POLICY BRIEF

Strategic Health Purchasing in Nigeria

A Summary of Progress, Challenges, and Opportunities

JUNE 2021

STRATEGIC HEALTH PURCHASING FOR UNIVERSAL HEALTH COVERAGE IN SUB-SAHARAN AFRICA

The Strategic Purchasing Africa Resource Center (SPARC), a resource hub hosted by Amref Health Africa with technical support from Results for Development (R4D), aims to generate evidence and strengthen strategic health purchasing in sub-Saharan Africa to enable better use of health resources. SPARC and its technical partners created a framework for tracking progress in strategic health purchasing and are applying it in countries across sub-Saharan Africa to facilitate dialogue on what drives progress and to promote regional learning.

Health Financing Schemes in Nigeria

Nigeria is a lower-middle-income country and the most populous country in Africa. It has a decentralized system of governance, with 36 states and a federal capital territory. The three tiers of government—federal, state, and local—all have a role to play in financing and providing health services. The 2014 National Health Act provides the legislative framework for the health sector and seeks to advance universal health coverage (UHC) by asserting the rights of citizens to a basic minimum package of health services. Strategic purchasing priorities outlined in the 2016 National Health Policy and the 2016 National Health Financing Policy aim to achieve value for money in purchasing high-impact, cost-effective services that are essential for achieving the health-related Sustainable Development Goals and national priorities. Government spending on health is low, however, making up only 15% of current health expenditure. Out-of-pocket spending constitutes 76.6% of current health expenditure, while only 23.4% is pooled in fragmented health financing schemes.

NIGERIA AT A GLANCE

- Population (2019): **200.9 million**
- GDP per capita (2019): **US$2,230**
- Poverty headcount at $1.90/day (2016): **39.1%**
- Life expectancy (2018): **54 years**
- Current health expenditure (CHE) per capita (2018): **US$84**
- Domestic government expenditure as % of CHE (2018): **15%**
- Out-of-pocket expenditure as % of CHE (2018): **76.6%**
- External expenditure as % of CHE (2018): **8%**

Source: World Bank Databank

The main types of health financing arrangements in Nigeria include:

- **GOVERNMENT BUDGET FINANCING AT THE FEDERAL AND SUBNATIONAL LEVELS.**
  - Nigerians are expected to have some level of access to health care services at primary, secondary, and tertiary public health facilities that are financed through federal tax revenues. States contribute from state tax revenues, depending on capacity and priorities.
  - The Basic Health Care Provision Fund (BHCPF), financed through 1% of consolidated general tax revenues, provides access to a basic minimum package of health services focused on maternal and child health. BHCPF funds are channeled through three gateways, in the following percentages:
    - 45% to the National Primary Health Care Development Agency (NPHCDA) to fund primary health care (PHC) services through State Primary Health Care Development Agencies (SPHCDAs).
    - 50% to the National Health Insurance Scheme (NHIS) for coverage of vulnerable groups through State Health Insurance Schemes (SHISs).
    - 5% for emergency medical services, shared equally between the National Expert Committee supervised by the Department of Hospital Services of the Federal Ministry of Health (FMOH) and the National Centre for Disease Control (NCDC).

- **NATIONAL AND SUBNATIONAL HEALTH INSURANCE SCHEMES.** These include the federal and state-level insurance schemes.
  - NHIS manages a number of contributory schemes at the federal level, with the compulsory Formal Sector Social Health Insurance Programme (FSSHIP) as the main scheme. Social health insurance coverage remains low, at less than 4% of the population.
    - FSSHIP is compulsory for all federal government employees and also targets employees in the organized private sector and the armed forces. Companies with more than 10 employees are eligible to join this scheme voluntarily.
    - The Voluntary Contributors Social Health Insurance Program targets companies with fewer than 10 employees, informal-sector employees, self-employed workers, retirees, legal residents, and individuals willing to contribute to the scheme.
    - The Community-Based Social Health Insurance Programme is a nonprofit contributory program for groups of households or individuals or occupation-based groups with at least 1,000 members.
    - The Vulnerable Group Social Health Insurance Program includes government-subsidized programs targeted at vulnerable groups, such as the Physically Challenged Persons Social Health Insurance Program, the Prison Inmates Social Health Insurance Program, and the Refugees, Victims of Human Trafficking, Internally Displaced Persons and Immigrants Social Health Insurance Program.
    - The Public Primary Pupils Social Health Insurance Program (PPPSHIP) and Tertiary Institutions Social Health Insurance Program (TISHIP) are for students in public primary schools and universities, respectively. PPPSHIP is subsidized by the government, while TISHIP is contributory.
    - The Children Under 5 Social Health Insurance Program provides specific child health services.
  - SHISs at the subnational level are mostly contributory. They cover state-level formal-sector employees and provide coverage for specific populations, such as poor and indigent people, through the BHCPF. Some states have used the BHCPF to fund initiation of a state-level scheme.
- **DONOR-FUNDED PROJECTS.** Nigeria has multiple health sector projects funded by external donors. Project focus areas include HIV/AIDS, malaria, tuberculosis, maternal and newborn health, and reproductive services. Most donor-funded projects are implemented at the state level, but some cover multiple states.

Nigeria also has private and community-based health insurance schemes, which have low coverage.

Table 1 compares the purchasing functions of the federal health financing schemes in Nigeria as well as the Anambra State Health Insurance Scheme, as an illustration of an SHIS.

Table 1. **Purchasing Functions in Nigeria's Federal and State Health Financing Schemes**

	Federal Government Budget Financing	Basic Healthcare Provision Fund (BHCPF)	State Government Budget Financing	Anambra State Health Insurance Scheme	National Health Insurance Scheme (NHIS)
% of Total Health Expenditure (2018)*	14.3%				0.5%
Main Purchaser(s)	Federal Ministry of Health (FMOH) National Primary Health Care Development Agency (NPHCDA)	State Health Insurance Schemes (SHISs), State Primary Health Care Development Agency (SPHCDA), FMOH, National Centre for Disease Control (NCDC)	State Ministry of Health (SMOH) State Primary Health Care Development Agency (SPHCDA)	Anambra State Health Insurance Agency (ASHIA)	NHIS, health maintenance organizations (HMOs)
Governance	The Federal Ministry of Finance (FMOF) and Ministry of Planning and Budget (MOPB) allocate resources to FMOH and its departments and agencies, NPHCDA, and states and local governments. FMOH is responsible for policy direction and federal-level facilities. NPHCDA is responsible for PHC service delivery. Health facilities have limited financial autonomy over the use of these funds, according to FMOF guidelines on the use of public funds.	The 2014 National Health Act provides the BHCPF legislative framework. Health facilities have some financial autonomy over the use of BHCPF funds, according to FMOF guidelines for the use of public funds.	FMOF and the Ministry of Planning and Budget allocate resources to states and local governments. SMOH is responsible for state-level facilities. SPHCDA is responsible for PHC service delivery. Health facilities have limited financial autonomy over the use of these funds, according to FMOF guidelines for the use of public funds.	ASHIA was established in 2018 by the Anambra State Health Act. It has a State Health Insurance Board that oversees ASHIA management, which is led by the Executive Secretary. ASHIA receives resources from NHIS through the BHCPF insurance gateway and collects insurance contributions. Health facilities have some financial autonomy over the use of the ASHIA funds, according to FMOF guidelines for use of public funds.	NHIS, established in 1999 by an Act of Parliament, has a governing council that oversees NHIS management, which is led by the chief executive officer. NHIS has authority over purchasing functions. HMOs contract with and pay providers on behalf of NHIS. Private facilities have financial autonomy. Public facilities have some financial autonomy over the use of the NHIS funds, according to FMOF guidelines on the use of public funds.
Financial Management	MOPB provides a budgetary envelope for planning and budgeting to FMOH, which then allocates the budgets to respective departments based on the budget envelope and the Medium Term Expenditure Framework (MTEF). Budgets are approved by the National Assembly. Budget overruns occur and may be corrected with supplementary budgets approved by the National Assembly.	FMOF allocates at least 1% of consolidated revenues based on the 2014 National Health Act to the NHIS (50%), NPHCDA (45%), and FMOH and NCDC (5%). NPHDCA remits funds to SPHCDA for infrastructure improvements, equipment, and medicines. NHIS remits funds to SHISs to cover vulnerable groups.	The states consolidate their allocation from the Federation Account Allocation Committee (FAAC) with the state's internally generated revenue and release annual budgets to SMOH, SPHCDA, and other departments based on state-level health budgets. Budgets are approved by the State Assembly. Budget overruns occur and are corrected with supplementary budgets approved by the State Assembly.	Budgets are set by ASHIA management based on membership and projected revenue. Overruns occur, and additional budget must be approved by the State Health Insurance Board.	Budgets are set by NHIS management based on membership and projected revenue. Overruns occur, and additional budget must be approved by the NHIS governing council.
Benefits Specification	Lacks an explicit benefit package except for disease control programs and donor-funded programs, which have explicit benefit packages.	Explicit benefit package with a focus on maternal, neonatal, and child health (MNCH) services and specific diseases.	No explicit benefit packages at the state level, except in the case of disease control and free MNCH program.	Explicit benefit package that covers basic essential services, basic MNCH services, and treatment of common adult and childhood illnesses. Secondary and tertiary health services are also covered.	Costed explicit benefit package, which includes approved services and drug tariffs for primary, secondary, and tertiary care. NHIS defines the cost-sharing policy for health services and medicines for beneficiaries.

Contracting Arrangements	Schemes mostly have loose agreements with public providers and selective contracting with private providers.	Schemes have selective agreements with providers on services to be delivered.	Schemes have loose agreements with public providers and selective contracting with private providers.	ASHIA selectively contracts with health facilities.	NHIS accredits health facilities. HMOs contract selectively with providers on behalf of NHIS.
Provider Payment	Input-based line-item budgets	Capitation and fee-for-service	Input-based line-item budgets	Capitation and fee-for-service	Capitation and fee-for-service
Performance Monitoring	Monthly facility activity reporting on DHIS2; ad hoc supervision visits	Monthly facility activity reporting on DHIS2; ad hoc supervision visits	Monthly facility activity reporting on DHIS2; SMOH ad hoc supervision visits	ASHIA quality assurance, SMOH ad hoc supervision visits	Accreditation processes (NHIS); supervision visits (NHIS and HMOs)

** 2017 National Health Accounts*

Progress and Challenges in Strategic Health Purchasing

Some progress toward strategic purchasing has been made in federal and state-level financing schemes in Nigeria. NHIS and SHISs have well-defined benefit packages and use output-based provider payment methods. The BHCPF, which is funded through the government budget, focuses mostly on maternal and child health services to address high maternal and child mortality in Nigeria. Budgeting under government budget financing is linked to a medium-term expenditure framework, which ensures that budgets reflect the government's social and economic priorities.

Highlights of progress and remaining challenges are described below.

GOVERNANCE. Institutional roles and responsibilities for purchasing are clear, although complex. The National Health Act defines the roles of the three levels of government in providing health care, while Act 35 of the 1999 Constitution established the NHIS. Public providers have limited financial autonomy under federal and state-level budget financing but have broader financial autonomy for budgeting and execution under the NHIS, SHISs, and BHCPF.

FINANCIAL MANAGEMENT. A defined process is used to set the purchasers' budgets, and mechanisms exist for tracking budget execution in the financing schemes, but budget overruns occur. Overruns in the government and federal and state budget-financed schemes are sometimes managed through additional allocations in supplementary budgets. NHIS and SHISs budget overruns require additional budget approval by the governing council and by the insurance board.

BENEFITS SPECIFICATION. The available benefit packages—BHCPF, NHIS, and SHISs—reflect health priorities but lack systematic processes for benefits specification and review. Clinical guidelines defined by the FMOH are used as service delivery standards by federal and state schemes, but they are not enforced through contracting. BHCPF, when fully operational, will cover provision of the Basic Minimum Package of Health Services (BMPHS), fund PHC operational expenses across Nigeria, and fund the provision of basic emergency medical treatment and public health emergencies. NHIS and SHIS benefit packages are designed for each target population, with well-defined cost-sharing procedures. NHIS and SHISs have approved service and drug tariffs that define enrollee entitlements under various schemes.

CONTRACTING ARRANGEMENTS. NHIS and SHISs have formal accreditation and contracting arrangements with public and private providers, while BHCPF, the FMOH, and SMOHs use loose agreements with public providers and selective contracting with private providers for some disease control programs. NHIS accredits providers, who sign contracts with health maintenance organizations (HMOs)—third-party payers for NHIS. NHIS and SHISs contracts specify expected services and provider payment methods. However, experience shows that providers do not adhere to the contracts and NHIS and SHISs are unable to enforce contractual obligations.

PROVIDER PAYMENT. BHCPF, NHIS, and SHISs use output-based payment, while the federal and state government budgets use input-based payment. The FMOH and SMOHs pay their individual providers monthly salaries. NHIS and SHISs pay providers using capitaition for primary care and fee-for-service for hospital care. These payment mechanisms are not well harmonized, and NHIS has experienced overreferrals due to capitation and supplier-induced demand due to fee-for-service.

PERFORMANCE MONITORING. Provider-level and system-level performance monitoring of the federal and state schemes is mostly paper-based and not well coordinated. The quality and accuracy of reporting varies widely. Performance monitoring systems do not inform purchasing decisions.

Table 2 summarizes progress made in strategic purchasing functions along the dimensions of progress defined by SPARC for the health financing schemes in Nigeria. (See the annex for a detailed explanation of how the levels of progress are indicated using ○, ●●, and ●●●.)

Table 2. **Progress Made Across Purchasing Functions in Nigeria**

Purchasing Function	Indicators of Strategic Purchasing	Federal Government Budget Financing	BHCPF	State Government Budget Financing	SHIS	NHIS
Governance	Purchasing functions have an institutional home that has a clear mandate and allocation of functions.	●●	●●	●●	●●	●●
	Providers have autonomy in managerial and financial decision-making and are held accountable.	○	●●	○	●●	●●
Financial Management	Purchasing arrangements incorporate mechanisms to ensure budgetary control.	●●	●●	●●	●●	●●
Benefits Specification	A benefit package is specified and aligned with purchasing arrangements.	●●	●●	●●	●●	●●
	The purchasing agency further defines service delivery standards when contracting with providers.	●●	●●	○	●●	●●
Contracting Arrangements	Contracts are in place and are used to achieve objectives.	○	●●	○	●●	●●
	Selective contracting specifies service quality standards.	○	●●	○	●●	●●
Provider Payment	Provider payment systems are linked to health system objectives.	○	●●	○	●●	●●
	Payment rates are based on a combination of cost information, available resources, policy priorities, and negotiation.	○	●●	○	●●	●●
Performance Monitoring	Monitoring information is generated and used at the provider level.	○	○	○	○	○
	Information and analysis are used for system-level monitoring and purchasing decisions.	○	○	○	○	○

Strategic purchasing is limited in Nigeria because of the small share of total health spending that flows through strategic purchasing mechanisms, and that small share of funding is further fragmented across multiple schemes. Only 15% of health expenditure flows through the federal and state government budgets, BHCPF, NHIS, and SHISs. High out-of-pocket expenditure on health (76.6% of current health expenditure) potentially exposes households to catastrophic health spending and hinders strategic purchasing efforts. The low proportion of funds that flow through NHIS reduces leverage to improve purchasing functions and provide adequate incentives to providers. HMOs in Nigeria are an additional administrative cost for NHIS. SHISs offer an opportunity to improve some of the weaknesses of NHIS by creating clear accreditation guidelines, contracting with facilities directly rather than through HMOs, using output-based mechanisms, and improving performance management. However, these mechanisms are in the nascent stages and are currently poorly enforced.

Opportunities to Improve Health Purchasing

Generally, capacity to undertake strategic purchasing is inadequate and strategic health purchasing has not been well entrenched in the federal and state-level schemes. The National Health Financing Policy calls for a focus on high-impact, cost-effective interventions, integrating strategic purchasing at the federal and state levels, using strategic purchasing in BHCPF implementation, and establishing outcome-focused provider payment mechanisms and evidence-based decision-making. Nigeria envisions that full implementation of the BHCPF and decentralized social insurance schemes will fast-track the country's progress toward achieving UHC by reducing financial access barriers to health services for all Nigerians.

The BHCPF has increased public resources for the health sector and, through strategic purchasing approaches, has prioritized vulnerable groups in the benefit package and output-based payment linked to service delivery objectives. However, BHCPF implementation has been slow and has not resulted in expected improvements. Fragmentation of benefit packages across and within schemes contributes to inefficiencies in resource allocation and utilization.

Improving strategic health purchasing in Nigeria requires reducing out-of-pocket payments and channeling those payments into prepaid funding pools, and pooling across schemes to increase purchasing power. Strengthening FMOH and SMOH strategic purchasing capacity can improve linkage of the budget to MTEF and state operational plans and achievement of Nigeria's health goals and targets. FMOH can lead the implementation of national strategies to ensure that health purchasing is more coherent and that policy objectives are achieved. FMOH and NHIS can also support the capacity building of states on strategic purchasing as they establish state health insurance schemes.

FMOH and NPHCDA can monitor the implementation of the BHCPF to ensure timely and complete release of BHCPF funds. Implementation learning can support evidence-based decision-making to improve provider payment methods. A strategic decision is required for the continued role of the HMOs in NHIS and the best way to meet capacity gaps at NHIS to make it a more transparent and accountable purchaser. NHIS may benefit from reducing fragmentation in its numerous schemes and strengthening monitoring of providers to ensure adherence to contractual obligations and monitor adverse provider behavior. Strengthening performance management of providers and the schemes at the federal and state levels and using this information to make purchasing decisions that provide appropriate incentives to health facilities will promote higher-quality and more efficient service delivery and contribute to progress toward UHC.

SPARC and its technical partners view strategic purchasing as a way to improve resource allocation, provide coherent incentives to providers, and improve accountability for health resources. As next steps, SPARC's partner in Nigeria—the Health Policy Research Group based at the University of Nigeria—will validate the SPARC findings with Nigerian stakeholders and determine appropriate actions to make further progress in strategic purchasing as a way to achieve UHC in Nigeria.

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RESULTS FOR DEVELOPMENT

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Annex. **Strategic Purchasing Progress Indicators**

Governance	**Purchasing functions have an institutional home that has a clear mandate and allocation of functions.**	○	An agency or agencies have responsibility for carrying out one or more purchasing functions, but mandates are not clearly defined and capacity is weak.
		●●	An agency or agencies have responsibility for carrying out most or all purchasing functions and capacity is improving, but some overlaps and gaps in responsibilities remain. Mechanisms are in place for stakeholder engagement.
		●●●	An agency or agencies have responsibility for carrying out all purchasing functions, capacity is strong, and there are no overlaps or gaps in responsibilities. There is inclusive and meaningful stakeholder engagement.
	Providers have autonomy in managerial and financial decision-making and are held accountable.	○	Public providers have no autonomy or extremely limited autonomy to carry out financial and managerial functions, and they have limited ability to respond to financial incentives created by provider payment systems.
		●●	Public providers are given a larger degree of financial and managerial autonomy, but accountability mechanisms are weak.
		●●●	Public providers are given a large degree of financial and managerial autonomy, and accountability mechanisms are effective.
Financial Management	**Purchasing arrangements incorporate mechanisms to ensure budgetary control.**	○	A defined process is used to set the purchaser's budget, and mechanisms are in place to track budget execution/spending, but these mechanisms are not well enforced.
		●●	A defined process is used to set the purchaser's budget, and mechanisms are in place to track budget execution/spending. These mechanisms are enforced, but budget overruns routinely occur.
		●●●	A defined process is used to set the purchaser's budget, and mechanisms are in place to track budget execution/spending. These mechanisms are enforced, and budget overruns rarely occur.
Benefits Specification	**A benefit package is specified and aligned with purchasing arrangements.**	○	A benefit or service package is defined and reflects health priorities, but it is not well specified, is not a commitment, and/or is not aligned with purchasing mechanisms.
		●●	A benefit or service package is defined, reflects health priorities, and is a commitment, but it is not well specified and/or not aligned with purchasing mechanisms.
		●●●	A benefit or service package is defined, reflects health priorities, is a commitment, is well specified, and is aligned with purchasing mechanisms, and a transparent process for revision is specified.
	The purchasing agency further defines service delivery standards when contracting with providers.	○	The purchaser defines some general standards for delivering services in the package (e.g., for gatekeeping), but enforcement through contracts is weak.
		●●	The purchaser defines some general service delivery standards and some specific service delivery standards (e.g., number of prenatal care visits) that are enforced through contracts.
		●●●	The purchaser defines general service delivery standards and specific service delivery standards in line with national service delivery policies and clinical protocols, and service delivery standards are enforced through contracts.
Contracting Arrangements	**Contracts are in place and are used to achieve objectives.**	○	Loose agreements are in place between the purchaser and public providers for specified services in exchange for payment instead of or in addition to input-based budgets. Formal agreements may be in place with some private providers.
		●●	Formal agreements are in place between the purchaser and public providers for specified services in exchange for payment or in addition to input-based budgets. Formal agreements may be in place with some private providers.
		●●●	Formal agreements are in place between the purchaser and public and private providers to help achieve specific objectives, and they are linked to performance.
	Selective contracting specifies service quality standards.	○	The purchaser has loose, nonselective agreements or contracts with all public providers and selective contracts with some private providers based on some definition of quality standards.
		●●	The purchaser contracts at least somewhat selectively with public and private providers based on accreditation or some other definition of quality standards.
		●●●	The purchaser contracts selectively with public and private providers based on uniformly applied quality standards.
Provider Payment	**Provider payment systems are linked to health system objectives.**	○	Some output-based payment is used.
		●●	Output-based payment is used, and payment systems are linked to specific service delivery objectives.
		●●●	Output-based payment is used and is linked to specific service delivery objectives; payment systems are harmonized across levels of care, and they allow purchaser budget management.
	Payment rates are based on a combination of cost information, available resources, policy priorities, and negotiation.	○	Provider payment rates are determined based only on the purchaser's available budget.
		●●	Provider payment rates are determined based on the purchaser's available budget and at least one other factor (e.g., cost information, priorities, or negotiation with providers).
		●●●	Payment rates are based on a combination of cost information, available resources, policy priorities, and negotiation.
Performance Monitoring	**Monitoring information is generated and used at the provider level.**	○	Some form of monitoring happens at the health provider level (e.g., supportive supervision visits, monthly activity reporting, claims audits, quality audits).
		●●	Provider-level monitoring is at least partially automated and is used for purchasing decisions.
		●●●	Provider-level information is automated, fed back to providers, and used for purchasing decisions.
	Information and analysis are used for system-level monitoring and purchasing decisions.	○	Some form of analysis is carried out at the system level (e.g., service utilization, medicines prescribed, total claims by service type).
		●●	System-level analysis is automated and carried out routinely.
		●●●	Information and analysis are used for system-level monitoring and purchasing decisions.