



FEDERAL REPUBLIC OF NIGERIA

ZERO DRAFT

NATIONAL HEALTH FINANCING POLICY 2006

Foreword

The National Health Financing Policy represents the collective will of the governments and people of this country to provide a fair and sustainable health financing system. It describes the goals, the structure and policy directions of health financing in Nigeria. It also provides a framework for health financing functions including the process of revenue generation, mechanism for pooling and risk management as well as resource allocation and purchasing. It establishes the appropriate regulatory framework for health financing as part of the stewardship role of government.

Furthermore, it defines the roles and responsibilities of the three tiers of government as well as other stake stakeholders for financing human resources for health, information system, implementation, monitoring and evaluation. Its long term goal is to ensure that adequate and sustainable funds are available and allocated for accessible, affordable, efficient and equitable health provision and consumption.

However, it is my view that while a clear sense of strategic approach is essential for any health financing system, implementing the changes which follow from the strategy is more challenging, and therefore calls for more concerted efforts from the stakeholders. It will be recalled that in the 56th session of WHO regional committee for Africa, it was recognized that in order to reach the MDGs, and achieve national health-related development objectives, national health systems in the African Region urgently need more money; greater equity in health services financing and accessibility; efficient use of health resources; and expanded coverage of health services, especially those targeting the poor. Countries are urged to institutionalize national health accounts to facilitate financial planning, monitoring and evaluation.

To this end, this policy has been developed to address a number of key challenges including investment and public spending on health, achieving universal coverage and strengthening social safety nets, developing pre-payment schemes including social health insurance, supporting the national and international health development process, improving evidence for health financing policy development, implementation, monitoring and evaluation

I therefore, wish to emphasize the need for all stakeholders to collaborate with my ministry and health authorities at the state and local government levels to ensure the successful implementation of this policy. This will result in improving the performance of our health system.

I recommend this document for all stakeholders in the health sector, the Nigerian public as well as the international community.

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Honourable Minister of Health
October, 2006

FOREWORD

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Abbreviations/Acronyms

AIDS	Acquired Immune-deficiency Syndrome
CBHS	Community Based Health Insurance Scheme
DRF	Drug Revolving Fund
FMOH	Federal Ministry of Health
GDP	Gross Domestic Product
HIV	Human Immuno-deficiency Virus
IGR	Internally Generated Revenue
LEEDS	Local Government Economic Empowerment Development Strategy
LGA	Local Government Area
M&E	Monitoring and Evaluation
MDGs	Millennium Development Goals
MTEF	Medium Term Expenditure Framework
MTSS	Medium-Term Sector Strategy
NEEDS	National Economic Empowerment Development Strategy
NEPAD	New Economic Partnership for African Development
NGOs	Non-Governmental Organizations
NHFIS	National Health Financing Information System
NHIS	National Health Insurance Scheme
NHMIS	National Health Management Information System
NHP	National Health Policy
OOP	Out of Pocket Payment
PPP	Public Private Partnership
SEEDS	State Economic Empowerment Development Strategy
TB	Tuberculosis
WHO	World Health Organization

CHAPTER 1: INTRODUCTION

Provision of adequate and sustainable finance is vital for effective, efficient and equitable health system performance. In view of this, fairness in health financing has been recognized as one of the goals of a health system. The Nigerian health system has been rated poorly in this area over the years. For example household out-of-pocket expenditure as a proportion of total health expenditure averaged 64.5% between 1998 and 2002. This indicates that the burden of health expenditure is very high on households. Hence the need to explore and improve other sources of financing that are efficient, fair and sustainable.

Though Nigeria has made considerable progress in financing the health system, sustaining and improving on this performance will depend on the availability of equitable and efficient revenue generation mechanisms; pooling and managing financial risks, the extent to which vulnerable groups are protected as well as the existence of efficient health care purchasing arrangements. It is in this context that the National Health Policy prescribed the development of a National Health Financing Policy, as one of the means of achieving accessible, sustainable, affordable, equitable and efficient health care delivery.

CHAPTER 2: SITUATIONAL ANALYSIS

All states in Nigeria rely on a mixture of government budget, health insurance (social and private), external funding and private out-of-pocket spending to finance health care. Despite the variety of financing sources, the level of health spending is relatively low. Nigeria spends less than 5% of their gross domestic product (GDP) on health, and annual per capita health spending is less than US\$ 35 proposed by Commission on Macroeconomics and Health. This is a benchmark cost of a basic package of services to which a population should be entitled. However, public spending on health accounts for 20-30% of total health expenditure.

Evidence indicates that private health spending accounts for about 64% of total health expenditure and could be more that US\$ 23 per capita. The results provide evidence on the impoverishing effect of healthcare payments on households. On average, about 4% of households are estimated to spend more than half of their total household expenditures on health care and 12% of them are estimated to spend more than a quarter.

While health care costs are increasing faster than public revenues available for the health sector, economic constraints appears to have limited the amount of funds required to ensure universal coverage of necessary health interventions. Evidence from visits to states indicated that user charges for health care in the public sector are common, which can mean significant out-of-pocket spending (US\$ 22.5 per capita) at the time of care or illness.

There is limited awareness about the potential impact of prepayment financing, which spreads risk and pools funds, on issues of health care equity, financial protection and social safety net improvements. The link between health and development is not fully appreciated in most of parts of the country, and a better

understanding of that link could help foster a broad consensus on increased health investments and the effective delivery of health services, especially for the poor. The health care financing regulatory framework is still relatively weak, and strong government leadership and intervention are essential for improvement.

In terms of institutional framework for health financing at all levels of government, there is lack of effective coordination at the Federal level of healthcare expenditures from various financing mechanisms. There is also a need to establish a system of expenditure tracking to improve the effectiveness and impact of public expenditure. However, there is now an improvement at the Federal level with the advent of Medium Term Sector Strategy and Medium Term Expenditure Frameworks for budgeting. Harmonization of donor funds has also been hampered by the inconsistency between the Federal, State and Local Government. National Health Accounts remains an ad hoc exercise while majority of the states are yet to develop State Health Accounts

Comprehensive health policy formulation, implementation and monitoring largely depend on reliable data and information on existing and potential financing initiatives, health expenditures, as well as financing sources and levels. However, there are wide variations from state to state within the country in terms of implementation modalities, impact, data availability, comparability, data source, scope, collection, presentation, and the use of the data for health policy formulation, implementation and monitoring.

Most states do not have a health financing policy in place but some have health laws that provide mechanisms for financing the health system. Health is considered a priority of most state governments and many have developed the SEEDS and LEEDS for all their local governments derived from the NEEDS.

Other sources of revenue include Drug and other forms of Revolving Fund Schemes, Cost Recovery Schemes, Donor Support, and Community Base

Health Insurance. In many of states, public hospitals have functioning and efficient DRF systems. Visit to the most facilities during the collection of data for the health financing policy formulation revealed that some of the recovered money is yet to be retained at the facility level, despite a 15% mark-up of which 5% of the mark-up was to be retained at the facilities. However, Deferral and Exemption policy is effective in many States and should be encouraged at all levels of health care delivery.

Most of the states are yet to commence the implementation of Social health insurance. However with the implementation of National Health Insurance Scheme by the federal government, public and private health facilities have now been registered as major health care providers for the programme. Thus, these facilities now generate additional revenue from the NHIS. A cursory look at the income the Hospitals revealed an increased revenue generation by the hospital as a result of participation in the NHIS. On the average, NHIS is accounts for about 30% of the total income of the hospital.

CHAPTER 3: FEATURES OF THE POLICY

3.1 Strategic Context

The National Health Financing Policy has been formulated within the framework of:

- i. The United Nations Millennium Development Goals (MDGs) to which Nigeria, like other countries, has committed to achieve.
- ii. Paris Declaration on Aid Effectiveness
- iii. The Health Strategy of the New Partnership for Africa's Development (NEPAD), a pledge by African leaders based on a common vision and a firm conviction that they have a pressing duty to eradicate poverty and place their countries individually and collectively on a path of sustainable growth and development.
- iv. The New Economic Empowerment and Development Strategy (NEEDS) which is aimed at re-orienting the values of Nigerians, reforming government institutions, growing the role of the private sector, and enshrining a social charter on human development with the people of Nigeria.
- v. The National Health Policy (2004) which objective is to strengthen the national health system such that it would be able to provide effective, efficient, quality, accessible and affordable health services that will improve the health status of Nigerians.
- vi. The Health Sector Reform Programme (2004)

3.2 Guiding Principles and Values

The National Health Financing Policy is guided by the following principles and values:

- i. The principle of social justice and equity and the ideals of freedom and opportunity that have been affirmed in the 1999 Constitution of the Federal Republic of Nigeria.
- ii. Health and access to quality and affordable health care is a fundamental human right
- iii. Equity in health care and in health for all Nigerians is a goal to be pursued
- iv. Good quality health care shall be assured through cost-effective interventions that are targeted at priority health problems and that promote the ideals of families as “creators “ of health
- v. A high level of efficiency and accountability shall be maintained in the development and management of the national health system.
- vi. Effective partnership and collaboration between various stakeholders shall be pursued while safeguarding individual identities
- vii. Since health is an integral part of overall development, inter-sectoral cooperation and collaboration between the different health-related and finance Ministries, development agencies and other relevant institutions shall be strengthened
- viii. Community involvement and sustainability shall be encouraged

3.3 Health Financing Policy Declarations and Commitment

Guided by the National Health Policy, the National Health Financing Policy Declarations and Commitments are as follows:

The Federal, State and Local Governments as well as the private health sector of Nigeria hereby commit themselves and all the people to intensive action to attain

the goal of health for all citizens, that is, a level of health that will permit them to lead socially and economically productive lives at the highest possible level.

1. All Governments of the Federation are convinced that the health of the people does not only contribute to a better quality of life, but is also essential for the sustained economic and social development of the country as a whole.
2. The people of this nation have the right to participate individually and collectively in the planning and implementation of their health care. However, this is not only their right, but also their solemn duty.
3. The people of this nation have the right to health information, education and community mobilization processes that empower them to promote their health, prevent disease and effectively manage common health problems
4. All Nigerian Governments and their people are determined to formulate strategies and plans of action, particularly such plans of action to be taken by governments, to relaunch and sustain primary health care in accordance with this National Health Financing Policy.
5. All Nigerian Governments agree to cooperate among themselves in a spirit of partnership and service to ensure primary health care for all citizens, since the attainment of health by people in any one area directly concerns and benefits people in other areas of the Federation.
6. The Federal Government undertakes:
 - a. To provide policy guidance and strategic support to States, Local Governments, the private sector and Development Partners in their efforts at establishing efficient, equitable and sustainable health financing mechanisms;
 - b. To coordinate efforts of stakeholders in order to ensure a coherent, nationwide health financing system;
 - c. In collaboration with the State and Local Governments and the organized private sector as well as Non Governmental Organizations (NGOs), to undertake the overall responsibility for monitoring and evaluation of the implementation of the national health financing policy

7. All Governments accept to exercise political will to mobilize and utilize all available health resources rationally and responsibly.

The major thrust of the National Health Financing Policy shall relate to the following issues:

- i. Revenue Generation and Collection
- ii. Revenue Pooling and Risk Management
- iii. Resource Allocation and Purchasing
- iv. Regulatory Framework for Health Financing
- v. Health Financing Management Including:
 - Financing Human Resources for Health
 - Health Financing Research
 - Health Financing Information System
 - Implementation, Monitoring and Evaluation

3.4 Goal and Objectives of National Health Financing Policy

3.4.1 Goal

To ensure that adequate and sustainable funds are available and allocated for accessible, affordable, efficient and equitable health care provision and consumption.

3.4.2 Objectives:

- i. To establish mechanisms for continuous availability of adequate funds for the provision of cost-effective health services
- ii. To ensure that all citizens have timely access to quality health services as needed and for better health outcomes without financial barriers
- iii. To ensure the efficient use of financial resources for health
- iv. To put in place adequate regulatory frameworks for health financing

CHAPTER 4: HEALTH FINANCING FUNCTIONS

4.1 Guiding Principles

- a. Funds would be available now and in the future to maintain optimal levels of essential services and ensure financial protection
- b. The revenue collection mechanisms to finance the health system should be seen to be fair, that is access to health care would be based on need rather than ability to pay
- c. The process of raising revenue would create minimal distortions in the economy
- d. The methods and levels of pooling would ensure cross subsidization (re-distribution from the rich to the poor, the healthy to the sick, gainfully employed to unemployed etc.)
- e. Prepayment mechanisms amongst others would be encouraged and used
- f. The number and type of services purchased and consumed would maximize community welfare by producing the desired health outcomes
- g. Quality health services would be produced at the lowest possible costs
- h. There would be no financial and physical barriers to accessing health care services including health information, materials and skills for informed health decision making
- i. People would have full access to requisite information on health care financing mechanisms
- j. Consumers would have full value for money spent on health
- k. Rights of consumers would be ensured

4.2 Revenue Generation and Collection

- 4.2.1 Government at all levels (Federal, State and Local Government) shall seek to allocate not less than 15% of their total budgets to health
- 4.2.2 Government shall explore opportunities for ear-marked taxes and foreign direct investment for health
- 4.2.3 Special financial provisions shall be made for diseases of public health significance such as malaria, HIV/AIDS, TB, Leprosy, vaccine preventable diseases and others
- 4.2.4 Financial provisions shall be made for poor and vulnerable groups in the form of direct payments, subsidies, paying for insurance contributions or any other methods
- 4.2.5 Identifying, adapting and scaling up financing schemes that have been shown to work to expedite universal access and sustainability of health financing. For example the drug revolving funds and their features like deferrals and exemptions etc.
- 4.2.6 Social Health Insurance through the National Health Insurance Scheme shall be encouraged for all and expanded to cover the informal sector as a means of increasing resources for health, ensuring universal access to care and providing financial protection to the poor and vulnerable.
- 4.2.7 Existing employer financing schemes like retainership shall be discouraged and such funds channelled to health insurance
- 4.2.8 States shall be encouraged to develop social health insurance schemes, taking into account the over arching responsibility for regulation at the federal level
- 4.2.9 Community Based Health Care Financing Schemes shall be explored and strengthened, especially for the informal sector and rural areas as a means of achieving universal coverage

- 4.2.10 Private Health Insurance shall continue to be available and purchased based on individual choice
- 4.2.11 All external aids for health shall be harmonized, monitored and evaluated in line with health priorities and plans at all levels of government
- 4.2.12 Domestic philanthropy and charities shall be encouraged, promoted and harnessed to improve resource availabilities for health at all levels of government and community level
- 4.2.13 As much as possible efforts shall be directed to minimising the use and burden of out-of-pocket spending
- 4.2.14 Fiscal discipline shall be ensured in the mobilization and utilization of funds for health financing with a view to reducing deficit financing
- 4.2.15 Private-Public-Partnerships for health financing shall be encouraged at all levels

4.3 Revenue Pooling and Risk Management

(This does not apply to selective out-of-pocket payments)

- 4.3.1 Financing mechanisms shall involve pooling of funds, risks and management
- 4.3.2 There shall be a split between funding and purchasing and the powers for both shall not reside in same agency
- 4.3.3 Efforts shall be made to avoid adverse selection and cream skimming
- 4.3.4 Mechanisms for risk equalization amongst schemes such as risk equalization fund and health re-insurance etc, shall be established

4.4 Resource Allocation and Purchasing

- 4.4.1 There shall be a split between purchasing and provision and the powers for these functions shall not reside in same agency
- 4.4.2 Both public and private facilities shall be involved in the provision of health services irrespective of the funding mechanism
- 4.4.3 Allocation of resources shall be made according to defined objective criteria
- 4.4.4 Institutionalization of the medium-term sector strategy (MTSS) and medium-term expenditure framework (MTEF) in the allocation and management of public sector health expenditure shall be adopted at all levels
- 4.4.5 There shall be commitment to developing and using provider payment mechanisms that ensure optimal provider performance without escalating cost
- 4.4.6 Cost containment mechanisms shall be adopted in the purchase and use of services
- 4.4.7 There shall be commitment to developing mechanisms that ensure that those who cannot afford to pay, can still purchase services
- 4.4.8 Priority shall be given to the purchase of cost-effective services and those essential for achieving the MDGs and national priorities
- 4.4.9 A framework for regular evaluation of benefits and costs of interventions and technologies shall be put in place to ensure optimal choices
- 4.4.10 There shall be quality assurance for services purchased , irrespective of funding mechanism and level of care

CHAPTER 5: HEALTH FINANCING MANAGEMENT

5.1 Financing Human Resources for Health

5.1.1 Background:

Of all the inputs required for an effective, responsive, equitable and relevant health delivery system, the human resources are the most critical in that they are necessary for the manipulation of all other resources.

Experience has also shown that problems in health care delivery may not always be as result of deficiency in resource availability but may be as a result of poor or inadequate management of existing resources. This poor management of resources has also included the poor management of human resources.

Based on the registers of health professionals in the country, it is obvious that the population:health worker ratios are still far from ideal and yet unemployment and under-employment of health workers are been reported. As an example, doctors graduating from medical schools are finding it difficult to get placement in housemanship positions while this is a required training post before they can be fully registered by the Medical Council.

There is therefore a need for adequate financing to allow a proper health human resource needs assessment, support relevant professional training and development of health human resource, maintain a database of human resource availability and distribution, and provide necessary financial mechanisms to support an equitable distribution of human resources to include underserved areas.

The goal of a health human resource financing policy will therefore be to support the identification of the health needs of the citizens and the categories of health manpower required to support the training and development of the various

categories of health workers; to maintain adequate databases on human resource availability and distribution and to support an equitable distribution of human resources with the use of appropriate financial mechanisms.

5.1.2 Establishment of the System

A system for financing human resources for health shall be established by the Government of the Federation with the clear objectives of ensuring availability in adequate numbers of relevant health human resources who shall be the fulcrum of an efficient, qualitative, accessible, and responsive health system

In recognition of the above, the FMOH in collaboration with State Ministries of Health and Local Government Health Authorities and professional bodies shall:

1. Provide the necessary financial and other support that will induce health workers to serve anywhere their services are required in Nigeria as well as reduce the emigration of trained/skilled health workers
2. Finance the production and development of quality human resources for health care delivery
3. Finance the pursuit of the training of specialized human resources in the rare but required fields of health care.
4. Invest adequately in the pre-service, in-service and continuing professional education of health workers to ensure quality delivery of health services including health promotion and disease prevention.
5. Invest adequately in the pre-service, in-service and continuing professional education of health workers to ensure effective client-focused interface between providers and consumers and education and mobilization of communities on health.

6. Encourage Private sector participation in human resources for health development through the establishment of foundations, philanthropies, and endowments.
7. Put in place systems for assessing health worker performance and rewarding excellent performance including the use of financial incentives.
8. Put in place appropriate mechanisms to ensure the safety at work of health workers as well as providing protection against work-related risks including compensation when required (including insurance)
9. Allocate a minimum of 15% of the health budget to development of human resources. (NHP 2004)

5.2 Health Financing Research

Government and relevant stakeholders shall ensure that research in health financing is conducted on the three core functions of health financing plus a fourth group that deals with cross-cutting issues. The research activities shall include:

5.2.1 Revenue Generation and Collection

1. Undertaking inventory and market share of different healthcare financing mechanisms in Nigeria.
2. Assessing the relative contribution of different healthcare financing mechanisms to money available to finance healthcare in Nigeria.
3. Tracking healthcare expenditures at different levels of government for optimal public expenditure management and institutionalizing the national health accounts.
4. Analyzing equity and efficiency of different healthcare financing mechanisms.

5. Examining modes for increasing healthcare financing from equitable and risk pooling sources.
6. Assessing mechanisms for coordinating budgeting, planning, monitoring and evaluation of different healthcare financing mechanisms.
7. Developing strategies for scaling-up of financing mechanisms that are pro-poor and assure greater financial risk protection.
8. Conducting studies on how to reduce out-of-pocket payments (OOPs) for healthcare and getting value for money

5.2.2 Revenue Pooling and Risk Management

1. Assessing the feasibility of different healthcare financing mechanisms in Nigeria.
2. Developing innovative efficient and equitable healthcare financing mechanisms.
3. Determining the nature of financial risk protection of healthcare expenditures/financing mechanisms.
4. Assessing the feasibility of demand side healthcare financing (vouchers, cash transfers etc).
5. Assessing the mechanisms for coordinating healthcare financing.

5.2.3 Resource Allocation and Purchasing

1. Conducting economic and policy analysis of different benefit packages.
2. Studying the efficiency of using the medium-term sector strategy (MTSS) and medium-term expenditure framework (MTEF) as the basis for public financing of healthcare.
3. Studying the effects of market failure on health financing, especially in health insurance markets (moral hazard, cream skinning, adverse selection) and the existence of supplier-induced demand.

4. Conducting benefit and financial incidence analyses of different health financing mechanisms in Nigeria (who pays and who benefits?).
5. Determining which services to purchase, especially to ensure equity, as well as to achieve the MDGs, other international and national priorities.
6. Assessing the allocative and technical efficiency of different services to be purchased.

5.2.4 Cross-cutting issues

1. Determining the supply and demand barriers to different health financing mechanisms.
2. Examining modes for raising sufficient and sustainable revenues in an efficient and equitable manner to provide individuals with both a basic package of essential services
3. Examining how to provide people with financial protection (safety nets) against unpredictable catastrophic financial losses caused by illness or injury.
4. Assessing household coping mechanisms to health expenditures and to different payment mechanisms.
5. Investigating equity in health financing, especially with respect to revenue generation, risk pooling, actual payment and purchase of services.
6. Assessing the effectiveness of the roles, responsibilities and implementation framework for the government to ensure equity and efficiency in health financing.
7. Investigating the existence and effectiveness of the regulatory framework for health financing, especially with regards to equitable, transparent and efficient management of revenues.
8. Determining the mechanisms for improving and using the health financing information system for optimizing healthcare financing in Nigeria.

9. Determining the extent to which closer levels of interactions/ cooperation can be fostered between federal, state and local governments, as well as with donor agencies and the private sector in health financing.
10. Examining the roles and rights of consumers and communities in health financing.
11. Undertaking economic and policy analysis of different health financing interventions, especially the NHIS and CBHIS
12. Evaluating the extent of implementation of the Health Financing Policy

5.3 National Health Financing Information System (NHFIS)

5.3.1 Background

The availability of accurate, timely, reliable and relevant health financing data and information is an essential step towards the development and maintenance of fair and sustainable health financing system. The use of this evidence-based data will aid health policy formulation, implementation, management as well as monitoring and evaluation and research of health financing reforms. These will help to protect people living in poverty from catastrophic health expenditures and promote efficient and high quality healthcare service provision leading to good health for all. Therefore, it is imperative that for an effective health financing information system, government at all levels have an overriding interest in supporting and ensuring the availability of health financing data and information as a tool for utilization by the public and private sectors.

The implementation of fair and sustainable health financing reforms, strategies and action plans are hampered by the dearth of reliable data on health financing at all levels of implementation. This is worsened by lack of quality assurance and good governance resulting in poor accountability, non-transparency, discriminatory and poor stakeholder participation. It is observed that poor performance and poor practice can too often thrive behind closed doors. Processes which are open to public scrutiny, while respecting individual party confidentiality, and which can be justified openly, are an essential part of quality

assurance. Until recently, the fundamental data about health financing were unreliable. The system for a closer analysis of the three health financing functions of revenue collection, risk pooling and purchasing at all levels is not satisfactory. Also, the system of collecting basic quality data on health spending and other indicators on a country-wide basis is still underdeveloped. The available estimates are obtained from the centres where such data are generated and collected, from national surveys, from institutional records and from special studies.

5.3.2 Establishment of the System

A National Health Financing Information System shall be established by the Government of the Federation. It shall be used as a tool for informed decision making at all levels of health care and related services to:

1. Assess the health financing capacity of health institutions, to identify major health financing constraints and set priorities for action at local, state and national levels.
2. Monitor progress towards the attainment of the stated goals, objectives and thrust of health financing Policy.
3. Provide indicators to monitor and evaluate the utilization of funds and their impact on the health status of the population.
4. Identify and maintain procedures by which the utilizations of funds are tractable by all stakeholders in order to entrench accountability, quality assurance and good governance.
5. Provide information for use by all stakeholders

5.3.3 Development of the System

The development of the health financing information system shall include the following components:

1. The financing information system shall be developed in a phased manner, starting with the simplest data which can be collected at peripheral institutions. Efforts shall be made to implement community-based systems for the collection of vital health financial statistics of the three health financing functions of revenue collection, risk pooling and purchasing at all levels. Such data shall be used for the planning of health services at the local level.
2. The State Ministry of Health shall promote and support the collection of health financing data by the Local Government Health Authorities to improve the quality and quantity of health financing information. The methods of collection and recording shall be standardized, as much as possible, to facilitate their collation and evaluation.
3. At the Federal, State and LGA levels, there shall be a Health Financing Coordinating Committee. This shall consist of respective ministries of Health, stakeholders and relevant donors which shall be responsible for sourcing, obtaining, collating, harmonizing, analyzing and interpreting health financing data and fund on a national basis. The committee shall in addition identify and maintain procedures by which the utilizations of funds are tractable in order to entrench accountability, quality assurance and good governance in the fund management. The committee shall support the development of health financing information systems at various levels.

5.3.4 Sources of Health Financing Data and Information

The principal sources of health financing data and information shall include the following:

1. *Public-Governments and their Agencies.*

Budgetary allocation data, direct and indirect taxes, compulsory insurance contributions and payroll taxes, voluntary insurance premium, medical saving accounts internally generated revenue (IGR), loans, grants and donations shall be made available by appropriate authority.

2. *Private-Firms, Corporate Entities, and Employers, Foreign and Domestic Non-Government*

Organizations, Foreign Governments and Companies, Compulsory insurance contributions and payroll taxes, voluntary insurance premium, medical saving accounts loans, grants and donations shall be made available by appropriate authority.

3. *Surveys*

Household expenditure, Donations, Grants,

5.3.5 Health Financing Information Responsibilities of Each Level of the System

There shall be five levels of responsibility in the system as follows;

1. Local Level where the Local Government Health Authority shall be responsible for:

- (i) The collection, analysis, utilization and dissemination of data in its area of jurisdiction.
- (ii) Ensuring timely forwarding/sharing of data to and with relevant departments, agencies and programmes operating at the LGA level.
- (iii) Ensuring the forwarding of aggregated data and signed prescribed forms to the state level.
- (iv) Ensuring immediate submission of financial data to the Health Coordinating Committee of the State Ministry of Health and
- (v) Training and supervision of relevant personnel of the health facilities within its area of jurisdiction

2. State Level where the State Ministry of Health shall be responsible for:

- (i) Collecting and aggregating relevant health financial data and information from all local government areas within the State.
- (ii) Ensuring timely forwarding/sharing of data to and with relevant department, agencies and programmes operating at the State level;
- (iii) Ensuring immediate submission of data to Health Coordinating Committee of the Federal Ministry of Health.
- (iv) Ensuring the preparation of a State Health Profile for decision making, dissemination and feedback and
- (v) Training and supervision of State health personnel and LGA officials.

3. National Level where the Federal Ministry of Health shall be responsible for:

- (i) The development, introduction and maintenance of an effective National Health Financing Information System (NHFIS)
- (ii) The central coordination of the national health financing information data.
- (iii) Collecting, processing and presenting relevant and necessary information required both for national health planning and for monitoring the utilization of resources in accordance with national priorities and objectives.

- (iv) Providing technical and management support to strengthen national health financing information system at all level.
- (v) The flow and feedback paths of health financing data and information shall be from the community level to the national level and
- (vi) Adequate funding shall be provided by all levels of governments as support for the development and operations of the NHFIS.

5.3.6 NHFIS and National Health Information Management System (NHIMS)

The HFIS shall be incorporated into the National Health Information Management System to facilitate standardization and ensure cooperation and coordination among relevant agencies and make information available to communities, individuals and research groups.

5.4 Implementation, Monitoring and Evaluation

Implementation of health financing mechanisms in this policy needs to be monitored and evaluated at regular intervals. This exercise is needed for building more evidence for future policy and for the assessment of whether the policy objectives have achieved the expected results.

The success of the national Health financing Policy would depend on how well its provisions are implemented. Mechanisms shall, therefore, be put in place for monitoring, measuring and evaluating the Policy's performance and impact, and for identifying possible problems and evolving effective strategies to address them. In this regard government shall ensure:

- i. That citizens have unfettered access to information on health revenue, expenditures and health financing in general
- ii. The setting up of a National Health Financing Policy Monitoring and Evaluation Sub-Unit in the NHMIS Unit and M&E Unit at the State and

- LGA levels to measure progress in the implementation of the policy and to run a national assessment profile of the health financing mechanisms;
- iii. Compilation of indicators for monitoring the National Health Financing Policy as an integral part of the national Health Information System, and evaluating these indicators at all levels of health care at the local, state and federal governments;
 - iv. Institutionalising of public expenditure management as a means of ensuring accountability, planning, budgeting and monitoring.
 - v. Total commitment to its stewardship role in the development of monitoring and evaluation frameworks
 - vi. Development and implementation of effective management information system for the NHIS and other financing mechanisms.
 - vii. Putting in place adequate legal frame work for collecting, storing, analysing and disseminating information on health financing
 - viii. Collaboration between policy bodies, stakeholders and academic institutions in capacity building for implementation, monitoring and evaluation
 - ix. Effective monitoring of the donor support, NHIS, and other financing initiatives on access to health care
 - x. Publication of government's annual budgets and expenditures at all levels
 - xi. Regular and effective tracking of revenues and expenditures at all levels of government, health care facilities and programmes
 - xii. Annual production and dissemination of health accounts at all levels
 - xiii. Full evaluation of a full evaluation of National Health Financing Policy every three years

In order to ensure the comprehensive monitoring and evaluation of health financing, the minimum categories of indicators shall be as follows:

1. Revenue Generation and Collection Indicators
2. Pooling and Risk Management Indicators
3. Purchasing and Allocation Indicators

5.5 Health Financing Indicators

1. Revenue Generation and Collection Indicators

1. *Health Revenue*

- i. Total real funds available for different sources of health financing
- ii. Ratio of total expenditure to allocation from federation account
- iii. Ratio of total health expenditure to total revenue
- iv. Ratio of donor health funding to total health expenditure

2. *Health Expenditure*

- i. Total expenditure on Health as percentage of Gross Domestic Product(GDP)
- ii. Per capita health expenditure
- iii. Annual real growth of
 - Total health expenditure; and
 - Per capita health expenditure

3. *Government Expenditure on Health*

- i. Government-funded health expenditure as percentage of GDP
- ii. Ratio of capital to recurrent expenditure
- iii. Ratio of salary to non-salary expenditure(within recurrent expenditure)
- iv. Recurrent to total health expenditure
- v. Government-funded health expenditure as percentage of total health expenditure

- vi. Government-funded health expenditure as percentage of total government expenditure

4. *Out-of-pocket Health Expenditure*

- i. Out-of-pocket health expenditure as percentage of total health expenditure
- ii. Out-of-pocket health expenditure as percent of total private health expenditure
- iii. Private prepaid plans as percent of private expenditure on health

5. *External Health Sector Aid*

- i. Total external health sector grant aid as share of total expenditure
- ii. Bilateral and multilateral debt stock for health as per cent of total government debt stock

2. Pooling and Risk Management Indicators

1. *Health Insurance*

- i. Per cent of total population covered by different health insurance schemes
- ii. Prepayment ratio in health insurance plans
- iii. Total expenditure on health insurance as a percentage of total health expenditure
- iv. Total premium of health insurance as a percentage of total expenditure on health insurance

- v. Proportions of health expenditures from different health insurance mechanisms

2. Financial Protection

- i. Population exposed to catastrophic health expenditure as per cent of total population
- ii. The number of people confronted with excessive or catastrophic expenditure in relation to their capacity to pay
- iii. The intensity of catastrophic health expenditure
- iv. Incidence of health-related poverty measured as per cent of population falling into poverty due to ill health
- v. Percentage of poor and vulnerable population covered by social safety nets

3. Purchasing and Allocation Indicators

1. Equity in Health Expenditure

- i. Benefit incidence ratios of different financing mechanisms (health expenditure by zones, states, LGAs, urban/rural, gender, age, income groups, level of care etc.)
- ii. Financial incidence ratios of different financing mechanisms

2. Equity in Service Access and Use

- i. Ratio of per capita health service use of lowest income quintile to per capita health service use of highest income quintile

4. Cross Cutting Indicators

1. Regulation

- i. Measure of content compliance of the regulation to the financing policy: proportion of the rules and regulations in the legal framework conforming with the requirements of the financing policy

2. Human Resources for Health

- i. Percentage of total health expenditure allocated to human resources for health

3. International Health and Development

- Attainment of MDG for poverty and health
 - Proportion of population below \$1(PPP) per day
 - Poverty gap ratio
 - Share of poorest quintile in national consumption
 - Proportion of population with access to affordable essential drugs on a suitable basis

Glossary of Technical Terms

Adverse selection The tendency of purchasing health insurance benefit packages by individuals with high health risk affecting health expenditure increases more than people with low health risk.

Benefit package A minimum set of services that are offered to an insured person within a level of contributions.

Capital cost, Capital expenditure Cost of inputs whose useful life is usually longer than one year. In terms of health investments, refers to expenditure on physical assets such as hospitals, beds, health centres, medical and diagnostic plant and equipment, etc.

Catastrophic health expenditure A situation where a household spends on health more than 40% of its income after paying for subsistence needs, e.g. food. It can be caused by catastrophic illness, either high cost but low frequency event or by low cost and high frequency events.

Contracting The process in which a legal agreement between a payer and a subscribing group or individual such as purchasers, insurers, takes place which specifies rates, performance covenants, the relationship among the parties, schedule of benefits and other pertinent conditions.

Co-payment A fixed amount of payment, which must be paid by a beneficiary for each service at time of service use.

Cost Resources in monetary terms expended in carrying out activities.

Recurrent cost: Costs of inputs whose useful life is less than one year.

Cost-effectiveness analysis A form of economic evaluation where costs are expressed in money terms but consequences are expressed in physical units. It is used to compare different ways of achieving the same objective.

Costing The techniques and processes of ascertaining the expenditures the amount of expenditure incurred on particular products and services.

Debt stock Total value of borrowings of an entity such as a sovereign country or a firm, which constitutes a liability of the entity, measured at a given point in time.

Decentralization Transfer of administrative power from a central to a local authority. Also referred as “devolution of power”.

Demand The level of consumption preferred by consumers at different prices.

Deferral and Exemption Deferral and Exemption scheme aims at guaranteeing access to quality health care to the mass population of the poor in the society. It tends to encourage those who temporarily lack the capacity to pay cash immediately for the treatment or other health service to have the service and later come back at a specified period for payment (**deferral**). Those who permanently lack the money to pay for the service can also access the service without personally paying for it (**exemption**). These are the unemployed and others unable to pay for economic and social reasons

Earmarked tax Contribution dedicated to health or particular function. Earmarked taxes sometimes reduce flexibility over time in allocating public funds to the best possible use. It may also reduce accountability of agencies to which funds are allocated when those revenues are determined by factors independent of the number or quality of services provided.

Effectiveness The effect of the activity and the end results, outcomes or benefits for the population achieved in relation to the stated objectives. It is an expression of desired effect of programme, service intervention in reducing a health problem or improving an unsatisfactory health situation.

Efficiency The effect or end results achieved in relation to the effort expended in terms of money, resources and time.

Technical efficiency: The production of the greatest amount or quality of outcome for any specified level of resources.

Allocative efficiency: An allocation of the mix of resources for maximal benefit, i.e. such that no change in spending priorities could improve the overall welfare.

Equity The absence of systematic disparities in health between social groups who have different levels of underlying social advantage or disadvantage - that is, different positions in a social hierarchy. Inequities in health systematically put groups of people who are already socially disadvantaged such as by virtue of being poor, female, and/or members of a disenfranchised racial, ethnic, or religious group at further disadvantage with respect to their health.

Fair financing A way health care is financed is perfectly fair if the ratio of total health contribution to total non-food spending is identical for all households, independently of their income, their health status and their use of health services.

Fee for service Payments to a provider for each item or services provided.

Foreign Direct investment (FDI) Investment by firm based in one country in actual productive capacity or other real assets in another country, normally through creation of a subsidiary by a multinational corporation. Used as a measure of globalization of capital. Effects on growth and inequality in developing countries disputed.

Formal sector Enterprises, which are registered and licensed to conduct business and whose employees earn regular salaries and wages.

Functions of health care financing The core functions of health financing are: collecting revenue, pooling of resources and purchasing:

- **Collecting revenue:** is the process by which health systems receive money from households, companies and institutions as well as from donors. Various ways of collecting revenues are general taxation, social health insurance, private health insurance, out-of-pocket payments and grant and charitable donations and multilateral borrowing.
- **Pooling of resources:** the process of accumulation and management of revenues to ensure that the risk of having to pay for health care is borne by all the members of the pool and not by each contributor individually. Various forms of tax and social health insurance schemes aiming at sharing the financial risk and funds among the contributing members are the main focus of this function.
- **Purchasing:** of health services is the process by which the most needed and effective health interventions are chosen and provided in an efficient and equitable manner, and the providers are paid appropriately from the pooled financial resources for delivering defined sets of services and interventions. Purchasing has three interwoven elements; "allocating financial resources", establishing "provider payment options" and "contracting" with providers.

Funders Organizations contributing to the coverage of health care expenditures or providing the funding for health care through budgets, contracts, grants or donations to a health care provider.

Gross domestic product (GDP) The total value of goods and services produced within a country each year.

Health insurance Financial protection against medical care costs arising from disease or injury. The reduction or elimination of the uncertain risks of loss for the individual or household, by combining a larger number of similarly exposed individuals or households who are included in a common fund that makes good the loss caused to any one member.

Community based health insurance (CBHI): A micro-insurance scheme managed independently by community members, a community-based organization whereby the term community may be defined as members of a

professional group, residents of a particular location, a faith-based organization etc.

Social health insurance: Compulsory health insurance, regarded as part of a social security system, funded from contributions – often community rated- and managed by an autonomous yet state/parastate legal entity.

Private health insurance: A health insurance scheme often characterized with the following features: voluntary, managed outside the social security system where premiums are risk-rated rather than community-rated, managed by an independent legal entity (an incorporation, organization, association or foundation) not by a state/quasi state body, operating for profit or non-profit.

Voluntary health insurance. Health insurance that offers benefit to its members entitled on a voluntary basis, which can be managed by a private, public or quasi-public body.

Health Maintenance Organization (HMO) An organization that accepts responsibility for organizing and providing a defined set of services for its enrolled population, in exchange for a predetermined, fixed, periodic payment for each person or family unit enrolled (see also *Managed Care*).

Health spending As one of the *Health for All* global strategy, WHO advised the Member States to spend minimum 5% of GDP on health. In many countries only one disease, such as diabetes could consume the entire amount. High level of spending may not necessarily lead to high health outcomes. At any given level of income and spending health outcome varies. Therefore, efficient use of available funds becomes critical. It is also important to correct imbalances, low spending in some areas and high spending in others.

Informal sector Enterprises, which are not registered and licensed to conduct business but do so in an entrepreneurial, independent manner, and whose earnings are not reported or declared as part of a payroll process. Compared with wage-earning workers in the formal sector, the informal sector has more labour-intensive mode of production. Informal production units typically operate at a low level of organization, with little or no division between labour and capital on small-scale labour operations. Their existence is based on casual employment, kinship or personal and social relations rather than contractual arrangements with formal agreement.

Moral hazard Abuse of insurance benefit by insured people which yields to an increase in health expenditure.

National HealthAccounts (NHA) A framework and methodology for measurement and presentation of information on total national health expenditure including public and private sources of funds. NHA tracks financial

resources from sources, to providers and functions. It is important because, health systems are complex and policy makers need tools to analyse HCF, how and how much resources used in a health system, what resource allocation patterns, use and options exist.

Out-of-pocket payments Payment out of private purse as opposed to public made directly by a patient to a health service provider without reimbursement.

Payer The public or private organization that is responsible for payment for health care expenses. Payers may be insurance companies or self-insured employers or persons.

Pay roll taxes Contributions levied against labour income. They are inexpensive to administer but easier to avoid than other forms of taxes.

Per capita income A measure of human progress, using overall well-being to judge the level of a country's development.

Policy An agreement or consensus among relevant partners on the issues to be addressed and on the approaches or strategies to deal with them.

Poverty gap ratio is the mean distance separating the population from the poverty line (with the non-poor being given a distance of zero), expressed as a percentage of the poverty line.

Prepayment scheme A method of paying for the cost of health care services in advance of their use. A method providing in advance for the cost of predetermined benefits for a population group, through regular periodic payments in the form of premiums, dues, or contributions, including those contributions that are made to a health fund by employers on behalf of their employees.

Prepayment ratio Ratio between the benefit paid by health insurance and total benefit provided to a patient.

Premium Amount paid to a carrier for providing insurance coverage under a contract. Money paid out in advance for insurance coverage. Contributions are often defined as percentage of salary for formal sector employees or monthly level of payments for informal sector employees to health insurance fund on regular basis.

Provider payment methods Ways or means of paying health care providers such as on a capitation, case based, fee-for-service or other basis (see also individual definitions).

Purchaser This entity not only pays the premium, but also controls the premium amount before paying it to the provider. Included in the category of purchasers or payers are patients, businesses and managed care organizations. While patients and businesses function as ultimate purchasers, managed care organizations and insurance companies serve a processing or payer function.

Resource allocation The process by which available resources are distributed between competing uses as a means of achieving a particular goal.

Social safety nets A system that would allow economically and socially deprived citizens to continue to receive social services through free services, subsidized care, social insurance and social assistance. The system should assure that citizens retire with dignity and income – pension benefits; citizens are insulated from the loss of income due to economic forces out of their control – unemployment benefits; citizens not bear the full risk and costs for illness and injury – health benefits; and citizens are provided social welfare support.

Special consumption taxes Taxes used for effectively reducing the demand for harmful substances such as tobacco and alcohol by raising the price closer to its true social cost. These taxes may create a conflict of interest in a way that lowered demand and consumption can affect sources of revenue.

Universal Coverage Access to key health promotion, preventive, curative and rehabilitative health interventions for all, at an affordable cost, thereby achieving *equity in access*. Incorporates two dimensions: *depth*-health care coverage as in *adequate* health care-and *width*-population coverage.

User charges Payment for goods and services according to price list or fee schedule. User fee system is inequitable by its own nature. It makes the patients bear the cost of services and it makes the poor pay proportionally more than the rich.