

**NATIONAL HEALTH INSURANCE SCHEME
FORMAL SECTOR DEPARTMENT**

TO: _____ **TMC**

FROM: _____ **Ag.GM(FSD)**

Date: _____ **April, 2015** _____.

**MEMORANDUM OF THE HONOURABLE MINISTER OF HEALTH ON
THIMPLEMENTATION OF STATE SUPPORTED HEALTH INSURANCE
SCHEMES (SSHIS)**

1. PURPOSE

This memorandum seeks to formally notify Council of the development of Implementation Guidelines for State Supported Health Insurance Schemes (SSHIS), towards the achievement of Universal Health Coverage in Nigeria and the need for States to adopt and implement the State Supported Health Insurance Schemes

2. BACKGROUND

2.1 Universal health coverage represents a sustainable development goal for health. This stems from the implicit truth that healthy populations mean higher labour productivity and higher returns to households from labour participation. According to the World Health Organization, universal health coverage (UHC) not only guarantees every citizen access to acceptable and quality healthcare, it also provides financial protection to them, thus cushioning them from the impoverishing effects of ill health and the costs thereof. Universal access to healthcare improves system's health outcomes, improves productivity and positively correlates with economic development.

2.2 Movement towards UHC can be achieved by expanding pooled financing across the following three dimensions (WHO, 2010):

- i. Population coverage: increase the share of the population that benefits from pooled financing;
- ii. Cost coverage: Countries need to work to reduce the amount of out-of-pocket payments through more financing with pre-paid insurance and taxation;
- iii. Service coverage: To expand the scope of services that are paid for from pooled financing sources.

2.3 The need for Nigeria to make investments towards UHC cannot be overstressed. This stems from the demand for a healthy workforce that will drive the expected economic growth from the Transformation Agenda of the present Administration. Fortunately, the Government seems to be positively inclined to this. As a result, the Nigerian government established the National Health

Insurance Scheme as the institutional framework for the UHC goal attainment. The hosting of the Presidential Summit on UHC and the recent signing into law of the National Health Act all further point to a favorable disposition of the government of Nigeria towards UHC.

2.4 The National Health Insurance Scheme (NHIS), was established in 1999, with the core objectives of protecting families against the financial consequences of huge medical bills and providing citizens access to qualitative, affordable and equitable healthcare. The Scheme effectively commenced operation in 2005, following the launch of its Formal Sector Programme. This Programme provides health insurance coverage to employees in formal employment. At the outset, the Scheme disaggregated the Formal Sector into the Public sector and the organized private sector (OPS) and started with the Federal Public Sector. The federal public sector has been covered up to 97%, leaving the States' workers not yet covered.

2.5 Several constraints have been identified as militating against a scale up of health insurance coverage in Nigeria. These include, inadequate government financing for health; weak governance and enforcement; inadequate and inequitable distribution of healthcare infrastructure; poor service quality; poverty constrains; and insufficient risk pooling mechanisms. Beyond these constraints, one major critical issue is the non-adoption of NHIS programmes by states in Nigeria. A recent study identified some of the reasons for this to include;

- i. Inadequate leadership and buy in from the state governors
- ii. Lack of control over the state schemes
- iii. Perceived lack of transparency by the NHIS
- iv. Absence of positive responses by stakeholders in the scheme
- v. General lack of trust in insurance
- vi. Lack of technical capacity for managing the schemes at the state level

2.6 In spite of these, it is an altruism that states have important stewardship functions and could play a central role in the achievement of UHC through their active participation in the overall implementation of health insurance in Nigeria. States have the capacities to mobilize resources for health insurance, pool these resources, carry out purchasing functions (directly or through third parties) as well as provide healthcare service, although it is always advocated for a separation of purchaser – provision roles by stakeholders. The states could play these role in conjunction with LGAs, which would function as mobilization bases as well as carrying out key functions such as enrolment, provider engagement and contribution (premium) collection. A major advantage is that this leads to the harnessing of already available resources and the strong stewardship roles the states already play in health.

3.0 ONGOING REFORMS AT THE NHIS

Recognizing the urgent need to scale up population coverage, the NHIS, with the assistance of the International Finance Corporation (IFC) conducted a diagnostic

of the Scheme. The output of this work was the development of the National Health Insurance Scheme Financial, Regulatory, Information Management and Business Practices Improvement Programme (FRIMP), referred to as the NHIS/IFC report. The study identified key policy and operational challenges that have hampered coverage expansion and by extension, the achievement of universal health coverage in Nigeria.

3.1 ENGAGEMENT OF THE STATES BY THE NHIS

To ensure a very fruitful engagement of the states in the achievement of UHC, the NHIS has resolved to hand over most of the health financing functions to states. This is the hallmark of the decentralization process ongoing as part of the reform at NHIS.

3.2 Consequent upon this decision, the NHIS constituted a Technical Working Group (TWG) to develop a template/guideline for the states as they commence the implementation of the SSHIS. A draft guideline has been developed which was subjected to a wider stakeholders' meeting involving all the states. Key resolutions from this meeting include:

A. LEGAL FRAMEWORK

- i. States are to operate State health Insurance Schemes
- ii. NHIS will develop a model legal template to be partly or wholly adapted by States
- iii. State laws must align with NHIS Act, National Health Act to facilitate collaboration
- iv. Accreditation of HMOs would be done by NHIS
- v. Health insurance must be mandatory for all
- vi. SSHIS should create a budget line to cover those who cannot afford to pay premiums under an equity fund i.e. indigents
- vii. Composition of boards to include stakeholders such as NHIS, civil society.
- viii. HCF/HCP are to be accredited by an all-inclusive team i.e. State Agency, NHIS, PCN, MDCN etc.
- ix. Private health insurance plans in States to contribute to State Health funds dedicated to plans for the poor and vulnerable
- x. SSHIS should retain administrative charges of not greater than 10% of disbursed funds

B. GOVERNANCE AND ADMINISTRATION

- i. SSHIS are to be domiciled as autonomous parastatals under the Governor's office with its own budget line and an independent board not linked to any Ministry
- ii. Functions
 - a. Policy & regulatory
 - b. Provider mx
 - c. Fund holding/ Fund management
 - d. Communications/marketing

C. FINANCING

- i. NHIS to set up an equity funds to catalyze efficiency, investment and expansion of risk pool
- ii. States are to clearly define sources of sustainable funding for respective SSHIS
- iii. States are encouraged to develop alternative sources of funding separate from Federal allocation
- iv. States are encouraged to channel existing free health programs into SSHIS for efficiency
- v. States need to put in place strategic policies to target vulnerable groups

D. ROLE OF HMOs/THIRD PARTY ADMINISTRATORS (TPAs)

- i. TWG recognizes the NHIS model(use of HMOs) however to guarantee flexibility
- ii. SSHISs have discretion of deciding on managing the scheme
- iii. Under provider contracting, States can consider a variety of options
 - a. States to consider HMOs/TPAs for expertise in recruiting contracting and purchasing services of HCP
 - b. Where states decide to engage directly with providers in a bid to mitigate cost escalation they should also be aware of the consequences

E. BENEFIT PACKAGE

- i. States to select at least the basic minimum package as defined by the National Health Act (to be determined by NHIS/NPHCDA)
 - a. Wealthier States are at liberty to take on additional benefits based on ability to pay
 - b. SSHISs to base their benefits on health actuaries to estimate cost of services
 - c. State can alter basic minimum package to address the local disease burden

F. ENGAGEMENT, SELECTION AND PAYMENT OF HEALTHCARE PROVIDERS

- i. National Health Act makes provision for classification of HCPs and referrals
 - a. FMOH to provide guidance
- ii. Provider selection should ensure maximum access to services by beneficiaries
 - a. Provider mix(public & private) is recommended for service delivery
 - b. Beneficiaries are allowed to select preferred providers to ensure satisfaction
 - c. Performance based financing to be linked to provider payment to promote efficiency
 - d. Provider accreditation by States & could be used to achieve policy objectives

- e. *States may decide to partner with Clinical Social Franchising Network Providers which may not be accredited by the NHIS but put in place accredited quality assurance mechanisms

G. TARGETING MECHANISM

Tools to identify the poor in States need to be developed including use of IT and linking this to other pro poor policy and funding interventions, such as the National social safety net program

H. MONITORING AND EVALUATION/ICT

- i. M&E tools to be developed by Stakeholders, including States, for assessing the performance of SSHIS
 - a. Robust Integrated ICT infrastructure for data collection and assessment
 - b. Development of management (NHIS, SSHIS), financial (Fis, DFIs, NHIS) and impact indicators (NPHCDA, NCH, SMOHs, FMOH)

I. RISK EQUALIZATION

- i. This is a way of organizing risk adjusted subsidies in individuals i.e. creating cross subsidies from low to high risk in the same pool in the current contract period.
 - a. Subsidies (implicit & explicit)
 - b. Mandatory HI
 - c. Mandatory community rating
- ii. Need to put in this idea to work for states as well
 - a. NHIS to put in place a comprehensive risk adjustment criteria to determine risk equalization for States from the UHC fund.

J. SUPPORT FROM NHIS TO SSHIS

- i. Financing for the poor and vulnerable through their equity funds/plans
- ii. Capacity building for SSHIS
 - a. Study tour for legislators and technical officials
 - b. Workshops
 - c. Sharing best practices
- iii. ICT Infrastructure support and deployment
- iv. Coordination for SSHIS

v.

Template for legal framework

4. PRAYER

Council is hereby invited to:

- i. Note that the development of Implementation Guidelines for State Supported Health Insurance Schemes (SSHIS) by the NHIS towards accelerating the achievement of Universal Health Coverage in Nigeria
- ii. Endorse the recommendations of the expert TWG that have been ratified by a wider stakeholders' meeting the implementation of the SSHIS.
- iii. Encourage States to adopt and implement the State Supported Health Insurance Schemes, using opportunities presented by the National Health Act.

Honorable Minister of Health

March, 2015