS Law) and the plans provided thereunder, the Nasarawa State Health Insurance Agency should take steps to popularize the available schemes as well as enforce the mandatory provisions of S.4 and S.6 of the Law vis:

> *S.4: The aim shall be to provide mandatory Health Insurance which shall entitle the insured person, their spouse and four children to the benefits of prescribed good quality and cost effective health services as set out in this Law.*
>
> *S.6: The Scheme shall be mandatory and apply to all residents of the State except those who have proof of coverage by the National Health Insurance or other Schemes.*

The mandatory provisions of NSHIS Law are further supported by the National Health Insurance Authority Act which makes health insurance compulsory and universal.

According to S.5 of the NSHIS Law, the objectives of the Scheme shall be to: (a) Ensure that every resident of Nasarawa State has access to good healthcare services; (b) Protect families from financial hardship of huge medical bills; (c) Control the rise in cost of health care services; (d) Ensure equitable distribution of health care costs among different income groups; (e) Maintain high standards of health care delivery services with the scheme; (f) Ensure efficiency in health care services; (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 equitable patronage of all levels of health care; and (j) Ensure the availability of alternative sources of funding the health sector for improved services.

[17] David Agu in CSJ's Contributions to Health Sector MTEF 2019-2021.

Table 6 shows the amount appropriated for the Agency from 2019 to date.

Table 6: Allocation to Nasarawa State Health Insurance Agency

YEAR	RECURRENT EXPENDITURE	CAPITAL EXPENDITURE	TOTAL EXPENDITURE
2022	*864,072,981.00*	*25,000,000.00*	*889,072,981.00*
2021	*1,099,520,632.00*	*25,000,000.00*	*1,124,520,632.00*
2020 (Amended)	*243,865,500.00*	*1,000,000.00*	*244,865,500.00*
TOTAL	***2,207,459,113.00***	***51,000,000.00***	***2,258,459,113.00***

Source: Nasarawa State Budgets

From Table 6, it appears that the recurrent vote supports the state's contribution to the funding of health services for the poor and vulnerable groups. Ideally, this vote 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 allocation. Furthermore, the capital vote of N25million a year in the last two years is very low. More funds should be made available for this purpose.

SECTION SEVEN: RECOMMENDATIONS

Based on the foregoing review, this Memorandum makes the following recommendations.

7.1 Prepare a new Strategic Health Development Plan 2023-2027: Considering the need for a State Strategic Health Development Plan, prepare a new Nasarawa State Strategic Health Development Plan 2023-2027 to provide a framework, guide and policy basis for state level health budgeting.

7.2 Prepare a Health MTSS: The State Ministry of Health should take steps towards the preparation of a Health MTSS. This is to compliment the requirement of the Nasarawa State Fiscal Responsibility Law which demands the preparation a Medium Term Expenditure Framework. It is mandatory for the compositional distribution of the annual budget to be in accordance with the priorities of the MTEF.

7.3 Mainstream the Plan, Policy and Budget Continuum in Health: Plans and policies provide the legal and policy framework for sectoral governance and service delivery while budgets activate plans and policies through providing resources for their implementation. The disconnect between plans, policies and budgeting has been largely responsible for poor PHC and health outcomes in most states of Nigeria.

7.4 Whole-of-Government, Health-in-all Policies Approach: The Ministry of Health should prepare an executive memorandum and seek the approval of the State Executive Council for a whole-of-government and health-in-all policies approach. The whole-of-government approach is an understanding that securing the health of the population cannot be achieved by the Ministry of Health and its departments and agencies alone. It requires inter-ministerial/agency collaboration and mainstreaming health in other sectors.

For example, the ministry in charge of information should be involved in the critical task of information dissemination as a resource for preventive and promotive health interventions.

Health-in-all-policies approach is a collaborative approach that integrates and articulates health considerations into policy making across sectors to improve the health of all communities and people. Health should be made an explicit objective of every policy decision.

7.5 Stakeholder Engagement and Popular Participation in Preparation of MTSS and Annual Budget: In the preparation of the MTSS, formulation and preparation of the annual health budget, there is the need to mobilize all stakeholders in the Health Sector, engage them and ensure popular participation. Most policy and budget failures in Nigeria have been attributed to top-down approach to policy development and implementation. Conscious involvement of all relevant stakeholders in the development and implementation of health sector plans and budgets will be of great benefit to the sector.

7.6 Whole of Society Approach to Health: Further to the last recommendation, the State should adopt the *whole-of-society approach involving the* engagement of all relevant stakeholders in society to address socio-economic and livelihood issues that affect health. This includes public health, education, food security, agriculture, power and energy, communications, environment, employment, industry, and social and economic development.

7.7 Update the Minimum Service Package for Primary Health Care: The MSP is the minimum core content of PHC, being the minimum package of health services to be delivered at the primary and secondary levels of care funded by the state. This is to ensure the best health/value for money in government expenditure, so that scarce resources are deployed to the areas of greatest need and impact.

7.8 Increase Funding to the Sector and Invest in Value for Money: It is imperative to increase health sector funding to ensure that the 15% target is met in actual releases and utilization of the vote. Furthermore, the Ministry of Health should invest in value for money tools and processes to increase economy, efficiency, effectiveness and equity of its investments across the health value chain.

7.9 Moratorium on New Capital Projects: Considering that the year 2023 will witness a change in the executive and legislative leadership of the State, there should be a moratorium on new capital projects and the focus should be on completing existing and ongoing projects. In this way, the resources of the State will not be spread too thin and project abandonment will be minimized.

7.10 Invest in Transparency and Accountability: The SMOH should invest in improving the transparency and accountability of its operations through collating and publication of timely and quarterly line item by line-item expenditure details. This will build the confidence of stakeholders and increase contributions and collaborations for improving the standard of health in the State.

7.11 Annual State of Health Report: To boost transparency and accountability and in accordance with S.2 (2) (d) of the National Health Act, the Commissioner for Health should prepare and present an annual report on the state of health of residents in Nasarawa to the Governor and the State House of Assembly and publish same on the State Government's website.

7.12 Ensure Maximum Benefits from BHCPF: The State should ensure that it derives the maximum benefits available from the BHCPF through guaranteeing the required equity and counterpart funding, accrediting more health institutions especially PHCs, timely and meticulous retirement of disbursed funds from the National Primary Health Care Development Agency and National Health Insurance Gateways. The State Primary Health Care Development Agency should provide detailed information on its engagement with the NPHCDA Gateway of the BHCPF.

7.13 Full Implementation of NSHIS Law and the National Health Authority Act: NSHIS Law and the National Health Insurance Authority Act envisage a universal and compulsory health insurance regime in Nasarawa State and across the Nigeria Federation. The Agency should draw up an action plan that will start from awareness creation and massive sensitization to enforcement over a period of three years. The first one year should focus on awareness creation and enforcement follows in the second two years.

Government should increase the funding of the Agency, especially in terms of the Equity Fund (not less than 0.5% of the annual Consolidated Revenue Fund of the State Government) being resources to enroll the most vulnerable groups. The Agency should establish a website to provide information on its activities including details of receipts, expenditures on its engagement with the BHCPF.