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Assessment of Health Purchasing Functions for Universal Health Coverage in Nigeria: Evidence from Grey Literature and Key Informant Interviews

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Abstract

Objective: Out of pocket expenditure is the primary means of financing healthcare in middle and low-income countries. The 2021 government health expenditure in Nigeria at 4.52% falls short of the 15% recommendation of the 2001 Abuja Declaration. This paper examines healthcare purchasing in Nigeria, in order to explore how resources were allocated and create better insight into healthcare purchasing for universal health coverage. **Data Source/Study Setting:** The study was conducted in the Federal Capital Territory and three states—Lagos, Enugu and Sokoto. **Study Design:** A cross sectional method was used to examine health purchasing functions in Nigeria. Key informant interviews and review of grey and published literature on health financing in the selected study areas. **Data Collection Methods:** Primary data were collected from relevant stakeholders across the selected study areas, using a structured interview guide. A search of grey and published literature gave a total of 57 references. **Principal Findings:** The NHIS has a clearly articulated benefit package, for its formal sector and pro-poor BHCPF program. NHIS covers only about 5% of the Nigerian population. BHCPF (SOML) program targets the bottom 40% of Nigerians on paper, but there is no specific design for reaching them. The NHIS uses both public and private sector providers. It is not clear which providers are used for the BHCPF (SOML) program. The NHIS uses actuarially calculated capitations for primary care services and market-based fee-for-service rates for reimbursing secondary and tertiary care. BHCPF (SOML) uses a macroscale pay-for-performance mechanism to re-

ward states achieving specific health outcomes. **Conclusion:** Health purchasing functions have serious implication for UHC. However, health care provision in Nigeria is not pro-poor and government efforts do not promote efficiency. Available option is prioritization of health initiatives that ensure value for money through performance-based financing and partnering with the private sector.

Keywords

Universal Health Coverage, Nigeria, Healthcare Purchasing, Insurance, Healthcare Funding

1. Introduction

Health care spending in Nigeria is predominantly through Out of Pocket (OOP). Currently, OOP expenditure accounts for 60% to 70% of the Total Health Expenditure (THE) [1]. The implication is that funding for health care comes principally from individual payments at the point of accessing a service, whether in public or private health facility. Evidence shows that the percentage of Nigerians covered by any form of prepayment or risk pooling schemes is less than 5% of the population, and they are mostly civil servants and formal private sector workers [2].

In an effort to reduce OOP spending, and improve on overall health care challenges, the Nigerian government in 1999 established a social tool known as National Health Insurance Scheme (NHIS). The aims of the scheme among others were to ensure access to quality health care services and efficiency, enhance risk sharing, reduce OOP, and ultimately provide financial risk protection. NHIS is a combination of both compulsory and voluntary contributory health insurance schemes targeting the formal and informal sector workers [3]. The formal sector is made of those who are on monthly wage from where health insurance premium could be deducted. The informal sector is made of members of the society, who are artisans, traders, peasant farmers, disabled, indigents, students etc. They need to be covered by health insurance as they consist of more than 70% of the national population [4] [5].

Countries of the world are encouraged to focus more on innovative health systems that will help them achieve the goals of Universal Health Coverage (UHC) and Sustainable Development Goal 3 (SDG3). SDG 3 aspires to ensure health and well-being for all, including a bold commitment to end the epidemics of AIDS, tuberculosis, malaria and other communicable diseases by 2030. It also aims to achieve universal health coverage, and provide access to safe active medicine and vaccines for all [6]. This goal can be achieved if there is adequate health system that makes healthcare affordable at all levels [7]. To achieve this, the World Health Organization (WHO) recommended adopting Strategic Health Purchasing (SHP) as a valuable tool for improving healthcare system's performance and quality of service delivery [6] [8].

The passage of National Health Act in 2014 led to the formation of Basic Health Care Provision Fund (BHCPF) that provides additional revenue for health through the national budget. States were encouraged to set up their respective Primary Health Care Development Agencies to be able to access the fund. The states were also encouraged to establish health insurance agencies. All these aim at ensuring that citizens are provided with prepayment system that protects them against unforeseen health spending. However, there appears to be weak institutions that will ensure enforcement of the health policies and laws [9].

Purchasing is a component of health financing functions that is key in determining what form of health care that could be available and the extent beneficiaries are provided with the available healthcare [10]. It seeks to answer the following questions that border on what health services need to be purchased? How should purchases be made? as well as from whom the purchase should be made? Purchasing can be done in two forms—*passive* and *strategic purchasing.* While passive purchasing is not specific in determining what needs to be purchased and in what measures, strategic purchasing involves careful examination of health care need that could be demanded for or supplied [11] [12]. It is therefore important to understand the state of healthcare purchasing in Nigeria, and also ascertain the country's readiness for an increase in public spending for health and available health risk pools that aim at achieving UHC.

Assessment of purchasing functions involves the examination of the three relationships purchasers have with healthcare providers, citizens and government. This study therefore, aims to assess the state of healthcare purchasing and Nigeria's preparedness for an increase in public spending for health and expanded healthcare risk pools in Nigeria. The study involves describing the state of healthcare purchasing function at the federal level and in selected states of Nigeria, and highlighting the key gaps in supply side financing functions in Nigeria that may hold back efforts to mobilize larger resource for health or dampen growth in risk pooling systems.

2. Methods

2.1. Study Area and Design

This study was conducted in the Federal Capital Territory (FCT) and three selected States—Sokoto, Enugu and Lagos. The study employed a cross-sectional descriptive method to examine healthcare purchasing functions in Nigeria. Key informant interviews and review of grey and published literature on health financing in the selected study areas and identified themes relating to healthcare purchasing were undertaken.

2.2. Data Collection Procedure

Stakeholder Interviews

Primary data were collected from relevant stakeholders across the selected study areas. This was done using a structured interview guide developed for the pur-

pose of the study. The interview guide explored information on institutional arrangement and governance; benefit package; providers selection and contracting; provider payment; and monitoring. The study respondents included stakeholders from Ministry of Health, WHO, World Bank, NHIS, HMOs, and Providers at the Federal and State levels. The tool explored information relating to purchasing of healthcare in Nigeria. The key informant interviews were done through telephone and face-to-face contacts. The phone interviews were put in place due to the limitations of novel coronavirus pandemic (COVID-19). All participants were informed of the study objectives before commencement of interviews. All interviews were audio recorded with the permission of participants. A total of 17 stakeholders were interviewed between December 2020 and February 2021. All the interviews were audio-recorded and transcribed, with the findings on each health purchasing pillar summarized in excel spreadsheet. The secondary data collection that involved review of relevant literature and documents was collected using a template designed for the study.

2.3. Search Strategy for Review

Literature search for publications were limited to English language articles, published in peer-reviewed journals with keywords—health purchasing, formal sector health insurance scheme, service delivery, health systems, government tax funding and Nigeria. The search on the databases gave a total of 57 references (PubMed-24; HINARI-33). These were later vetted. We linked the search to the abstracts and inspected their relevance with further text scanning and review. Grey literature involved searching of government websites for documents. Such documents as health policy, health plans, economic and strategic plans, health accounts, medium term expenditure framework, and operational guidelines for health programmes were reviewed. We assessed grey materials to understand the context, perspectives and rationale for purchasing functions.

Selection of Studies for Review

Qualitative, quantitative and mix-method studies with emphasis on health purchasing functions in Nigeria were included. Duplicated studies, articles that are not related to Nigeria, and articles that did not concentrate on health purchasing were excluded. A total of 4 eligible peer-reviewed articles and 8 grey documents were reviewed and used for this report.

2.4. Data Extraction and Analysis

Data extraction was done using Microsoft Excel data extraction template. It contained worksheet with content analysis of governance (Who buys what?); decision on benefit package (What services to purchase?); contracting with providers; decision on whom to buy for; decision on how to buy; policies and legal frameworks; monitoring and accountability. Extracted information from document review (secondary data) was triangulated with the primary data to ensure accuracy of review findings. Our emphasis was on different benefit packages and

what the country has been exposed to in terms of decisions on what to buy including the forms of medicine, service delivery and quality standard.

The key gaps in supply side function in Nigeria were determined by questions that relate to health purchasing functions which stemmed from inability of the system to respond to the decision on what to purchase. We also determined this through a document review, in-depth interviews and the strength of the key players in the health system towards achieving the purchasing functions. We highlighted how much such documents as National Health Act 2014, SHDP II 2018, National Health Financing Policy, 2016, BHCPF, etc. have influenced the level of health care financing in the country. Review of other documents such as Public Expenditure Management Review (PEMR), Medium Term Expenditure Framework (MTEF), Public Financial Management (PFM), and National Health Account (NHA) laid credence to the quality of health care purchasing for UHC in Nigeria.

The results were analysed based on the key components of the purchasing function, namely: what to buy? for whom to buy for? from whom to buy? and how to pay?

3. Results

3.1. Health Care Purchasing Functions

The result of this study was organized in two phases. First, we analysed the findings of the grey and published literature on health purchasing functions in Nigeria. Secondly, we provided empirical analysis of health purchasing functions through key informant interviews.

3.2. Findings from the Grey Literature

3.2.1. Benefit Package (What to Purchase)

Benefit package represents a whole lot of decisions on what to provide for the healthcare consumers or beneficiaries of a health program. The national health insurance scheme has its benefit package that covers primary, secondary and tertiary levels of healthcare. These include inpatient services, oral health, eye care services, maternity care and emergency. It is defined as services that are within the NHIS's scope of coverage [3]. Private health insurance schemes also exist with their benefit package. For instance, the Catholic Diocese of Enugu has Faith-Based Health Insurance with benefit package that covers primary and secondary care. This Faith-Based Health Insurance covers curative services for common ailments, outpatient care, drugs and pharmaceuticals, maternity, laboratory, health education, accident and emergency services among others.

3.2.2. From Whom to Buy Decision

There are guidelines about minimum requirements for establishment of different health facilities for public and private sectors as coordinated by the Department of Medical Service [13]. Public-Private Partnership (PPP) for health policy exists at the Federal and State levels and they form channels for health care pro-

vision. For instance, in the area of logistics, Enugu State MoH partners with Annunciation Specialist Hospital—Faith Based Central Medical Foundation to provide drugs and logistics in the Southeast, Nigeria.

The low-level facilities are weak, ill equipped and incompetent to face the health needs of the people [14]. The major challenge includes retaining the number and level of qualified health staff at the primary health facilities and the poor distribution of staff across urban and rural areas. These impose difficulty when it comes to decision from where health care could be bought [6].

NHIS plays key function in health purchasing including facility accreditation, screening of application, and certification of facilities. As soon as accreditation has been given to a provider, different HMOs negotiate service agreements on behalf of their enrolees. The HMO and provider come into agreement with amounts, referral terms, and medicines/consumables stock for patients.

Private organizations make decisions on health purchasing and how to purchase care. Banks and corporate organizations decide which facilities serve as their health providers. They examine services that are provided and choose the preferred healthcare providers based on prevailing benefit package. Individuals also make their decisions with respect to health purchasing. Most effective demand for health care in Nigeria happens out of pocket [15], and so individuals and households have numerous decisions to make before they could purchase health care. Who they purchase from depends largely on the households' disposable income and conviction that their choice is adequate and affordable. There is evidence that people patronize Patent Medicine Vendors and Community Pharmacists colloquially called chemists in Nigeria because they are affordable and flexible in meeting their health challenges [16] [17].

3.2.3. How to Pay

The Federal Ministry of Health is the purchasing organization using the national budget flows to provide budgets for providers at health facilities. The recurrent budget provides direct subventions for overhead and other recurrent expenditure as stipulated in the Strategic Health Development Plan II (2018). Line-item budget takes care of consumables and supply [18] [19].

NHIS uses actuarial studies to determine payment mechanisms based on their benefit package and tariff. Some services can be negotiated based on needs, and if there are limited providers in a particular area [3]. Fee for Service (FFS) and Capitation are provider payment mechanisms that are used in the health insurance arrangements. Capitation is ex-ante for primary care and it is remitted to the providers monthly, whether or not the enrolee accesses care. FFS is ex-post for secondary and tertiary care per utilization [3]. Level of access by enrolee determines whether payment would be fee for service or by capitation. For instance, a patient that is on referral would be treated based on fee for service as the primary care provider does not cover the service hence the need for referral.

Currently the provider payment process is paper based. This causes administrative bottlenecks. Nevertheless, some HMOs have started deploying real-time

electronic packages for patient, while providers also send counter information to HMOs through emails.

3.2.4. Whom to Buy for

Currently, the federal government has made effort through NHIS to cover all its employees with the employees paying 5% of their annual salary for the health insurance cover. However, the federal workforce represents less than 5% of the total population. At the state level, the states are expected to buy health care for all the citizens. The states have serious task of ensuring that all the citizens both in the formal and informal sectors are covered by the state health insurance. Some states have been encouraged to practice adoption, a form of health insurance that enables the rich accommodate and make altruistic payments for the poor to access healthcare.

The Save One Million Lives (SOML) initiative aims at bottom 40% of Nigeria's population. Established in 2012, SOML aims at ensuring that health care is provided to the people especially the poor and vulnerable groups. The six pillars of SOML include 1) improving maternal, new-born and child health; 2) improving routine immunization coverage and achieving polio eradication; 3) elimination of mother to child transmission of HIV; 4) scaling up access to essential medicines and commodities; 5) malaria control; 6) improving child nutrition. Purchasing of care is through Disbursement Link Indicators (DLIs). The DLIs aim at increasing 1) increasing quality of high impact reproductive and child health and nutrition interventions 2) improving M & E system and data utilization 3) private sector innovation and 4) increasing transparency in management and budgeting for PHC. SOML PforR resources are expected to be ploughed back into the health sector to achieve better performance and improve health outcomes in form of a virtuous cycle.

3.3. Evidence from Key Informant Interviews (KIIs)

This study involved interviews with key stakeholders in health. Their responses formed a strong judgment about the current situation of healthcare purchasing gaps in the country. Their responses were pulled and analyzed based on the themes of the study.

3.3.1. What to Purchase

What to purchase on the part of government depends on what the government has on its budget envelop and priorities that are put in place. A key informant in the FMoH said, "*In Nigeria government health expenditure is supposed to be based on existing medium term expenditure framework that examines what the tiers of government have been set aside as priority to the health sector. Expenditure framework is expected to inform government spending. But to a great extent, this is not done*". Budgeting processes for healthcare is not the only problem to the health purchasing as noted by respondent from WHO that maintained that "*even planning for health care purchases are not adequate and usually*

not within the fiscal timeline and decisions on what to purchase are not based on the health sector plans." Lack of effective planning and poor budget implementation can also be highlighted as reasons for poor resource management.

3.3.2. From Whom to Buy

Primary care in different categories exists in Nigeria. One of the KIs from Sokoto SMoH maintained that different health facilities exist in the country, whether they are acceptable or not. In his words, "*you see places where people go for services such as chemist shops*, *community pharmacies*, *they are providers of health services. In this country*, *Traditional Birth Attendants* (*TBAs*) *are major providers and they are trusted. We have the orthodox based and non-orthodox based. Spiritual care providers for ailment also exist. What we have found is that providers that are in our setting are the unorthodox—chemists*, *dispensaries*, *etc. The unorthodox are known to have strong footing in providing healthcare*, *even though they create serious gap as they are not able to ensure adequate care to the people*". One of the respondents from private medical stores in Enugu noted that even though the poor purchase from the unorthodox they do so because they do not have enough finances to go for alternatives. In his words, "*The poor pay more and they fall sick more often. That is why the demand for low level providers is high. The poor do not go to hospital*, *so you find that it is not for the poor. Ideally prepayment scheme would be ideal. Then those who can pay will cross-subsidize those who cannot*". This highlights the gaps when one considers who to purchase healthcare from in the country.

3.3.3. How to Pay

Some people pay through fee-for-service because of the way the services are either provided or based on the existing structure. One of the respondents, a private medical practitioner in Lagos, said that "*out there* (*developed countries*), *it goes through government system*, *but here*, *it is not so. For example*, *out of pocket payment is mainly obtained in Nigeria. Less than 2% goes through health insurance. You now find a number of free services so to speak*, *possibly reimbursed for services that have been provided free at the point of use*". Apart from insurance, you have where people can exchange their goods and services for health care. This is obtainable in Nigeria as such that non-monetary payments are made in exchange for health goods. A community Pharmacist in Sokoto maintained thus, "*with insurance*, *we can pay through capitation or fee for service*, *and you know in such way they can be measured*". The aim is to demonstrate that providers could be remunerated based on number of lives they have been able to give service. In that case payment is tied to deliverable, and modalities for payment are clearly stated. Generally, however, how to pay for health care is still below the standard set by the WHO especially with respect to strategic purchasing. A country's how to pay is considered impressive if payment is tied to performance and access to care is encouraged through financial risk protection. This condition is still at the starting point across the country.

An informant from Lagos State Private Medical Practitioners maintained that: "*The gap here is our inability to manage our resources well. We are not able to ensure value for money in the health system. There is lot of waste in the health system*". However, trust was also raised as a major impediment to healthcare purchasing. A Private Healthcare Practitioner in Enugu State maintained that there is lack of trust. In his words, "*I was discussing on adoption model which has become successful in Anambra state. The very question is whether there is system in place to safeguard against embezzlement. They don't trust that government can manage things to their advantage*". This statement is however arising from previous health programmes in the country that were not effectively managed by the bureaucrats.

4. Discussion

In 2018, Nigeria's general government expenditure on health as a share of current health expenditure was only about 15% [6] [18], and it is not clear how well the resources are allocated. In year 2021, the country's total budget for health was only 4.5% (about N592.2 billion) of the proposed (N13.082 trillion) National budget [17], and because health budgets are grossly inadequate, decisions on what health care to purchase becomes critical at both the national and state levels of government.

Only the NHIS has a clearly articulated benefit package both for its formal sector programme and the newly initiated BHCPF Programme. Regrettably, NHIS covers only about 5% of the national population. The rest are left to make their decisions through fee-for-service. Expansion of prepayment mechanisms that accommodate all facets of the economy is imperative especially at a time like this when household income is very inadequate [20].

Decisions on from whom to purchase healthcare in Nigeria are weak even though they determine responsiveness of a health system. For instance, NHIS uses both public and private sector providers based on their acceptability by its current class of enrollees. It should be recalled that some of the health care providers in the BHCPF programme are not pro-poor [21] [22]. The objectives of the programme are hampered by inadequate attention to the category of providers that could be allowed. Nigeria's budgetary allocation to health is insufficient [23], implying that value for money should be considered in decision making.

A closer look shows that Nigeria's entitlement policies are poorly defined for most government health programmes. This has implication on decisions on what health care to purchase. One of the indices of UHC is the spread of health care across socioeconomic groups [24]. What to buy remains a hard decision to take as income is low and households are caught in the web of paying through fee for service, which often leads to complete deferment of health seeking as they have no financial risk protection against ill health [25].

Many of the states in Nigeria for instance have articulated their health laws and policies, but what to buy are poorly defined and process that lead to the ac-

tual decisions are not strong. How much the poor and vulnerable stand to gain is not clearly stated. This also implies that major health programmes in Nigeria do not specifically target the poor. Again, government health programmes have bias towards public sector providers and they are not most efficient providers and may not be the best means of reaching the poor [26]. This forms the basis for SOML PforR, disbursement link indicator which purchases care based on improved health outcomes. However, in the literature, this area (monitoring of provider and system performance) among other levers or pillars seem to have received the least attention even in Nigeria. This further points to the need for public private partnership in health when deciding from whom to purchase healthcare. PPP brings competition and ensures value for money and should be encouraged for the country's health system to be on the right track [27].

How to pay for health care is another key function of health purchasing. Fee-for-service remains the most widely means of paying for health care. Performance based financing has been identified as a veritable means of paying for health care [28], but it is at a very primordial state in Nigeria. Another method of paying for health care is conditional cash transfer which is also poorly managed and not widely in use to make positive impact on the lives of the poor [29]. What needs to be done is to articulate strategies that give room for fair implementation of these health financing mechanisms.

5. Conclusion

Health purchasing functions have serious implication for UHC. As already highlighted, health care provisions are not pro-poor and government efforts do not promote efficiency. Available option is prioritization of health initiatives that ensure value for money through performance-based financing and partnering with the private sector.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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