

**Centre for Health Economics and Development**

**LEAD CONSULTANT REPORT ON THE FEASIBILITY OF THE VULNERABLE GROUP SOCIAL HEALTH INSURANCE PROGRAMME IN NIGERIA**

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Of course the usual disclaimers apply. In particular, opinions, ideas and views presented in the report are exclusively that of the author and do not necessarily coincide with those of the public officials or offices involved. Despite the valuable advice from various sides, all the remaining errors and insufficiencies remain the sole responsibility of the author. Comments are appreciated and encouraged, and should go directly to the author[[1]](#footnote-1).

**ACRONYMS AND ABBREVIATIONS**

AA Attendance allowance

ACA Affordable Care Act

AIDS Acquired Immune Deficiency Syndrome

CBHIP Community-Based Health Insurance Programme

CBOs Community-Based Organisations

CHIP Children Health Insurance Programme

DHS District Health System

DLA Disability Living Allowance

EAs Enumeration Areas

ESA Employment and Support Allowance

EU European Union

FBO Faith-Based Organization

FMCH Free Maternal and Child Health

FMWA Federal Ministry of Women Affairs

GDP Gross Domestic Product

GTZ German Technical Cooperation

HIV Human Immunodeficiency Virus

HH Household

HMO Health Maintenance Organization

IGR Internally Generated Revenue

ILO International Labour Organization

ISSA International Social Security Association

LBW Low Birth Weight

LDCs Less Developed Countries

LGAs Local Government Areas

LMICs Low and Middle-Income Countries

MIP Medical Insurance for the Poor

MSF Medecins Sans Frontieres

NBS National Bureau of Statistics

NCB National Children’s Bureau

NGOs Non-Governmental Organizations

NHIS National Health Insurance Scheme

NHS National Health Service

NPA National Plan of Action

OOP Out-of-Pocket

OVC Orphan and Vulnerable Children

PEPFAR President’s Emergency Plan for AIDS Relief

PLWHA People Living with HIV/AIDS

PMT Proxy Means Test

RIVSACA Rivers State Action Committee on AIDS

SCHIP State Children's Health Insurance Program

SES Socio-Economic Status

SHI Social Health Insurance

SP Social Protection

SRM Social Risk Management

SSA Social Security Administration

SSI Supplemental Security Income

STD Sexually Transmitted Diseases

TB Tuberculosis

UBEC Universal Basic Education

UEA University of East Anglia

UHC Universal health coverage

UN United Nation

UNAIDS United Nations Programme on HIV/AIDS

UNHCR United Nations High Commission for Refugees

UNICEF United Nations Children’s Fund

USAID United States Agency for International Development

VAT Value Added Tax

WCA Work Capability Assessment

WHO World Health Organization

WHR World Health Report

**EXECUTIVE SUMMARY**

*Background*

Despite large investments in expanding coverage of health in Nigeria, barriers still exist that prevent adequate utilization of these services by the poor. Consequently, direct interventions are required to reach the socially and economically excluded. Ensuring a healthy population is one of the social welfare responsibilities of government particularly the provision of welfare support for these identified vulnerable sub-population groups. Therefore, strengthening social protection systems through policies targeted towards designing of appropriate social protection instruments, that are most suitable for reducing disparities in accessing health services is increasingly becoming a priority area of work for governments at all levels.

With the realization that urgent and explicit changes are required to organize, integrate, and improve the delivery system, Federal government held a Presidential summit on Universal Health Coverage (UHC) committed all levels of government to place a high priority on *establishing mandatory health insurance in Nigeria* with special funds to expand financial risk protection mechanisms for the poor and vulnerable groups. Hence the need for this study to generate evidence for NHIS and other stakeholders to develop financial protection strategies to target these disadvantaged population sub-groups against catastrophic medical spending.

But who are the vulnerable? While several research efforts on vulnerable populations have demonstrated that the causes of disparities are multifaceted, some have tended to focus on single categories of vulnerability, such as persons with low income or are financially vulnerable; those with disabling, catastrophic or chronic illnesses; individuals that are unable to advocate or speak for themselves; those with mental health issues; those requiring the use of multiple systems or transitioning in life; and persons facing barriers to access that may be physical, cognitive, age, language, cultural, literacy or stigma based ([Aday 1993a](#_ENREF_3)). The diversity of vulnerable populations highlights that some of these sub-groups could possibly be experiencing a convergence or multiple, interrelated characteristics simultaneously. Despite the foregoing varied definitions of vulnerable groups, three features - predisposing, enabling, and need factors have been identified as guide for determining vulnerable population ([Aday L and R. Andersen 1981](#_ENREF_1); [Aday 1993b](#_ENREF_4)). These features provide the multidimensional framework and perspectives for the conduct of this study.

*Study Objectives*

Since vulnerability exhibit a convergence of many risk factors which influence health and healthcare experiences, the study examined more comprehensively and explicitly the contributions of multiple risks within the demographic structure of vulnerable groups in Nigeria. Specifically, one of the objectives was to determine the different types/categories of vulnerable groups, their distribution, estimated size and characteristics in the LGAs and states in Nigeria. Another objective was to establish the disease pattern and health seeking behavior of different vulnerable groups and assess their coverage with key health intervention, resources and utilization. More important in this study was the identification of appropriate institutional arrangement for providing health insurance to different categories of these groups and the estimated the cost. Given that some have low income, financially vulnerable and/or unemployed, the study aassessed the current burden of catastrophic medical expenses in accessing available services.

*Methodology*

As part of preparation for the field work, series of technical workshops were organized for the development and harmonization of the tools, methodology, work plan and reporting format for the studies. An interactive and plenary format was adopted for each of the workshop process allowing the research teams to contribute to the design of the methodology, data collection tools, reporting format, etc. The suggestions at the plenary were extensively discussed and the agreed outcomes were harmonized and adopted as the appropriate tools for the survey and reporting format for all zonal research teams.

The studies used qualitative and quantitative analyses and the data obtained from both primary and secondary data sources. A holistic review of the literature was conducted with a view to underscoring national and global understanding of the concept of vulnerable groups and listing the available types and categories as well as their characteristics. The study was carried out in eight states across Nigeria Kano, Zamfara, Enugu, Rivers, Ekiti, Lagos, Bauchi and Benue. Two Local Government areas in each state have been purposively selected by NHIS, to reflect urban and rural settings.

The following are the local governments where the primary data will be conducted: Kano Municipal LGA, Kunchi LGA; Gusau LGA, Bukkuyum LGA; Enugu North LGA, Nkanu East LGA; Port Harcourt LGA, Abua-Oduah LGA; Ilejemeje LGA, Ado LGA; Agege LGA, Ibeju-Lekki LGA; Bauchi, Warji; Makurdi, Oturkpo. The target populations are: Households, Public Sector Officials, Health Facilities, HMO, Care givers/Homes/Institutions for Vulnerable Groups, Public Primary Schools. A two-stage cluster sample design was adopted in each LGA for the household (HH) survey.

*Results and Discussions*

Despite the progress of recent years in FMCH, high uninsurance rates among low-income children and families continue to be a difficult and complex policy problem, while problems of limited funding from state and federal to the health sector threaten to undo recent gains. Yet, the findings presented in this report suggest that if public sector investments in health sector are harmonized and diverted towards health insurance, there is potential for improving the lives of Nigeria’s most vulnerable children. If states and policymakers build on the success of existing programs through priority setting, improve efficiency, good governance and establishment of health insurance schemes, these could eradicate uninsurance among low-income children in Nigeria. With health insurance – public or private - children have greater access to health care services and reap the benefits of such services, and families are cushioned from the economic hardship that can accompany an illness or injury requiring medical care.

In collaboration with other social protection programs in Nigeria, federal government should provide grants for children to encourage states to enroll more children in SCHIP, to provide states with fiscal relief, and to simplify administration, regulation and management of all public and private health insurance programs for other vulnerable groups. Federal funding should be stable, secure, and adequate to meet the needs of programs and provide incentives for states to cover as many eligible children as possible. In addition, federal matching grants for SHIS should be sufficient to make states indifferent to covering children in respective of the differences in the levels of their health status. States, for their part, would behave responsively to make sure that programs were adequately funded over the long run, regardless of the state of the economy, and that benefit packages and the level of provider reimbursement were adequate to assure children access to appropriate health care.

In recent times, the predictability and sustainability of the FMCH programme has been of concern to policy makers because the large share of the funding is from MDG which is expected to end in 2015. Unless a better alternative financing mechanism can be urgently identified, the stoppage of MDG by 2015 will have a profound effect on states’ ability to continue to provide coverage. This is important because pregnant women should not only have unfettered access to health facilities because of the enormous risks they face but they should also be protected from the financial risks of impoverishment that could arise from expenditures on health. Given the volatility of oil revenue which contributes a major percentage of the Government’s source of statutory allocation and coupled with the rather slow rate of increase of the State’s internally generated revenue, it is suggested that Government should replace the FMCH with an insurance programme to provide a more far reaching package, coverage and predictable and stable health payment mechanism for pregnant women. Diverting the funds for the FMCH to insurance will not only increase access to maternity care, it will also help to bring stability to its funding. Funds for FMCH should be deployed to the envisioned Basic Health Care Provision Fund to be established when the National Health Bill 2014 is passed into law

Incorporating disability‐inclusive policies into development framework coupled with effective delivery of disability‐focused programmes will immensely help to address the inequalities experienced by persons with disabilities in the State. Outrageously, none of the vulnerable groups in the institutions are covered by health insurance. This groups needs to be urgently accommodated under the SHI with full exemption to be paid by public fund. For the prison inmates, the prison authorities advocated for the incorporation of inmates into the proposed SHI for the vulnerable groups as the best way to provide for the health care of inmates. They were also of the view that the federal, state and local governments should jointly take responsibility for funding the enrolment of inmates.

The study assumed that the entre basic health care provision fund (BHCPF) from the National Health Bill should be allocated to finance health insurance interventions. Table xxx presents the estimated cost of health insurance provision for the vulnerable groups identified in this study - such as pregnant women, children, older persons and persons with disabilities - if health insurance interventions for pregnant women, children, older persons and persons with disabilities are funded by the BHCPF, the study shows that approximately 80% of BHCF alone can be used to finance health insurance coverage of all the children under 5 in the country in 2014. Under second scenario, the entire (100%) BHCPF can be used to finance health insurance coverage of children under 5 and pregnant women. These thresholds only considered the use of BHCPF alone without the use of government budgets at federal, state and local government levels.

*Policy recommendation and conclusion*

Health insurance coverage for the vulnerable population is a multi-faceted economic, political and policy challenge. The reality is that full exemption – non-payment of premium - for groups may not be sustainable without the financial involvement of all the stakeholders within and outside the health economy but with largely proportion from public sector investments. In this regard, the study recommends that the federal government should facilitate the establishment of State Health Insurance Scheme across the 36 states of Nigeria. This would allow the design of the health insurance coverage that is context specific - demographic, financial, and political dynamics unique to each state. The rationale is that exploring mechanisms and solutions specific to each state and local coverage initiatives, will better equip the state to enact a coverage expansion model that is appropriate in providing affordable, accessible, and sustainable healthcare to Nigeria’s uninsured vulnerable groups.

The federal government and states should work together to streamline funding of the health sector so as to ensure stable and adequate funding for State Health Insurance Scheme (SHIS), State Children Health Insurance Programme (SCHIP) and other health insurance programmes for the vulnerable groups in all states. The NHIS Act presently in the National Assembly should be reviewed to make it necessary for all the States to set up State Health Insurance Schemes similar to the State Primary Health Care Board across the states in the country.

The findings from the study shows that people who are vulnerable are overwhelmingly uninsured and often lack access to the most basic health care services for their complex health care needs. Therefore, policy-makers and development partners should re-assess programme design components, particularly as it relates to the features of social health insurance for vulnerable group and consider focusing on scaling up the existing programmes to cover a larger proportion of the vulnerable groups. Development partners can support the govern­ment at the federal and state levels to develop an overarching VGSHIP policy and regulatory framework, which will also promote knowledge and awareness of the different types of health services instruments that may be suitable for addressing health poverty and vulnerability at the state level. In conclusion, the selection of policy instruments to target health insurance coverage of the vulnerable groups should involve careful detailed actuarial analysis, realistic assessment of available resources and the difficult fiscal choices federal, states and local governments have to make among competing needs in all sectors of the economy.

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