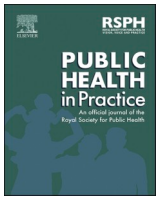
Public Health in Practice 6 (2023) 100445

Contents lists available at ScienceDirect

Public Health in Practice

journal homepage: www.sciencedirect.com/journal/public-health-in-practice



Operationalizing strategies for expanding UHC for the vulnerable population in Nigeria

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ARTICLE INFO

Keywords:
Health inequalities
Health policy
UHC
Vulnerable population
Health coverage
Health insurance

ABSTRACT

People living in vulnerable conditions have often been neglected or have a low coverage in health insurance which exacerbate poverty, vulnerability and social exclusion. This necessitates building and implementing insurance coverage that fully integrates social protection systems and community-based social care that prioritise the needs of the most vulnerable. To that end, we propose a decentralized system of sustainable financing and management of the vulnerable group fund that is performance driven with multi-stakeholder accountability systems premised on integrated data management. Integrating these elements will ensure that some of the existing gaps in the basic healthcare provision fund implementation in Nigeria are addressed with the following fundamental building blocks for the vulnerable group fund. These recommendations will help governments, resource partners and relevant stakeholders to consider in formulating strategies for operationalizing the vulnerable group funds and decreasing health inequalities among the population. In addition to implementation of this to accelerate universal health coverage and social protection, this will help to mitigate the currents challenges that exacerbate the inequality gaps, and build more resilient health and social protection systems, including the systems within humanitarian crises settings.

1. Background

Health insurance has the potential to improve access to healthcare and protect the vulnerable from the financial risk of diseases [1]. Countries aspiring for Universal Health Coverage (UHC) have often neglect or still have a low coverage for the vulnerable populations – which have necessitated a future-proof for policy and institutional architectures in line with the current realities [2]. Therefore, prudently targeting the most vulnerable populations is an effective strategy to ensure financial protection is expanding to all parts of the population. The world has arrived at a crucial moment, requiring a more resilient health systems to expand universal health coverage and implement the health-in-all-policies approach [3]. The Nigeria's new law which aims to provide health insurance to all Nigerians was signed in 2022, with an estimated 3 % of people covered at present. The Vulnerable Group Fund (VGF) was established by the National Health Insurance Authority (NHIA) act 2022 to provide financial support to subsidize the cost and/or pay premiums for the provision of healthcare services to vulnerable individuals in Nigeria [4]. The President has set a target for the NHIA to cover 83 million Nigerians who are unable to afford health insurance premiums using the VGF with funding source as provided in the act - which includes Basic Healthcare Provision Fund (BHCPF) and the Health Insurance Levy. Although social accountability and fund pooling strategies are increasingly expected to facilitate positive development outcomes for the implementation of these funds, there are historical gaps that need to be addressed to reflect existing contextual needs for the vulnerable population. Firstly, the Federal Government is relying on the 2019 National Bureau of Statistics (NBS) Report on Poverty and Inequality in Nigeria which reports that 83 million Nigerians live below the poverty line of 137,430 Naira ($381.56) per year. The data have been on questioned by many stakeholders and subject to physical verification with no clear information on the identity of health needs among the vulnerable population. Secondly, the method has been questioned for not being applicable in determining the actual number of vulnerable group persons requiring free insurance service and in the current economic time with millions of Nigerian falling into the vulnerable group. Thirdly, the current National Social Register for which the fund also relies on, have been questioned by the present government as it doesn't

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https://doi.org/10.1016/j.puhip.2023.100445
Received 22 May 2023; Received in revised form 11 October 2023; Accepted 20 October 2023
Available online 3 November 2023

contain valid identities to verify enrolees, prevent frauds relating to wrong profiling, and multiple enrolments. To achieve the goal of the UHC and targeting the vulnerable, it is necessary to establish a robust implementation mechanism that will ensure effectiveness and efficiency in the utilization of limited resources to achieve the best health outcomes for vulnerable groups. To that end, we propose a decentralized system of sustainable financing and management of the VGF that is performance driven with multi-stakeholder accountability systems premised on integrated data management. Integrating these elements will ensure that some of the existing gaps in the basic healthcare provision fund implementation in Nigeria are addressed with the following fundamental building blocks for the vulnerable group fund.

2. Conceptual framework

The conceptual framework for the health financing policy such as the VGF is depicted by the three dimensions of the universal health coverage (UHC) axes of a cube [5] with population, service and cost. The population axis which describes the population coverage with both financial protection and services offered are interdependent on the VGF well-designed benefit package within local context and how they are coordinated with the overall insurance policies on the revenue collection at source, strategic pooling arrangement between national and sub-national levels and strategic purchasing of health. The service coverage axis in terms of vulnerable group needs will ensures that everyone is able to access a quality health services that they need, and the designed benefits being realized in practiced which might requires performance driven systems in place. The cost axis will be one of the most important in the VGF, because it will be dependent on how possible to shrink the cube by strategically placing the right mechanism for cost-effective services, unified benefit packages and innovative financing of services. Under these circumstances, as population and service are increased, the proportion of strategic cost will be lowered which will expand coverage of UHC and till benefit more vulnerable population.

3. Discussion

One of the key pointers to what is possible with the VGF is the BHCPF [3]. A fund similar to the VGF as an instrument for resource mobilisation and application in dealing with the challenges of primary health care service delivery in Nigeria. The BHCPF implementation design promotes health system development, institutional reforms, and capacity transfer from national to subnational levels to improve efficiency in healthcare delivery. It catalyses increased funding and expansion of the vulnerable funds through institutionalization of counterpart funding arrangements by states through the Equity funds. The design also provides resources for program management at both NHIA and State Social Health Insurance Authority (SSHIA) to enhance monitoring, mentoring, supervision and accountability across board, as well as an opportunity to address issues as they arise.

The system of enrolment using social register and National Identification Number (NIN) helps in standardization of vulnerable identification and visibility, thereby promoting transparency and accountability. The robustness of the Basic Minimum Package of BHCPF makes it very similar to formal sector benefit packages in most states, provides ease of unification of benefits packages, and reduces cumbersome administrative processes at the SSHIA and Healthcare Facilities. The premium is far reaching and realistically close to premiums for most packages in SSHIA, provides system support in areas of program management, ICT and reinsurance funds. Building on these gains to operationalise the VGF will undoubtedly further strengthen the health system resilience at national and subnational levels.

However, despite the novel nature of the BHCPF design, the implementation encountered some challenges that needs to be factored in the design of the VGF to improve efficiency and accountability in the implementation. Only a few states provided cash backing to the equity fund, despite enacting laws to provide for it. The lack of incentives to reward those committed states, and the subsequent disbursement of the second phase to states irrespective of their prior commitments, made some of the committed states become reluctant in releasing subsequent disbursements of equity funds to their SSHIAs. The BHCPF design is public sector heavy with limited public-private sector competition, weak oversight from the statutory supervisory authority (LGA Health Authority/PHCB), weak monitoring and evaluation systems, lack of performance targets, and lack of incentives for healthcare workers in PHCs. These gave rise to poor management of funds through misappropriation, over bloated contracts, fictitious procurements, and outright loss of funds meant to improve the quality of care being provided.

Poor communication of enrolee entitlements and benefits, weaknesses in Ward Development Committees, and poor understanding of the program by communities' limit enrolee's visits to facilities to access healthcare services. Delayed transfer of funds from the Federal Government to states and states to health facilities, coupled with weak capacity of facility managers, also limits the potential impact of the program. There were also challenges of selecting vulnerable in LGAs/communities with no social registers. Although states used other alternatives, the transparency of such selections remains questionable. Using NIN has enhanced the transparency of the program, but most vulnerable persons, especially in rural locations, have no NIN. SSHIA has worked with National Identity Management Commission (NIMC) to conduct joint enrolment, but the payment for the cost of logistics of NIMC staff is becoming a burden on the SSHIA.

Lessons learned from the design of the BHCPF, and the challenges encountered so far must be harnessed and should inform future policies that can strengthen the operational framework for the VGF. To this end, the authors and Society for Family Health, Nigeria's health policy group proposed (Fig. 1), a decentralized system of sustainable financing and management of the VGF that is performance driven with multi-stakeholder accountability systems premised on integrated data management. Integrating these elements will ensure that some of the existing gaps in the BHCPF implementation in Nigeria are addressed the following fundamental building blocks for the VGF.

Fig. 1:

- **Decentralization:** The decentralized BHCPF design has enabled the SSHIAs to manage the BHCPF programme in their states, despite challenges, and has built capacity in managing capitation payment and claims management. ICT investment has been made for enrolment, database management, and beneficiary registers. VGF scheme should be built on this system to save time and resources.
- **Performance Driven:** The VGF design should include a performance-based financing system with targets at the state, LGA, and PHC levels. This will be coupled with other actions including the establishment and or strengthening of robust accountability systems at all levels of implementation.
- **Competition:** Private healthcare facilities participation should be increased to promote competition and provide more choices for enrolees. Competition will strengthen quality of service delivery.
- **Innovative Financing and Accountability:** Additional funding can be explored from National Social Investment Trust Fund (NSITF), Stamp duty, Sugar tax, Sin tax (Tobacco and Alcohol tax), or Telecom Tax. These ring-fenced taxes can be used to finance specific elements of the VGF and Nigerians provide feedback on its application. This will enhance accountability and build trust among taxpayers on the application of the fund. This will significantly reduce the resistance to such taxes which is the case with every attempt to apply such special taxes in recent times.
- **Professional Fund Management:** Professional and licensed fund managers should manage reserve funds to enhance returns on investment and increase transparency and stakeholder confidence.

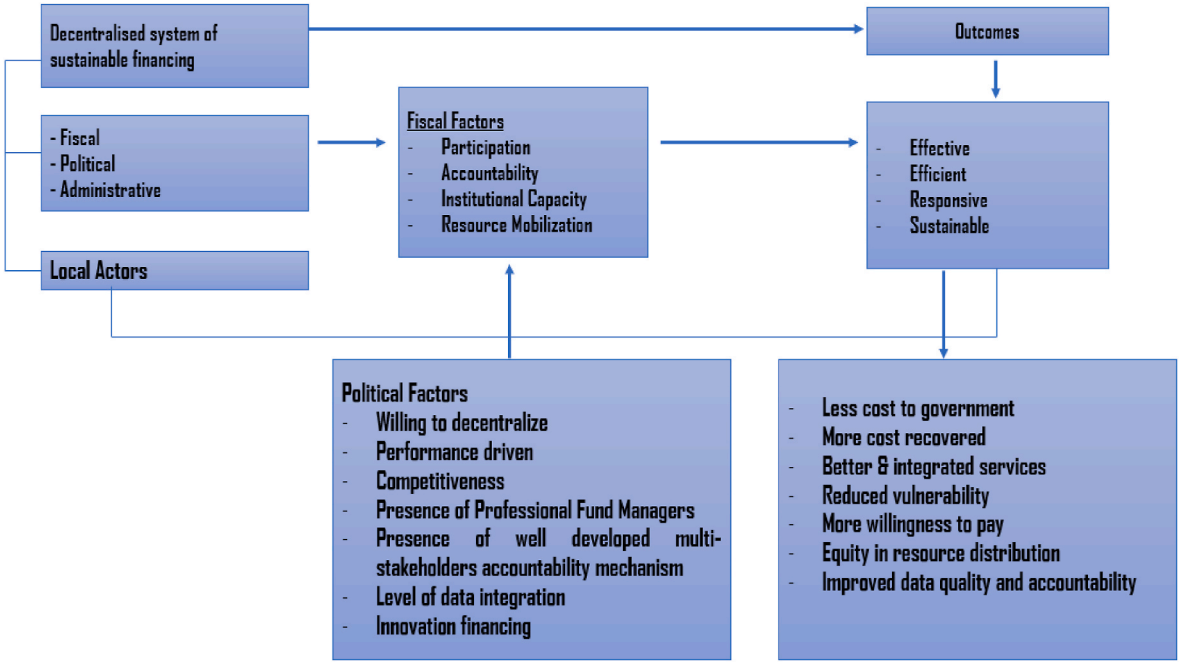

Fig. 1. A decentralized system of sustainable financing and management of the VGF.

- **Unified Benefit Packages:** NHIA unify the benefit package across all social insurance pools, including public sector, informal sector, and vulnerable groups, using the Basic Minimum Package as the least benchmark. Advocating for states to adopt a unified package will reduce administrative processes, improve service quality, and increase health insurance acceptance in Nigeria. State governments can also create budget lines for counterpart funding for BHCPF and ensure timely release and sustained allocation of 25 % counterpart funding in the yearly budget.
- **Multi-Stakeholder Accountability Mechanisms:** This approach should be applied in building accountability for the VGF with a robust M&E system that provides for third party and independent monitoring and evaluation systems. Trainers, mentors and technical staff of state primary healthcare development agencies (SPHCDA) and SSHIA should also be oriented on the changes to the guidelines periodically.
- **Data Integration:** this should be the underlying framework for data management and reporting to enable triangulation of performance indices across board.

4. Conclusion

The essence of UHC is to provide quality health for everyone and reducing inequalities in accessing healthcare for the vulnerable populations will be a bellwether for its accelerated success. The strategies discussed herein will accelerate progress in operationalizing the VGF and will require a holistic approach from all stakeholders to make it happen. This would require mainstreaming publicity and awareness on the economic benefits, enrolling people from hard-to-reach areas and ensuring non-state actors take part of the accountability processes. Effectively operationalizing these strategies would also require a strategic decentralization, multistakeholder accountability at the local level, unified benefit package in all health facilities, better information and awareness for the vulnerable, health system oriented towards competition and performance driven and adoption of innovative financing and technologies that close leakages of funds. We therefore recommend that government finds a balance between these political, administrative and fiscal factors to guide them on fulfilling its financial obligations and plans towards operationalizing this strategy. Reenergized relationships between civil society actors and government need to be placed to ensure vulnerable populations have a central role in decision making. This will help brings UHC closer to reality with limited health resources to support universalism and equity.

Contributors

All authors contributed to revieing literature, writing of manuscript, and reviewing and editing all versions of the manuscript.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Acknowledgements

We would like to thank the Health Systems Strengthening and Policy unit of the Society for Family Health for their contributions to this publication.

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