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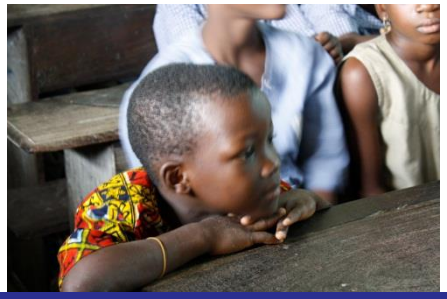

OSUN STATE FISCAL SPACE ANALYSIS FOR HEALTH SECTOR

August 2018
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Bureau for Global Health

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Abt Associates Inc. | 6130 Executive Blvd | Rockville, Maryland 20852
T: 301.347.5000 | F: 301.652.3916 | www.abtassociates.com

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ACRONYMS

BHCPF	Basic Health Care Provision Fund
CHO	Chief Health Officer
FAAC	Federation Account Allocation Committee
GDP	Gross Domestic Product
HMB	Hospital Management Board
IGR	Internally Generated Revenue
IMF	International Monetary Fund
JCHEW	Junior Community Health Extension Workers
LGAs	Local Government Areas
MDAs	Ministry/Department/Agency
MOH	Ministry of Health
OSCHS	Osun State Contributory Health Scheme
OSG	Osun State Government
OSHIS	Osun State Health Insurance Scheme
OSHS	Osun State Health System
OSMOH	Osun State Ministry of Health
PHC	Primary Health Care
SGDP	State Gross Domestic Product
SGHE	State Government Health Expenditure
SPHCDB	State Primary Health Care Development Board
UHC	Universal Health Coverage
WHO	World Health Organization

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HFG Nigeria Project Team		
Ope Abiodun	Juliana Aribo-Abude	Nura Musa
Dayo Abe	Dr. Elaine Baruwa	Chinyere Ndubisi-Nwankwo
Neha Acharya	Mainasara Bello	Helen Ochayi
Zainab Abdurrahman	Dr. Ekpenyong Ekanem	Faith Ochelle
Niyi Agunloye	Harriet Udeme Edumoh	Chinelo Odiakosa-Mmakwe
Ibiam Azu Agwu	Dr. Janet Ekpenyong	Michael Okpe
Dr. Sylvester Akande	Chidinma Eneze	Dr. Funto Ogundapo
Jennifer Ako	Chima Ibe	Chioma Oleru
Dr. Gafar Alawode	Dr. Frances Ilika	Muhammed Sani Ayuba
Ibrahim Angale	Abdulkareem Ismailah	Aisha Senchi
Dr. Atamunotoru Anikara	Bolade Jimoh	Muhammed Shuaib
Dr. Gaza Gwamna	Somtochukwu Mbelu	Inah Sunday

EXECUTIVE SUMMARY

The Government of the State of Osun is aligning with the global and national agenda of pursuing the goal of Universal Health Coverage (UHC). To this end, the state is implementing various health financing reforms to sustainably improve health. A pertinent question is how the government can identify the availability of resources or fiscal space to finance the impressive initiatives proposed to achieve this goal. This report assesses all potential sources of fiscal space including conducive macro-economic conditions, reprioritization of health sector within Government's existing expenditure envelope, earmarking for health, increasing resources from external sources, and obtaining efficiency gains from improving the quality of spending to achieve more value for money. This analysis of the fiscal space for health in Osun state will enable decision makers make informed decisions around target setting, advocacy and planning needs for resourcing the Osun health sector.

The concept of fiscal space for health defined as the budgetary room allowing a government to provide additional resources for health without jeopardizing fiscal sustainability. This study explored five pillars that could be used to generate fiscal space for health: conducive macroeconomic conditions; reprioritization of health; earmarking of funds; health sector specific grants and foreign aid; and increased efficiency of existing health expenditure. As the state engages in the implementation of its new strategic health development plan (SHDP), a fiscal space analysis was recommended to explore ways to increase resources for the sector, even in a constrained macro-fiscal condition and USAID's Health Finance and Governance Project supported the Osun State Ministry of Health (OSMoH) in this effort.

Need for Increasing Fiscal Space

Osun State has recently developed the Osun State Strategic Health Development Plan (SHDP) II in line with the national framework. The framework established a common approach for planning and an implementation time frame for health sector needs for a period of five years. There is a financial gap between what is needed and what is available to support the scale up proposed in the SHDP II.

Opportunities for Increasing Fiscal Space for Health

Macro-fiscal conditions are the key factors to consider on budgetary allocations to any sector. In Osun, the statutory revenue (from the Federal Government) for the period of 2011 to 2015 vacillated in both amounts and its proportionate share of government revenue from N41.1 billion (54%) in 2011 to N27.1billion (32%) in 2015 with an average being 38.8% of the state total revenue through the period. The state appears to be faced with the challenge of dwindling allocation from Federal level. Other federally allocated revenue (VAT) increased from N6.9 billion (9%) in 2011 to N8.1 billion (9.5%) in 2015. However, the state IGR appeared relatively static with no visible growth, from N11.9 billion in 2011 to N11.8 billion in 2015. The state total revenue declined at an average rate of 11.2% between 2012 and 2015. The surge in growth of 70% that occurred between 2011 and 2012 was because of the N30 billion received as bond proceeds in 2012. Given that revenue from FAAC is highly vulnerable to external shocks due to the volatility of international oil markets on which it mainly depends, it makes it difficult for Osun State to predict its expected revenue from this major source with a high degree of certainty. This is a recipe for weak budget performance on the revenue side. In general, capacity of the Osun State Government (OSSG) to generate sustainable revenue locally is challenged as the state increasingly underperforms relative to its projections. An analysis of the revenue generation indicated potential sources and opportunities that could turn out approximately N5.0 billion naira per month for OSSG, about 600% of the current internal revenue generation.

Reprioritizing Health: Budget allocation to the health sector is very low compared to the Abuja target of 15% and has been declining over time. An examination of budget allocations to the health sector in the state shows that the relative share of the health sector remains flat at 5.6% both in 2012 and 2016; although there was a sudden surge from 4.3% in 2013 to 7.1% in 2014, the reasons for this are not clear. Similarly, from an actual expenditure perspective, the relative share of the

health expenditure out of total government spending remains the same at 8.5% both in 2012 and 2015; although there was a sudden decline to 6.2% in 2013 and 6.9% in 2014. However, actual health expenditure as a share of total government expenditure was higher in 2012 to 2015 (except 2014) than health budget as share of total budget. If the state implements the prioritization of health along the lines of Abuja Declaration, the additional resources that would have accrued to the health sector amounts to N10 billion in 2012, N14.5 billion in 2013, N8.1 billion in 2014 and N4.8 billion in 2015. From the available bill of quantity estimates[1], the average gap of N9.4 billion per year between 2012 and 2015 is adequate to establish at least one functional Secondary Health Centre for referral for all the 31 State LGAs and renovate 450 PHC centers as contained in the SHDP as well as build and equip 1 standard public health Laboratory in each 31 LGAs.

Earmarked funds: Direct allocation from Consolidated Revenue Fund (CRF) is an option that the state is currently exploring in order to provide reliable earmarked funds for the health sector. The state is considering legislation to charge 1% of the state CRF into an equity fund for health insurance. Earmarking 1% CRF will provide additional N774 million in 2019. In addition, other expected funds to the state health sector are federal government earmarked funds - the Basic Health Care Provision Fund (BHCPF) stipulated in the National Health Act – 1% from Federal Government CRF estimated at N855 billion in 2019 to be shared equally between the states. Direct allocations from CRF have been used to enhance the fiscal space for delivery of other public goods such as education.[2] Raising the percentage of CRF to health from 1% to 3% could raise more allocations to health sector by 2.3 billion[3] in 2019.

External Grants: Donor funding is a vital source of health expenditure. However, there are limited donor-funded development programs within the health sector in Osun state compared to other states in Nigeria. Data limitations preclude analysis of resources from the external grants in this study.

Efficiency Gains: Fiscal space for health could be improved by identifying and exploiting opportunities for efficiency gains in the health sector. Analysis of efficiency gains is highly demanding in terms of operational and financial data. Data limitations preclude the analysis in this effort. However, anecdotal evidences show that OSSG could save money by demonstrating commitment towards: 1) the improved execution of health budget's capital component; 2) the improvement of budget performance; 3) reinforced oversight of the workforce in the health sector.

Fiscal Space Analysis for Osun Health Insurance Scheme

The population of Osun State is estimated at 5.2 million in 2018 at annual growth rate of 3.2% to reach 5.86 million by 2022. Reviewing the breakdown of the population into the individual categories that are relevant to analyzing the resource needs of the Osun State Health Insurance Scheme the core priority population groups comprising the informal pregnant women and children under-5 constitute about 13% of the state population and the remaining priority groups, the informal elderly and the indigent population and widows, constitute roughly 39% of the population. Together the broadly defined priority population groups account for 52% of the population. These groups are unlikely to be able to pay for coverage and the state government may have to fund their financial liabilities under the scheme with full subsidy.

We examine the possibility of OSSG increasing its commitment to an equity fund to 2% of CRF as well as under two equity fund scenarios. In terms of coverage, an increase of the equity fund contribution to 2% of CRF will raise the coverage of the core priority groups (informal pregnant

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[1] See Annex for the bill of quantity estimates determined in a separate analysis conducted by HFG in collaboration with OSMoH.

[2] For example, the Federal Government of Nigeria earmarks 2% of its CRF for financing of non-salary needs of basic education. More recently, it also earmarks (minimum of) 1% of its CRF to the health sector.

[3] Feasibility of earmarking 3% CRF may constrained by the macrofiscal environment and government solvency condition.

women and children under 5) from 46.9% to 69.3% in the scenario with premium of N4,990 per annum. This coverage is extended from 30.6% to 45.1% in the scenario with premium of N7,660.

In all, prospects for increasing fiscal space are limited in the short term. Earmarking of 1% CRF and increasing efficiency are viable short-term options. There is a critical need to address the weakening capacity for IGR to sustain the state recurrent expenditure. There is need for increased engagement and advocacy on the part of Osun State Ministry of Health (OSMoH) with development partners to achieve sustainable financing of proposed health insurance scheme. Sustained efforts in this direction would gradually widen the fiscal space for health sector.

Actionable Recommendations

Improving the Economy and Raising IGR

The state should aggressively pursue an internal revenue generation drive by following the guidelines listed below

- Increasing IGR from less than a billion monthly to the targeted N5billion every month as estimated in a recent study conducted in Osun State. This will support expansion of coverage of the vulnerable population groups and sustain other government initiatives. OSSG needs to institute measures to strengthen revenue collection and create a conducive atmosphere for private sector in order to both widen and diversify its earning base.
- All sources of revenue leakage should be eliminated
- Taxpayers should be given adequate Enlightenment and education
- Investors in Osun State should be supported as this will increase the internally Generated revenue of the state
- Up to date report should be generated showing revenue distribution by revenue types and revenue agency.

Reprioritization of the health

The state needs to place the heath sector and its funding as top priorities in its finance and planning activities in addition to pursuing efficiency gains. OSG should consider 15% budget allocation to health which will increase the fiscal room of the health sector. The OSMoH would need to actively engage on this.

Earmarking for health

The State should pass a health bill into law with the following provisions:

- At least 2% of State CRF to be itemized for funding coverage of the vulnerable groups with the expectation that the actual amount will not be constrained by debt service deductions.
- Employer and employee cost-sharing of salary contributions toward purchase of coverage for the public-sector employees.
- Consider LGAs creating an equity fund equivalent to at least 1% of LG CRF

External funding

OSSG should creatively court donor funds by proactive engagement of bilateral and multilateral donors for assistance.

- Strengthening donor coordinating platforms
- Recommend a specific proportion of donor funds to be applied toward the health insurance fund directly or in counterpart to state's own funding

Leveraging Fiscal Space

As stated in the SHDP 2010 - 2015, the state government desires to strengthen its relationship with donor partners in its drive to reform the health system. Donor partners can leverage this commitment and stimulate action on the part of the government using a counterpart funding approach. Based on the identified fungible fiscal space in this report, donors can request counterpart funding for their proposed intervention from the state government. It is highly recommended that the donors should support the state to strengthen the donor coordination platform in the state; this platform has the potential of monitoring health resources from all sources, prevent duplication of efforts and as well influence a better cost-sharing arrangement between the donors and the state government.

1. INTRODUCTION

1.1 Background

Sustainable health financing has been at the frontier of policy discussions within the global health development. In Nigeria, there have been concerns expressed by policy makers within the health sector and its development partners on how to increase sustainable fiscal space for health with a view to ensure the delivery of effective, affordable and sustainable health services to the entire population. The term fiscal space is defined as "the ability of governments to increase spending for a given purpose without any prejudice to the sustainability of its financial position" [4]or its ability to cover its recurrent expenditures and service its debts, both in the present and in future. Fiscal space analysis is used as a policy tool to monitor, evaluate or predict the sources and extent of available public resources for a desired purpose. When applied to the health sector, the intention is to identify the level of additional financial resources that is potentially available for health in the short and medium term in a way that is consistent with macroeconomic fundamentals such that long-term solvency of the government and its economic potential are not jeopardized[5].

The health care system in Nigeria is in poor condition. Recent analyses predict that if the current trend continues, Nigeria will be contributing 15% of global burden of under-five deaths[6] by year 2030. The substantial investments of development partners towards alleviating the health system burden in Nigeria while commendable have recorded only minimal progress in health outcomes. The anticipated health outcomes can only be achieved through concerted efforts from Nigerian government at all levels (Federal, State and Local Government) and development partners.

Anecdotal evidences show that previous collaborative efforts with memorandum of understanding (MoU) arrangement between government and partners in the health sector - especially those that include government financial contribution - suffer setbacks as most host governments does not always fulfil its obligation to fund its commitment towards healthcare interventions and development projects. This may be due to government aspirational commitments in the MoU without considering the macro-fiscal implications or impact on its financial solvency position. Others include lack of provision of its commitment in the budget; untimely disbursement; lack of transparency[7]; inadequate fund; lack of political commitments, etc. The combination of these challenges, among many others, indicates that government revenue generation will have to increase significantly to feasibly respect many of the MoUs endorsed by the state as well as increase the budgetary room for health sector. How increased revenue generation by the state government will enlarge the fiscal space for health is a question that needs to be addressed, if the proposed MoU will be effective.

In the renewed effort to support state governments to further strengthen and contribute more actively towards financing their health system, the USAID mission in Nigeria is exploring the feasibility of state government committing to the implementation of MoUs for health. Any MoU, between the host Government and USAID will be developed, based on evidence, with a view to

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[4] Heller, P. S. (2006), the prospects of creating 'fiscal space' for the health sector, Health Policy and Planning, 21 (2), pp. 75-79.
[5] Adam, C.S. and Bevan, D.L (2005). 'Fiscal Deficits and Growth in Developing Countries', Journal of Public Economics, vol. 89(4), pp. 571-597
[6] UNICEF - State of the World's Children 2016
[7] Some host governments will budget for counterpart funding with the view to make the Development Partners to bring their contributions. When such contributions are received by the State, they will later withdraw or divert the State's contribution to other uses.

ensuring that the state government commits to what is reasonable in its obligation as established in an MoU for health development projects and programs. To this end, USAID's Health Financing and Governance (HFG) Project in collaboration with Centre for Health Economics and Development (CHECOD) were asked to conduct a fiscal space analysis (FSA) for the Osun State health sector. This study responds to the need to examine recent financing trends and possible areas of additional fiscal space for health including recently established State Health Insurance Scheme (OSHIS) in Osun State, Nigeria.

1.2 Osun State Profile

Osun state is one of the youngest demographically with children under 5 years of age making up 12 percent of the population, and ultimately, 36.9 percent of the population being under age 15. Overall, the vulnerable population groups (children under 5, pregnant women and the elderly not covered by any formal sector employment and the indigent population) account for 52 percent of the state population. The state population is estimated at 4.8 million in 2017. The state estimated GDP and per-capita GDP are $9.4 billion and $2,356 respectively in 2012[8]. The capacity of the state for internal revenue generation is severely limited by the dependence of the economy on subsistence agriculture and the degree of indigence among the population. As a result, the state is fiscally dependent on allocations from the federal government and loans for provision of public good services including public health.

Osun State operates a mixed health economy of public and private healthcare delivery systems funded by government, donors, corporations and households. The health facilities include 916 primary health care out of which 90% are public PHCs; 34 secondary and 2 are tertiary health facilities, summing up to a total of 951 health facilities[9]. There are no private secondary or tertiary health facilities in the state. The State has made some progress towards improving the health status of its residents. A reflection of this can be seen in some of the health status indicators - percentage of skilled birth attendance, Measles immunization coverage, DPT-3 immunization coverage, etc. - that are better than the national average. However, other indicators such as under-five, infant and neonatal mortality rate are higher in Osun State more than the southwest average (Table 1).

Table 1: Key health performance indicators

Selected health indicators	Osun State	South West	National
Under five mortality per thousand live births	101	67	120
Infant Mortality rate per thousand live births	78	52	69
Neonatal mortality rate per thousand live births	56	36	39
Skilled attendance at birth, percentage	84.7%	82.70%	43%
Measles immunization coverage, percentage	67%	72%	42%
DPT-3 immunization coverage, percentage	60%	66%	33%
Antenatal care from skilled providers	95.6%	89.50%	65.8%
Facility-based delivery (rate)	73.4%	76.60%	37.5%
Modern contraceptive prevalence rate	25%	25.80%	13.4%
Percentage of children 12-23 months old fully immunized	43%	50%	23%
HIV prevalence rate	2.6%	N/A	4.1%
Household ownership of at least 1 ITN	18%	38.6%	66.3%

Source: MICS 2016/2017

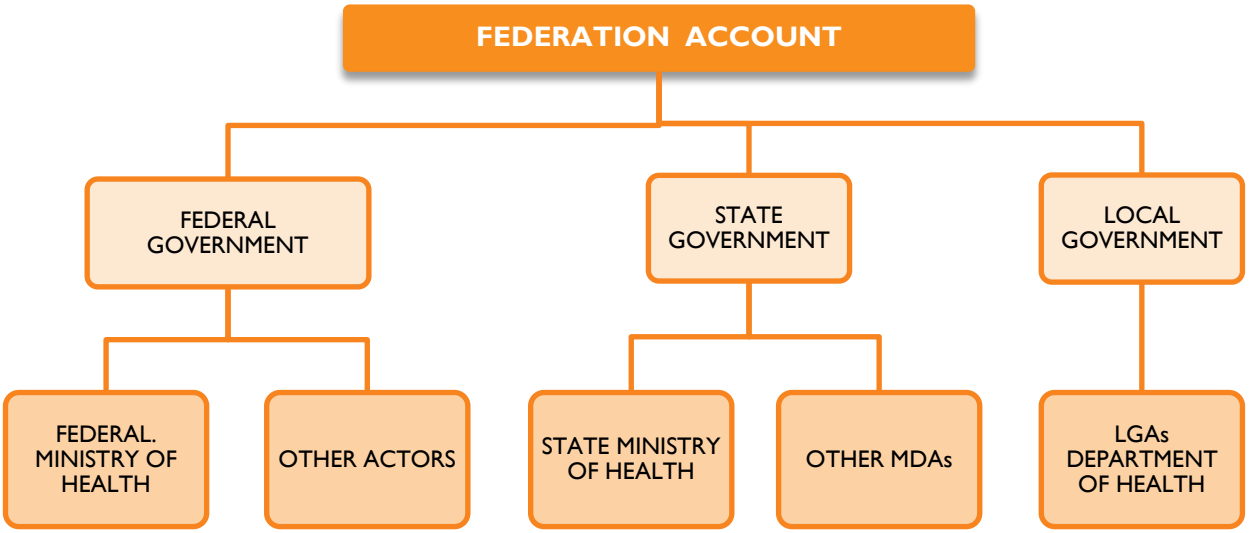
[8] http://osun.gov.ng/2014/04/19/report-osun-7th-largest-economy-nigeria-renaissance-capital/
[9] Health Management Information Unit of Osun State Ministry of Health

The state in its efforts towards achieving UHC and a sustainable financing base capable of reforming the state health system has undertaken a series of steps through the state ministry of health (OSMoH). These include the development of a 5-year strategic health development plan with goals, strategic objectives, interventions and activities across 15 priority areas or sub domains of the national framework for strategic health development plan. The need for resource mobilization to finance this plan cannot be overemphasized.

1.3 Osun State Health Financing

Osun operates a pluralistic health financing system comprising of the following health financing mechanisms; 1) government budgetary allocations, 2) external financing, 3) pre-payment contributions/deductions and 4) household spending on health. The main government budgetary allocation is the statutory allocation. The statutory allocations flow from the federation account to the three tiers of government (federal, state and local government). Other sources of government funds include internal gross revenue, value added tax, grants and other miscellaneous measures. Figure 1 below provides a diagrammatic representation of the flow of government funds to the state.

Figure 1: Funds Flow from Federation Account



Despite there being multiple health funding mechanisms, out of pocket expenditure still remains the major health financing mechanism in the state. This expenditure is discouraging to health care seeking behavior and inequitable, as it pushes families into poverty and denies them success to health services when they need them. However, the new policy direction in the county is focused on minimizing household spending and increasing government spending, which is a more stable and predictable means of health care financing. These four health financing mechanisms fall under three functions of health financing which include: revenue generation, pooling and purchasing and allocation:

1.3.1 Revenue Generation.

Budget allocation to the health sector is very low compared to the Abuja target of 15% and has been declining over time. At 7.1% in 2014, Osun State Government (OSSG) financing of health reached its peak last six years but declined to 5.6% in 2016. Given that government health suspending is the most effective and available for advancing equitable healthcare when focused on vulnerable population groups, the declining allocations to health must be reversed if the ambitions of UHC are to be realized.

1.3.2 Pooling

Osun State Government adopted free health care policy for all its citizens since 2003 that covers specific services: immunization, distribution of micronutrients, treatment of citizens against onchocerciasis (river blindness), tuberculosis, leprosy and the provision of health information. The free secondary health care element consists of registration of patient and consultations, minor investigations and surgeries, medications, care of pregnant women and drugs. However, the program has been characterized by non-availability of essential drugs, inadequate staffing, and the lack of well-equipped laboratories among others. As part of the renewed efforts to ensure access to quality and affordable health care delivery for the benefits of the people and in line with national policy direction, OSSG has established Osun Health Insurance Scheme (OSHIS). This scheme aims at alleviating the burden of health expenditure on households and ensuring access to quality healthcare without financial impediments. For legislative backing, the bill for the establishment of OSHIS is being examined by the executive and judiciary arms of the state government.

In the draft bill, OSSG has committed to funding the financial liabilities of the vulnerable group and earmark not less than 1% of the state consolidated revenue fund as equity fund for the group. This study examines the resource available for the equity fund, resource needs to fund OSSG obligation under the scheme as well as the resulting resource gap. It is expected that the passing of the bill will lay the ground work for an active program of institution building, including the Health Insurance Fund and Provider Payment System.

1.3.3 Resource Allocation and purchasing

Strategic purchasing is associated with improved health service delivery as well as equity in allocation of resources. In Osun state, the health purchasing mechanism has always been passive, since health funding has not been performance based. The state health insurance scheme is a major mechanism to initiating strategic purchasing due to its active health purchasing modalities, as it allows a defined set of health services to be made available to a defined group of people by a defined group of providers.

2. METHODOLOGY

In this exercise, quantitative and qualitative data collection techniques and sources were employed in estimating the cost and revenues and other financial and economic projections.

2.1 Stakeholders Meeting

A meeting of stakeholders focused on examining the fiscal space for Osun State Health Sector was held to achieve common understanding and agreement on the framework for conducting Fiscal Space.

2.2 Data Collection

Data collection from relevant stakeholders including:

- SMoH, State Ministry of Economic Planning and Budgeting (SMEPB) including State Bureau of Statistics, Donor Coordinating Unit – State Treasury Office, Auditor General of State and Local Government, etc.

Data was also sourced from the relevant Federal MDAs, including:

- National Bureau of Statistics (NBS)
- National Health Insurance Scheme (NHIS)
- Federal Ministry of Health (FMoH),
- Federal Ministry of Finance (FMoF)
- Central bank of Nigeria (CBN)

Key informant interviews were conducted with public officials in the state regarding their experience implementing similar laws with earmarked funds and working with federal agencies. Additional interviews covered senior officials from federal, state and local government ministries, department and agencies regarding their implementation responsibilities and experiences. The key informant interviews focused on the performances of earmarked funding in other sectors, facts behind the economic projections, scale-up targets, the major challenges and best paths forward for ensuring universal health coverage for the entire population of Osun State.

2.3 Data Analysis

Using the five fiscal space dimensions[10], this study presents an assessment of the fiscal space available to Osun State health sector. This analysis will provide decision-makers with options for informed choices. The purpose is not to define a single pathway but to provide evidence that can support the discussion of the financial, political and implementation feasibility of different combinations of opportunities leading to evidence-based decision making on the approach that the state will take to increase spending for health and scaling up coverage of health services. The findings will help to inform the target setting, advocacy and planning needs of the OSMoH as well as Osun State Health

[10] Regondi I. and Whiteside A. (2012), ' Fiscal Space for Health: Assessing Policy Options in South Africa', Journal of Contemporary Management

Insurance Agency. In other words, this will also be a guide to determine fiscally optimal trajectories of health insurance coverage expansion.

Table 2: Assessment of fiscal space available to Osun state

Dimension	Analytical Framework	Examples
Dimension 1	Macroeconomic Dynamics	Sources of government revenue, Trend of revenue mix, Government solvency conditions, Economic outlook
Dimension 2	Reprioritization of health sector	Budget Allocation to Health, Share of government health expenditure out of total government expenditure, Government Health Spending and Population Growth
Dimension 3	Health sector-specific resources /Earmarked funding	Available earmarked funds e.g through CRF or Taxation, Other health sector-specific resources
Dimension 4	External grants/Foreign Aid	Donor Contributions, Philanthropists, Other private sources
Dimension 5	Efficiency savings	Input versus Output, Sources of inefficiency, Efficiency gains

**Adapted from Fiscal Space for Health: Assessing Policy Options in South Africa by Ilaria Regondi and Alan Whiteside*

This analysis focuses on three main questions that each of the three components will help answer.

Part 1: Identify the need of the government of Osun State within the health sector emanating from its commitment in the draft State Strategic Health Development Plan 2017–2021.

Part 2: Identify and evaluate the revenue potentially available to the government of Osun State to fund its commitments to the health sector.

Part 3: Outline options that are available for policy makers to consider around the sustainable financing of the health system especially the priority interventions in the SSHDP.

In addition, an assessment of the fiscal capacity of Osun State government to implement and ensure the sustainability of health insurance scheme was conducted in four steps.

- Available current and potential financial resources quantified: the principal and earmarked sources of funding including equity fund and resources from the National Health Insurance Scheme
- Resource needs of the OSHIS estimated: a dynamic simulation model, accounting for population changes, was used to project the size of the Fund and the cost implications of providing the minimum package to the defined priority population categories and the entire population of the state using a milestone approach. In the simulation, which used 2015 as base year,[11] the dynamic population in the state was considered to assess the ability of government to sustain spending based on long-run projections of the state total government revenue (STGR) and the expected expenditures. The implications of using different premium thresholds and scale-up scenarios to determine the cost of implementing the scheme were also analyzed.
- Funding gaps estimated: gaps were calculated based on several scenarios and are presented alongside a discussion of options to fund them.

[11] The year 2015 was used as base year because the data for 2016 was not readily available or incomplete.

- Macro-fiscal analysis of additional space for OSHIS: this analysis is based on revenues accruing to the state, internally generated revenue, debt profile, budget and actual expenditure over a 5-year period.

2.4 Scenario Development for OSHIS Financial Modelling

There will be many combinations of coverage targets, premium levels and prioritization of populations that the government of Osun State could use to guide the scale up of health insurance coverage by the OSHIS. The purpose of this analysis is to identify some pathways along with their costs to stimulate an informed discussion about which pathway is politically and financially feasible as well as implementable in a complex environment with a very large population unused to the concept of health insurance.

- **Political considerations**: for example, the private sector already exists and may not be keen to be incorporated in to a state scheme. While there may be political approaches for ensuring the promulgation of a health law and establishment of a health scheme, the reality is that these may not be completed in the near term and it is important to understand the implications if any for the financial status of the scheme and the success of the risk pooling function of having a state program. Similarly, state employees, having enjoyed certain levels of health benefits may be unwilling to have their wages 'garnished' for health insurance premiums even if subsidized but once the approach to incorporating them has been identified and approved (which could be a quick or a lengthy process, unknown at this time), it should be quick to implement given the state's existing control of their salaries etc.
- **Financial considerations**: for example, it has been pointed out that some sources of funds are earmarked for priority populations and may not be fungible which must be accounted for when determining where the financial gaps between need and available resources are. Several options for increasing the required resources may exist that are outside the control of OSMoH and it important to at least be aware of how they may impact the resources available to the scheme. For example, the NHIS may cover all pregnant women and children completely or it may pay only a certain portion of the premium leaving the state to pay the difference, or it may have a ceiling on the number of people it will cover in each state.
- **Implementation considerations**: for example, certain populations are readily identifiable such as pregnant women who in turn could identify their other children under 5, leading to a rapid enrolment for this population that exceeds conservative estimates and resource available. On the other hand, the informal sector will be more challenging to advocate to and enrol which puts pressure on the scheme because this is a critical population whose premiums make the risk pool of the state viable and sustainable in the long run (as opposed to pregnant women and children who tend to be heavy users of the health system and who will be subsidized by government of Osun State).

Therefore, the analysis approach focuses on identifying the issues and decisions that need to be quantified and discussed by the key stakeholders in the planning process of the scheme.

3. OPTIONS FOR INCREASING FISCAL SPACE

The fiscal space for health can be enlarged based on macroeconomic performance of the country in general and Osun State in particular. Strong, inclusive economic growth and efficient tax infrastructure, or more generally, internal revenue generation, could translate to increased room for public spending as employment and earnings increase, and these contribute to government spending on health through taxation revenues. A reprioritization of health spending at the State level accompanied by renewed emphasis on health insurance is essential to increasing the fiscal space. This chapter presents the context in which OSSG finances its budget allocation to health and may point to resource options that can be incorporated into the OSHIS set of scenarios for further discussion.

3.1 Understanding the concept of fiscal space

Fiscal space has been broadly defined as "the capacity of government to create budgetary room to allow them to devote an increasing amount of resources to social services over time without jeopardizing financial sustainability[11]. In health, it refers to the ability to create additional budgetary space for the health sector in a manner that is both fiscally and economically sustainable over a short to medium term. Tandon and Cashin elaborated on the sources that could be used to generate fiscal space for health which includes: (i) conducive macroeconomic conditions, (ii) reprioritization of health within the government budget, (iii) an increase in health sector-specific resources (i.e. earmarked funds), (iv) health sector specific grants and foreign aid, and (v) an increase in the efficiency of existing health expenditure:

"Conducive" Macro Economic dynamics; this involves examining the economic and financial status of the country/state and determining how conducive/favorable it is as well as prospects of economic growth to allow improvements in the resources allocated to the health sector, improvements in revenue generated and sustainable levels of deficits and debts.

Health Reprioritization within the State Budget; this refers to the government prioritizing health by improving allocation and release. The Abuja declaration urges government to allocate a minimum of 15% of total budget to health; however only few states in Nigeria are meeting this call

Earmarking for Health; this involves setting aside all or a certain percentage of available funds for health.

Efficiency Gains; in order to identify additional funds for health, sources of inefficiency need be identified and addressed to free up wastage and hence create fiscal space. It also involves ensuring available funds are utilized properly to ensure maximum output. I.e. health outcomes.

External grants: This is an additional source of fiscal space but grants from donors are often short lived and not predictable. However, when used to stimulate or catalyze domestic spending on Health, its effectiveness can be optimized. Hence domestic aids as well as catalytic/additional counterpart funding alongside grants obtained from international sources from the government can be considered as fiscal space for health.

3.2 Need for Fiscal Space in Osun State

3.2.1 Health Sector Needs for Osun State SHDP II Implementation

Osun State is one of the 36 states and Federal Capital Territory (FCT) currently participating in the development of State Strategic Health Development Plan in line with national plan framework. The

national plan framework established common approach for planning and implementation time frame for health sector needs over a period of five years both at the federal and state levels. This includes 15 pillars or sub-domains namely:

1. Leadership and Governance
2. Community Participation and Ownership
3. Partnerships for Health
4. Reproductive, Maternal, Newborn, Child, Adolescent Health Services & Nutrition
5. Communicable Diseases (Malaria, TB, Leprosy, HIV/AIDS) And Neglected Tropical Diseases
6. Non-Communicable Disease, Care of The Elderly, Mental Health, Oral Health, Eye Healthcare
7. General and Emergency Hospital Services
8. Health Promotion and Social determinants of Health (Environmental Health)
9. Human Resource for Health
10. Health Infrastructure
11. Medicines, Vaccines and Other Health Technologies and Supplies
12. Health Information System
13. Research for Health
14. Public Health Emergencies: Preparedness and Response
15. Health Financing

A rapid cost analysis of some components listed in Pillar 10 and 15 of the SHDP have been carried out to gauge potential resources available. These include the required number of health facilities to be established, constructed or renovated (Pillar 10) and the financial liabilities of OSSG under the proposed Osun State Health Insurance Scheme.

3.3 Macro-fiscal Dynamics

Macro-fiscal conditions are main determinants of budgetary allocations to any sector. These conditions include continuous economic growth, improvements in revenue generation, and sustainable levels of deficits and debt. Periods of stout economic growth and macro-fiscal stability often result in increases in the level and share of the public sector in the economy, including health sector.[12]

In Osun State, the statutory revenue for the period of 2011 to 2015 vacillated in both amounts and its proportionate shares from N41.1 billion (54%) in 2011 to N27.1billion (32%) in 2015 with an average of 38.8% of the state total revenue through the period. The state appears to be faced with the challenge of dwindling allocation from FAAC. Other federally allocated revenue (VAT) increased from N6.9 billion (9%) in 2011 to N8.1 billion (9.5%) in 2015. However, the state IGR appeared static with no visible growth, from N11.9 billion in 2011 to N11.8 billion in 2015. The state total revenue declined at an average rate of 11.2% between 2012 and 2015. The surge in growth of 70% occurred between 2011 and 2012 was because of the N30 billion received as bond proceeds in 2012. Given that revenue from FAAC is highly vulnerable to external shocks due to the volatility of international oil markets on which it mainly depends, it makes it difficult for Osun State to predict its expected revenue from this major source with a high degree of certainty. This sets the state up for weak budget performance on the revenue side.

[12] ADB (2006), Measuring Policy Effectiveness in Health and Education, Manila: Asian Development Bank.

Figure 2: Osun State Revenue Profile 2011 – 2015

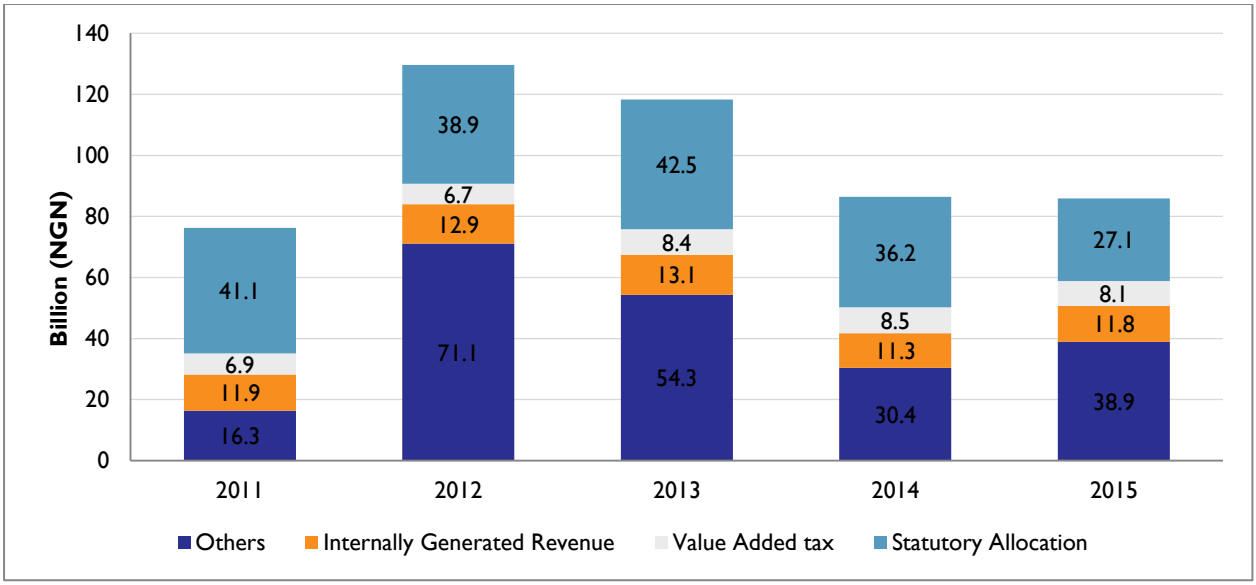
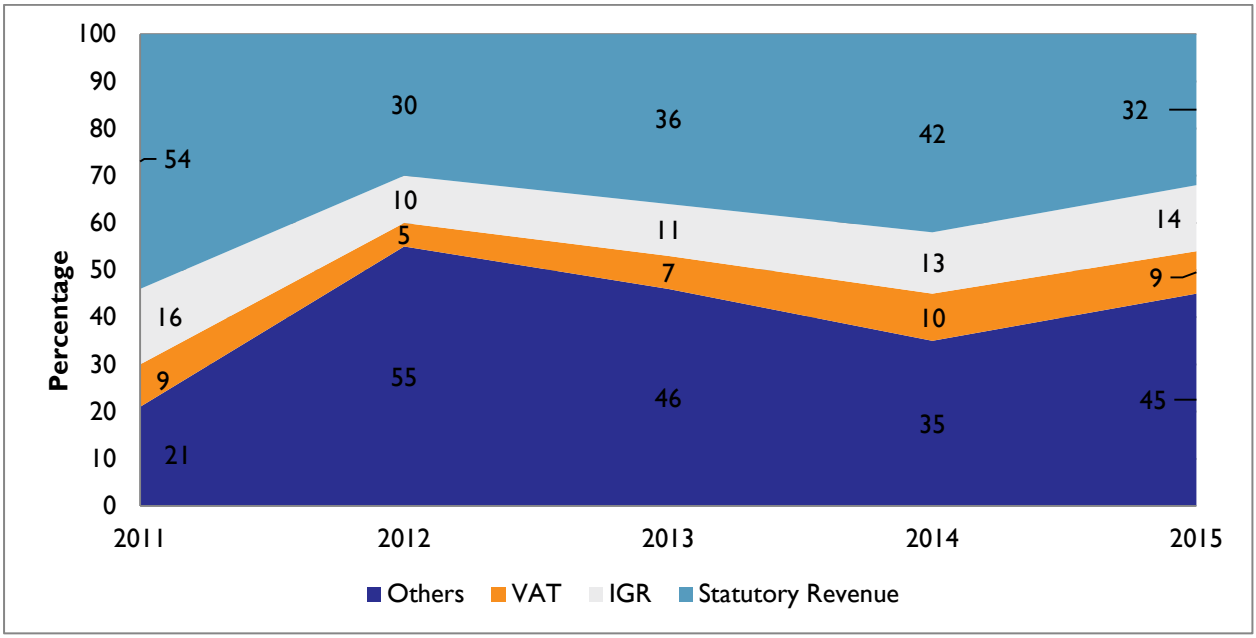


Figure 3: Trend of Government revenue mix



Source: Report of the Accountant General with the Financial Statements

3.3.1 Fiscal Sustainability Analysis of Internally Generated Revenue (IGR)

In Table 3, taxes accounted for an average of 38% of IGR during 2011-2015 while fines and fees made up 18% and have expanded as a source of internally generated revenue from N1.8billion (15%) in 2011 to N2.4billion (21.0%) in 2015. Actual IGR dropped in 2014 by 14% from its 2013 level, driven principally 53.6% decrease in miscellaneous and 12.6% decrease in taxes.

Table 3: Internally Generated Revenue 2011-2015 (N 'Millions)

YEAR	2011	2012	2013	2014	2015
Taxes	3,653	4,354	5,604	4,897	4,511

Fines and Fees	1,814	1,378	2,599	2,531	2,438
Licenses	173	140	487	486	703
Earnings & Sales	528	291	942	1,324	1,610
Rent on Gov't Property	193	59	213	413	426
Interest, Repayment &Dividend	597	122	185	205	347
Reimbursement	186	-	-	-	12
Miscellaneous	4,733	6,533	3,094	1,436	1,737
TOTAL	**11,877**	**12,876**	**13,125**	**11,291**	**11,784**
Tax/IGR	31%	34%	43%	43%	38%
Fines and Fees/IGR	15%	11%	20%	22%	21%
Miscellaneous/IGR	40%	51%	24%	13%	15%

Source: Report of the Accountant General with the Financial Statements

In general, the capacity of OSSG to generate sustainable revenue locally is challenged as the state increasingly underperforms relative to its projections. It is noted that revenue generation in 2015 showed no improvement over 2011. In addition, IGR performance dropped from 29% of projections in 2014 to 17% in 2015. Performance on taxes decreased from 33% in 2014 to 21% in 2015; fines and fees performance also dropped from 48% of projection in 2014 to 17% in 2015. The dwindling performance on these two most important revenue sources (accounting for 61% of IGR) is a signal of either weakening capacity to collect revenues or a declining (narrowing) revenue base.

Table 4: Distribution of Internally Generated Revenue Performance 2014-2015 (N 'Millions)

Sources of IGR	2014			2015		
	Budget	Actual	IGR Performance	Budget	Actual	IGR Performance
	(N'Million)		%	(N'Million)		%
Taxes	14,927	4,897	33%	21,096	4,511	21%
Fine and Fees	5,311	2,531	48%	14,308	2,438	17%
Licenses	529	486	92%	-	703	0%
Earning and Sales	2,043	1,324	65%	5,705	1,610	28%
Rent on Govt. Property	1,371	413	30%	10,437	426	4%
Interest, Repayment & Dividend	10,939	205	2%	11,271	347	3%
Reimbursement	150	-	0%	150	12	8%
Miscellaneous	3,221	1,436	45%	5,193	1,737	33%
Total	**38,491**	**11,291**	**29%**	**68,161**	**11,784**	**17%**

Source: Report of the Accountant General with the Financial Statements

There have been suggestions that the State could increase IGR capacity through a more progressive taxation regime as this will help accelerate revenue generation as the economy grows. More importantly however is the need to broaden the tax base given the large informal sector that is estimated to account for 90% of employment in the State. Improvement in capacity to collect taxes and fees is a potential option for improving Osun State Internal Revenue Service performance in internal revenue generation. An analysis of the revenue generation indicated potential sources and opportunities that could turn out approximately N5.0 billion naira per month for OSSG, about 600%

of the current internal revenue generation. Some of the steps that have been marshalled out by state internal revenue service to achieving this goal include:

- Enactment of Osun State Board of Internal Revenue Autonomy Law
- Management Structure
- Standard Operation, Policy and Procedures
- Human Resources
- Information Technology Infrastructure and Application
- Enhanced Internal Control and Blockage of Revenue Leakages
- Expansion of Tax Base – Bringing the Informal Sector to the Tax Net
- Debt Recovery/Tax Audit
- Tax Payer Database
- Increased Network of Tax Offices
- Review of Revenue Laws and New Revenue Sources
- Close Monitoring and Generation of Management Report
- Taxpayer Enlightenment and Engagement
- Enforcement of Provisions of Various Revenue laws
- Governor's Monthly Meeting with Ministries/Departments/Agencies

The implication of these initiatives for the health sector, if successful, is the additional public revenue that will be yielded for health. It is important to note that increase in IGR would lead to increases in the state consolidated revenue fund (CRF) as well as increases in the health insurance coverage of the vulnerable groups[13]. However, this expansion would be challenging due to two factors. One, there is generally low level of private investment in the state. An excessive tax burden beyond current levels (which is currently a source of complaints by the organized private sector) could be counter-productive as it could discourage private investment in the state. Two, the current tax base is narrow, leading to concentration of taxation income to few taxpayers. The implication is that there will be a need to support the state to identify and sensitize on innovative ways of increasing IGR of the state.

3.3.2 Relative Allocations to Capital and Recurrent Expenditures

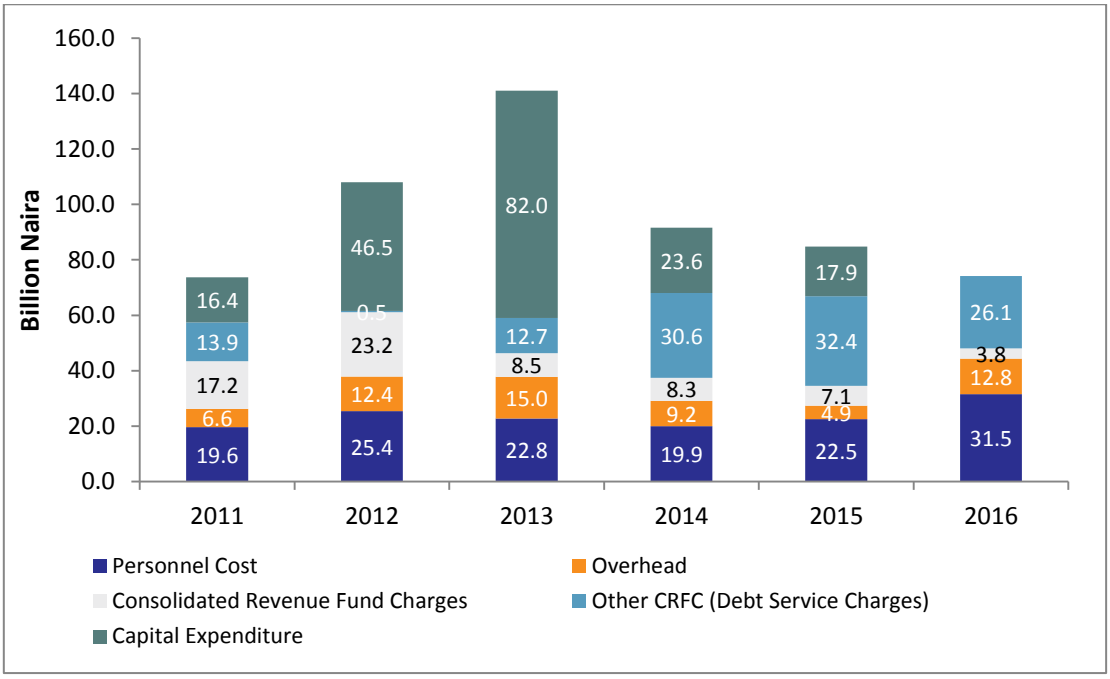
In Figure 4, the shift in the expenditure profile toward recurrent expenditure is driven by sustained growth of personnel cost, which increased from N19.6 billion in 2011 to N31.5billion in 2016 at an average of 12% annual growth between 2011 to 2016. The capital expenditure drastically increases from N16.4billion (22%) in 2011 to N82 billion (58%) in 2013, its relative share and amounts fell to N17.9billion 21.9% in 2015. The sudden increase in 2013 occurred within the same period OSSG collected a bond proceeds of N41.4 billion in 2012 and 2013. The bond was used to build 11 high schools14 and commission 21 new roads15 among other infrastructures.

The implication of high dependence by the state on FAAC allocations and its capacity to effectively implement its infrastructural plan without borrowing is severely constrained by external shocks as

[13] OSSG propose to earmark not less than 1% of State CRF as equity fund for health insurance coverage of the vulnerable group.
[14] www.osunsukukprojects.com
[15] https://www.premiumtimesng.com/regional/ssouth-west/159612-aregbesola-commissions-21-new-roads-osun.html

FAAC resources is heavily dependent on crude oil production and export with its attendant production challenges and volatile prices. As the total expenditure increased at an average annual rate of 4%, the state may continue to heavily rely on loans and bonds proceed. Thus, there is a critical need to address the weakening capacity for IGR to sustain the state recurrent expenditure[16] which currently cannot be addressed by the state's current revenue collection efforts. The limited and unpredictable fiscal space which reflects increased reliance on borrowing is not likely to engender sustainable fiscal policies and economic growth in Osun State including earmarked funds and budget allocations to the health sector.

Figure 4: Trend Analysis of Government Expenditure, 2011 - 2016



Source: Report of the Accountant General with the Financial Statements

3.3.3 Osun State Government Solvency Condition

Due to increasing debt stock, external and domestic debt stock at 2016 are $70.4 million and N147.1 billion[17] respectively, the solvency ratio of the state is about 1500%. The debt management office benchmark in Nigeria for a warning lies between 92% to167%. This implies that the state has already exhausted its capacity to borrow. In figure 5, the lethargic trend of IGR can no longer meet the loan repayment and debt service charges. Anecdotal evidence revealed that there were occasions where the state returned with little or nothing from FAAC allocation due to debt service deductions at source. The implications of these deductions led the state government to owe workers or reduce their salary to half.

This situation has also raised concerns within the health sector as OSSG propose to earmark not less than 1% of its consolidated revenue fund (CRF) as equity fund for OSHIS. Will this 1% CRF equity fund be determined before or after debt deductions? Most importantly, OSSG needs to institute measures to strengthen revenue collection and create a conducive atmosphere for private sector in order to both widen and diversify its earning base and stimulate the current flat trend of IGR.

[16] Currently, most State Government workers are being paid half salary since September 2015.
[17] Nigeria Domestic and Foreign Debt – 2016 by National Bureau of Statistics

Figure 5: Analysis of Osun State Solvency Condition

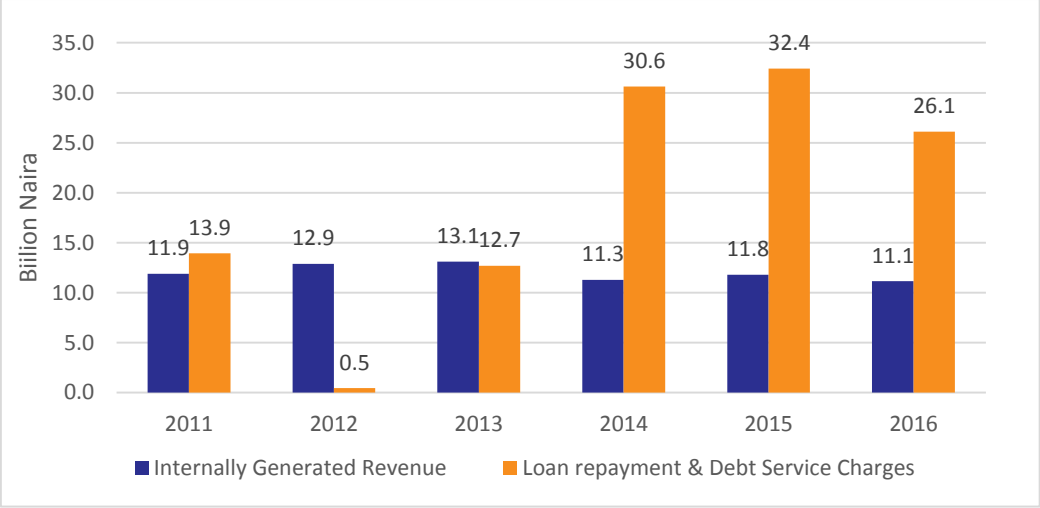
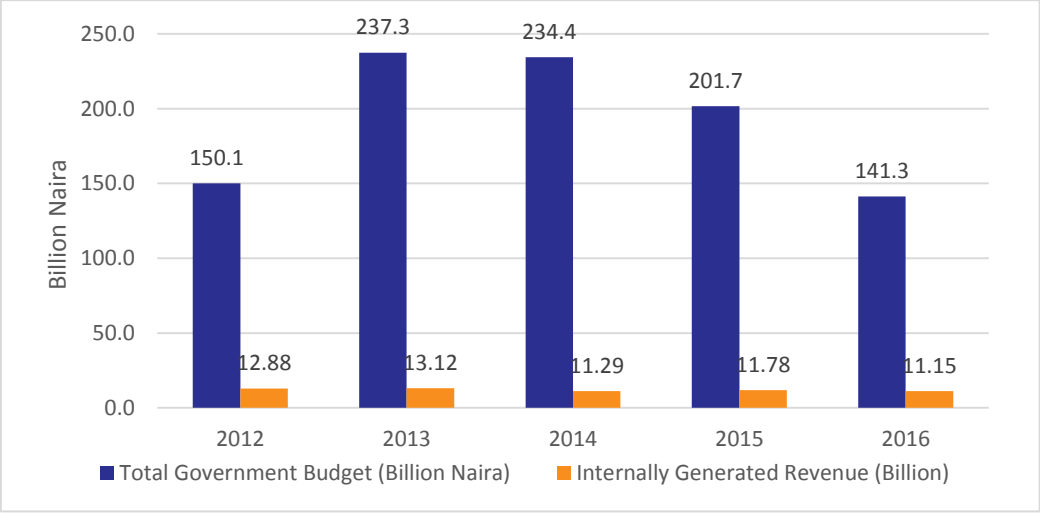


Figure 6: Sustainability analysis of Government Budget



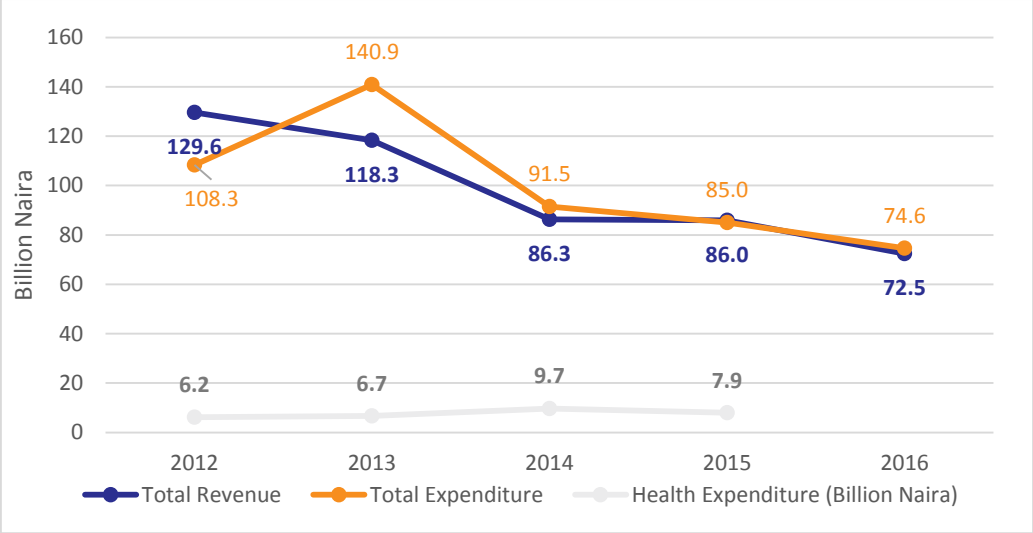
Source: Report of the Accountant General with the Financial Statements

Furthermore, it is important to note the contribution of IGR in government budget financing as shown in figure 6. These amounts are only able to fund an average of 7% of the Government budget with a peak of 9% in 2012. The funding of the remaining recurrent and capital budget had to be sourced from FAAC allocations, grant and loans, etc. It then becomes imperative for the state to improve its IGR collections if it intends to ensure fiscal predictability and sustainability as well as adequate and independent funding sources to provide quality services that will meet the health needs of its population.

3.3.4 Revenue, Expenditure and Health Spending

As shown in figure 7, total expenditure increased from N108.3 billion in 2012 to N140.9 billion in 2013 but declined 50 percent to N74.6 billion in 2016. Health expenditure showed minimal upward movement, only increased from N6.2 billion in 2012 to N9.7 billion in 2014 but declined to N 7.9 billion in 2015. Despite total revenue declining steadily from 2012 to 2016, health expenditure recorded an average increase of 11.6% during the same period. This depicts a scenario where increase in revenue could yield more resources for the health sector as political will appears to be a factor in prioritization to some extent.

Figure 7: Revenue, Expenditure and Health Spending



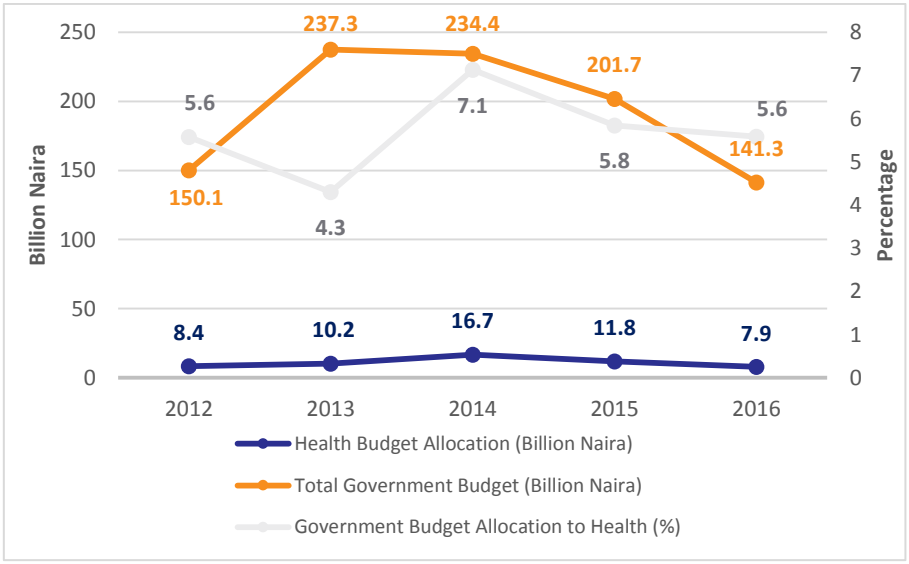
Source: Report of the Accountant General with the Financial Statements

3.4 Health sector prioritization

3.4.1 Relative importance of the Health Sector

Allocation to various sectors in the budget is a good indication of the importance government attaches to such sectors. An examination of budget allocations to the health sector in the state shows that the relative share of the health sector remains flat at 5.6% both in 2012 and 2016; although there was a sudden surge from 4.3% in 2013 to 7.1% in 2014, the reasons for this are not clear. At this rate, in addition to its meagerness compared to the 15% allocation agreed by Government in the Abuja declaration, there is a lot of room for increasing the current allocation towards achieving the target.

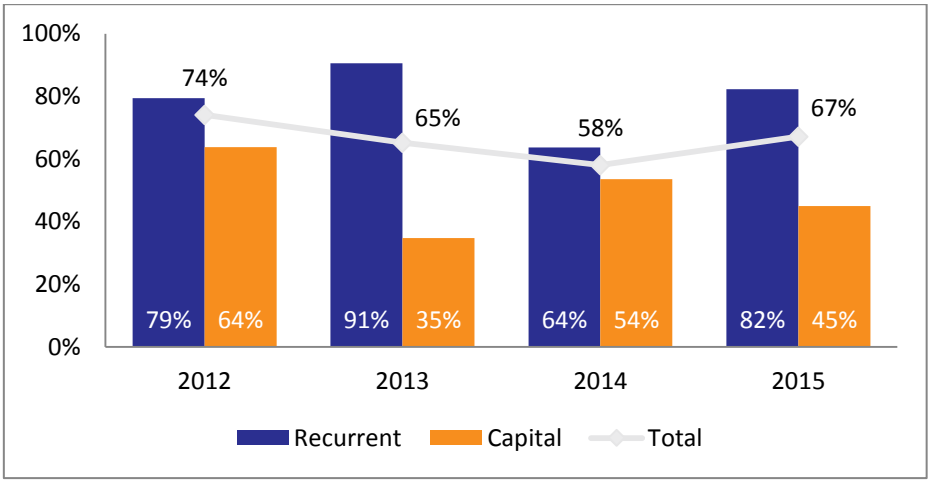
Figure 8: Osun State Government Budget Allocation to Health



Source: Report of the Accountant General with the Financial Statements, Author's Estimate

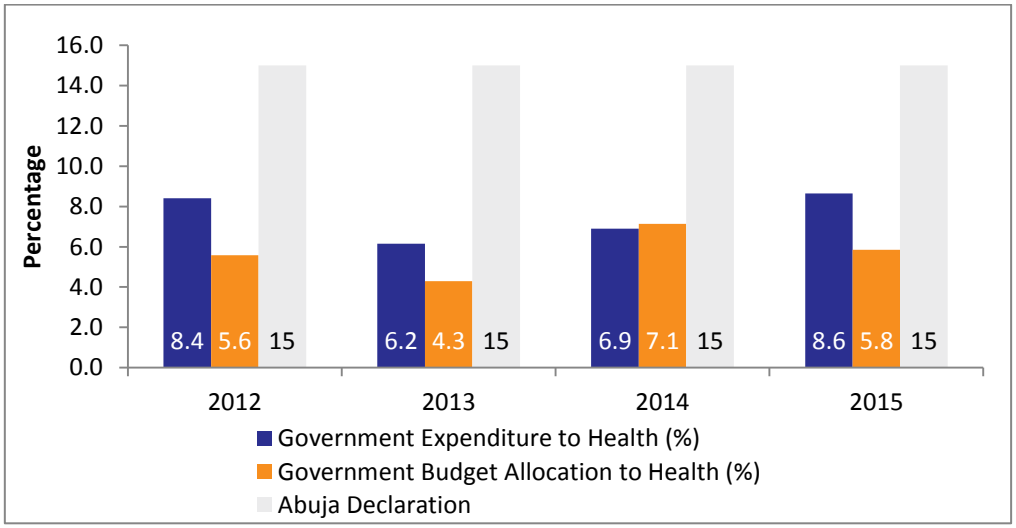
Budgeting allocation for health must be considered along with budget release and utilization in the sector, which constitute critical factors reviewed by ministries responsible for allocating and disbursing public budgetary resources. The budget performance in the health sector (ratio of actual expenditure to budget allocation) has been declining, from 74% in 2012 to 67% in 2015 (Figure 9). It is not clear, due to data limitations, if this downward trend continued into 2016 or has been reversed.

Figure 9: Health Budget Performance (%)



Similarly, from actual expenditure perspective, Figure 10 shows the relative share of the health expenditure out of total government spending remains the same at 8.5% both in 2012 and 2015; although there was a sudden decline to 6.2% in 2013 to 6.9% in 2014. However, actual health expenditure as a share of total government expenditure was higher in 2012 to 2015 (except 2014) than health budget as share of total budget. More importantly, health budget utilization is better than the state-wide budget utilization rate. Although, this may reflect some level of priority to the health sector but deliberate effort to raise the share of health expenditure to the Abuja declaration target of 15% is needed.

Figure 10: Relative importance of Health Sector



If the state implements the prioritization of health along the lines of Abuja Declaration, the additional resources that would have accrued to the health sector amounts to N10 billion in 2012, N14.5 billion in 2013, N8.1 billion in 2014 and N4.8 billion in 2015 (Table 5).

Table 5: Reprioritization of Health Sector according to Abuja Declaration

Fiscal Year	Total Government Expenditure (TGE)	Health Expenditure	Equivalent 15% of TGE	Gap
	(N' Billion)			
2012	108.3	6.2	16.3	10.0
2013	140.9	6.7	21.1	14.5
2014	91.5	5.6	13.7	8.1
2015	85.0	7.9	12.7	4.8

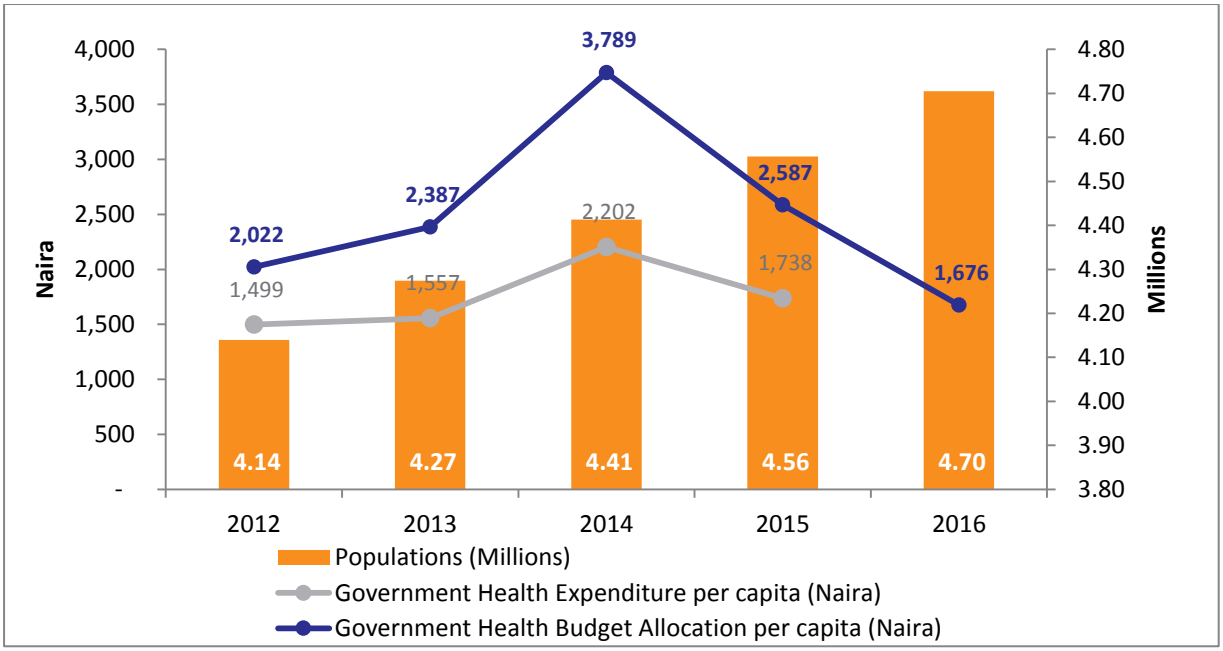
From the available bill of quantity estimates[18], the average gap of N9.4 billion per year between 2012 and 2015 is adequate to establish at least one functional secondary health centre for referral for all the 31 State LGAs and renovate 450 PHC centers as contained in the SHDP as well as build and equip 1 standard public health laboratory in each 31 LGAs.

3.4.2 Per Capita Health Expenditure

Figure 11 shows the elasticity of health budget allocation and expenditure per capita to the population growth. While it is evident that the population is growing, both health budget allocation and expenditure per capita increases from 2011 to 2013 but declined from 2014 to 2016. There is need to reverse the trend to avoid overutilization of health workforce e.g. doctor to population ratio, and infrastructure – an issue that the union of health workers and some civil society organizations are already expressing concern over. In addition, per capita Government Health Expenditure (GHE)[19] averaged N1,749 between 2012 and 2015 which, for ease of comparison with international benchmarks, was US$10.5 using exchange rates at that period. The share of SGHE out the state GDP[20] is less than 1%. Relative to the threshold of 6% recommended by WHO in 2014 as the minimum level needed to maintain a healthy and productive population, the level of health spending is not enough.

[18] See Annex
[19] Government health expenditure
[20] It is important to note there are component of GDP that are not within the fiscal control of the state

Figure 11: Health expenditure and expenditure per capita



3.5 Earmarking

3.5.1 Charges to Consolidated Revenue Fund (CRF)

The concept of earmarking funds is to set aside money collected from general tax revenue for a specific expenditure that will be used to help the government achieve a targeted objective (Cashin, 2016)[21], including improving access to quality health services. As noted earlier, there is a substantial resource gap for the health sector in Osun State.

Direct allocation from CRF is an option that the state is currently exploring in order to provide reliable earmarked funds for the health sector. Following the action at the federal level indicated in the National Health Act, the state is considering legislation to charge 1% of the state CRF into equity fund for health insurance. The below table shows that Osun State can improve health financing by raising the percentage of CRF to health.

Table 6: Earmarking through CRF

NHIS & State Equity Funds for vulnerable groups	2019	2020	2021	2022	2023
State Equity Fund (1% of CRF)	774	792	809	827	846
NHIS Contribution from BHCPF (Assuming BHCPF/ 37states)	855	951	1,058	1,177	1,309
Grand Total	1,629	1,743	1,867	2,004	2,155

[21] Cashin, C. 2016. Earmarking – A Safe Bet to Finance Health? Washington, DC: Results for Development

Direct allocations from CRF have been used to enhance the fiscal space for delivery of other public goods such as education.[22] Raising the percentage of CRF to health from 1% to 3% could raise more allocations to health sector by 2.3 billion[23] in 2019.

3.6 Mobilizing External Resources

Donor funding is a vital source of health expenditure. However, there are limited donor-funded development programs within the health sector in Osun state compared to other states in Nigeria. Data limitations preclude analysis of resources from the external grants in this study. The planning, budgeting and reporting systems for donor-funded programs and interventions is weak in the state. State-wide actors interviewed expressed concerns around the provision of donor budgetary information to the government. One of the key concerns is the exclusion from budget the donor projects supports that should be on the budget. Despite several efforts for collaboration and harmonization between partners for efficient utilization of donor resources in alignment with the development priorities of the state, donor priorities and contributions remain weakly aligned with state priorities, communication links among donors for learning and updates are weak, and projects are duplicated across institutions by different donors. Thus, it becomes expedient that the current systems for recording and reporting donor support are harmonized and coordinated to avoid increased inflows of off budget support.

3.7 Efficiency Gains

Fiscal space for health could be improved through actualization of efficiency gains in the health sector. Analysis of efficiency gains is highly demanding in terms of operational and financial data. Data limitations preclude the analysis here. However, anecdotal evidences show that OSSG could save money by demonstrating commitment towards: 1) the increase of health budget allocation into capital component; 2) the improvement of budget performance; 3) reinforcement of the workforce in the health sector.

Intra-sectorial analysis of the state's health budget into its recurrent and capital components shows that while the recurrent allocation increased in absolute and relative terms from N5.5 billion (65.5%) in 2012 to N7 billion (59.3%) in 2015; its capital portion also similarly increased in absolute terms from N2.8 billion (33.3%) in 2012 to N4.8 billion (40.7%) in 2015. The budget performance was 80% for recurrent expenditure and 64% for capital spending in 2012. However, the performance on recurrent component increased to 82.4% relatively higher than 2012 while the capital expenditure declined to 44.8% of the budget allocation in 2015. (Figure 12 and 13).

[22] For example, the Federal Government of Nigeria earmarks 2% of its CRF for financing of non-salary needs of basic education. More recently, it also earmarks (minimum of) 1% of its CRF to the health sector.

[23] Feasibility of earmarking 3% CRF may constrained by the macrofiscal environment and government solvency condition.

Figure 12: Osun State Health Budget Allocation

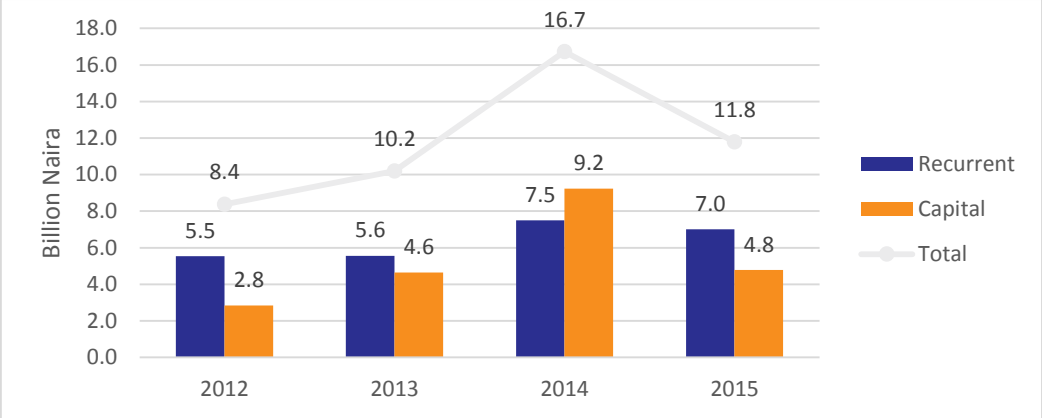
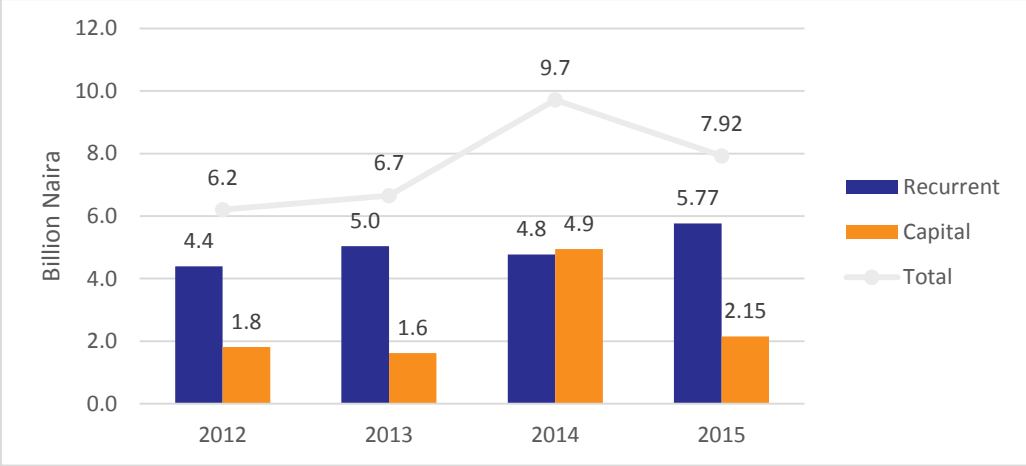


Figure 13: Osun State Health Actual Expenditure



Source: Report of the Accountant General with the Financial Statements

The reduction in capital expenditure is not only worrisome because it means that state is not meeting the investment levels required for high impact health interventions. An added analysis of the health spending would have required a further disaggregation of the expenditures into its preventive, curative, rehabilitative and promotive components among others. However, we are faced with considerable data constraints in this regard.

Other potential efficiency savings include (i) Use of zero-based budgeting and allocations based on performance as against the current financial envelope (ii) Identification of highest cause of death to prioritize the preventive interventions against such causes.

In terms of human resources, OSSG plans to but is yet to carry out biometric verification system of its workers. This system has the capability of identifying and eliminating ghost workers within the system thus leading to some savings. In addition, tackling absenteeism with strong monitoring systems and assessment, performance-based incentives, etc., has proven to enhance efficiency.

Table 7: Osun State health workers by cadre

Cadre	2010
Doctors	129
Mid-wives	66
Nurses	599
Medical Lab Scientists	45

Medical lab Technologists	4
Scientific officers	6
Pharmacists	28
Pharmacy Technicians	58
Environmental Health officers	45
Community Health Workers	37
Health Record officers	11
Health Record Technicians	26
Health Record Assistants	64
Physiotherapists	13
Dental Technician	13
Dental Technologists	11
Health Attendants	290

Source: Osun SHDP 2015

Other areas of savings include but not limited to mode of drug pricing purchase, Key equipment availability and maintenance in facilities, efficient referral system, strategic health purchasing at PHC level.

4. FISCAL SPACE ANALYSIS IN OSUN STATE

4.1 Population and Coverage Rates

The population of Osun State is estimated at 5.2 million in 2018 at annual growth rate of 3.2% to reach 5.86 million by 2022. Figure 16 provides the breakdown of the population into the individual categories that are relevant to analyzing the resource needs of the Osun state health system. The core priority population groups comprising the informal pregnant women and children under-5 constitute about 13% of the state population and the remaining priority groups, the informal elderly and the indigent population and widows, constitute roughly 39% of the population. Together the broadly defined priority population groups account for 52% of the population. These groups are unlikely to be able to pay for coverage and the state government may have to fund their financial liabilities under the scheme with full subsidy.

The formal sector, comprising civil servants and organized private sector, and their dependents account for only 8% and the non-vulnerable informal sector is estimated to be 40% of the population. These population groups account for a total of 48% of the population.

Figure 14: Osun State Population Categories

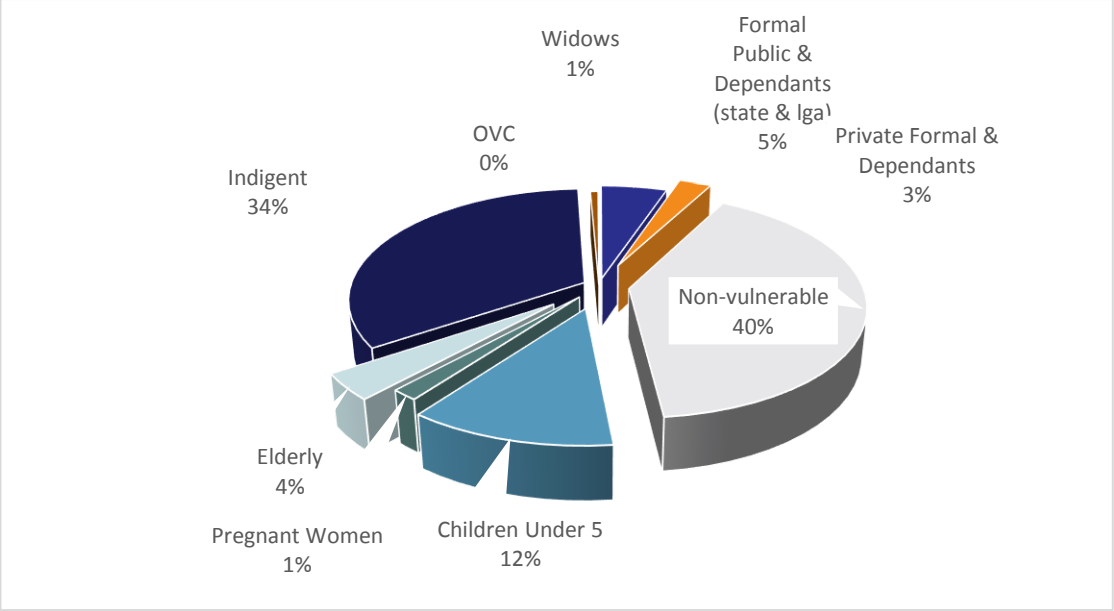


Table 8 shows the possible scenario of coverage scale up where 27% of the state's population is covered by 2022. Coverage of the subgroups of pregnant women and children under 5 is expected to begin at 15% and 10% respectively in 2018 while coverage of the elderly is expected to begin at 5%. The rationale for the rapid scale up for pregnant women to 80% in 2022 is that antenatal care attendance provides a net through which this population can be "captured" at facilities thus facilitating their registration. It is also expected that progress in immunization attendance will facilitate the capture of children under 5 but the habit of skipping immunizations will limit their expected coverage to 70% in 2022. Coverage for widows will be estimated to increase from 70% in 2018 to 95% in 2022. These groups are expected to remain in the program since their premiums will be subsidized. The lower coverage of indigent population starting at 1% in 2018 and reaching mere 15% in 2022 is based on potential challenges of identifying the indigent, which is expected to be based on means-testing. Other than the public sector and their dependents whose coverage is

expected to increase rapidly from 50% in 2018 to 100% by 2022, the remaining segments of the population that will not be subsidized are expected to gain coverage at the lowest rates.

Table 8: Population Coverage Rates

Year	2018	2019	2020	2021	2022
Formal Public	50%	100%	100%	100%	100%
Public dependent	50%	100%	100%	100%	100%
Formal Private	1%	2%	4%	8%	15%
Private dependent	1%	2%	4%	8%	15%
Non-vulnerable	1%	2%	4%	8%	15%
Children Under 5	10%	25%	40%	55%	70%
Pregnant Women	15%	31%	48%	64%	80%
Elderly	5%	10%	15%	20%	25%
Indigent	1%	2%	4%	8%	15%
Widows	70%	80%	90%	95%	95%
OVC	100%	100%	100%	100%	100%
Overall	**5%**	**11%**	**15%**	**20%**	**27%**

4.2 Resources Available to Osun State Health System

Osun State Government is currently in the process of formally establishing the Osun State Contributory Health Care Scheme through Legislation. It is proposed that, following the national directive on state equity funding, the state has proposed to earmark at least 1% of the State's CRF as equity fund toward coverage of the vulnerable population groups which form the priority groups for the scheme. It is expected that additional support from the NHIS in the form of contribution toward coverage of pregnant women and under-5 children will materialize.

Equity Fund: The equity fund is a recurrent source of funding, equivalent of 1% of the State's Consolidated Revenue Fund (CRF). The CRF is the repository of all revenues of the State, including statutory allocations from federal accounts, with exception of revenues earmarked for specific purposes such as capital receipts, grants for specific purposes and dedicated revenues. The size of the equity fund is determined by federal and state revenues and should grow as the federal and state economies grow and revenue mobilization infrastructure improves. The fund is expected to be dedicated primarily to coverage of the vulnerable population groups.

NHIS/Federal Government funding: The Federal Government through NHIS plans to support the state insurance schemes by providing coverage or subsidizing the cost of vulnerable population groups nationwide, including pregnant women, children under 5 years of age and also the elderly and indigents. This support will leverage on the provisions of the Basic Health Care Provision Fund (BHCPF) in the National Health Act (NHA), efficiency savings by the NHIS, and the private sector through innovative financing mechanisms. The funding requirements for coverage of the vulnerable groups are expected to be shared between the federal and state governments, with support from development partners and civil society organizations (CSOs).

Donor Grants: Given the lack of data, it is assumed that donor contributions to the scheme will amount up to 10% of donor funds committed in a year. However, the conservative approach of excluding this unknown from some scenarios is adopted.

4.3 Benefits Package and Premium Level Assumptions

We assumed the NHIS standard health package and actuarial risk premium rates. The annual gross premium for most basic package that excludes testing and screening services is priced at N4,990. The package including both testing and screening services is priced at N7,660 per annum (both prices are inclusive of administrative loading of 7.5%)[24]

4.3.1 Scenario at N7,660

4.3.1.1 Financing Dynamics for Public Employees & Dependents

Using point estimate analysis at full coverage in 2019 under the premium cost of N7,660 per person per year scenario, the total estimated liability (premium cost) is N2.1billion, 9.4% of the total basic salary. There is currently no earmarked funding to pay for coverage of public employees. Instead, funding depends on contributions from both government and employees. Most state-wide actors interviewed suggested a cost sharing ratio of 60:40. This implies that government will pay equivalent of 5.6% of the total basic salary (N1.2billion) while each government employee will contribute 3.7% of their basic salary.

Table 9: Cost and Financing Dynamics for Public Formal & Dependents Needs @ N7,660 Premium

Health Insurance Spending (Millions)	**2,058**
Total Basic Salary (State) per year	21,976
60% share of Employer Contribution (Millions)	1,235
40% share of Employee Contribution (Millions)	823
Equivalvent % of Basic Salary across all levels	9.4%
60% share of Government Contribution (% of Basic salary)	5.6%
40% share of Employee Contribution (% of Basic salary)	3.7%

Based on population estimates and assumed coverage rates (Table 8)[25], the liabilities of OSSG are estimated based on the basic health package (including screening and testing), and estimates are summarized by population groups for each year from 2018 to 2022.

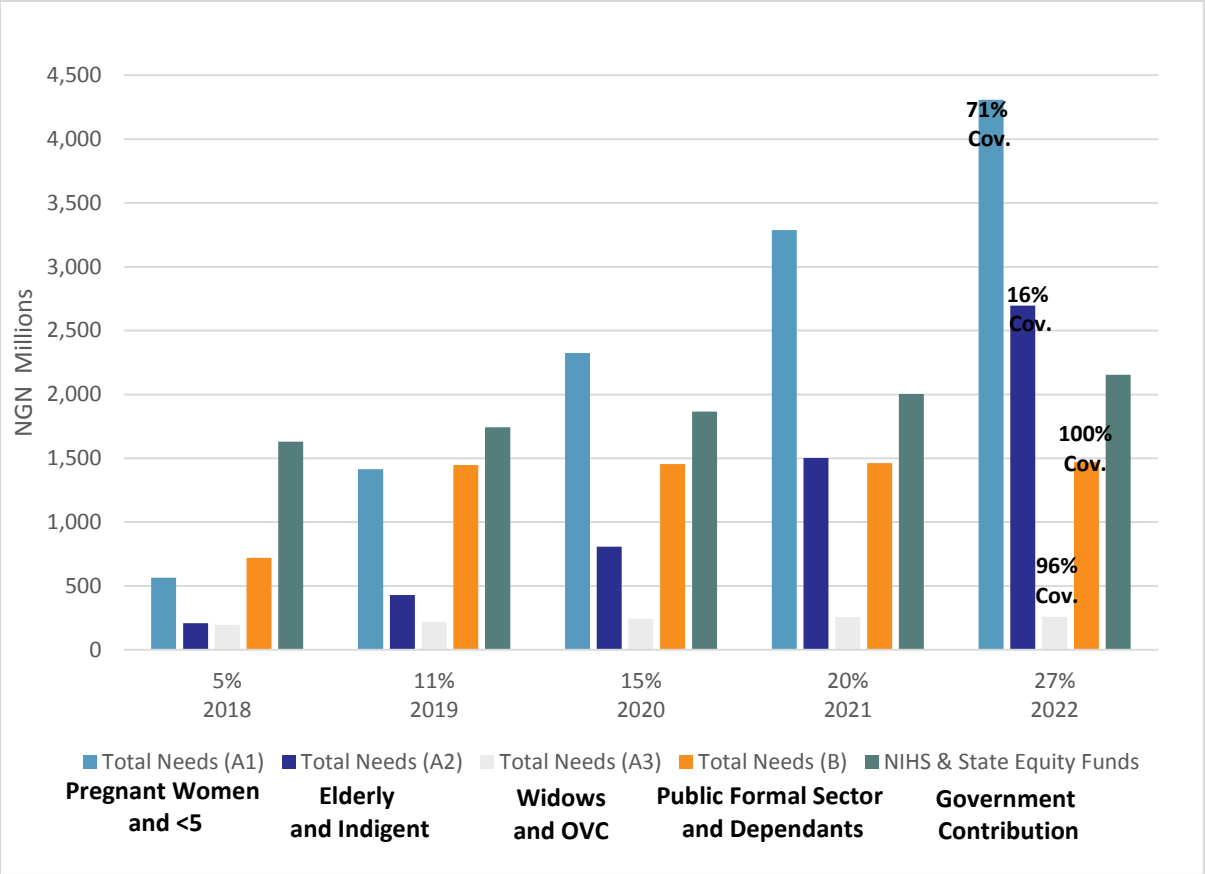
4.3.1.2 Financing Gaps between the available funding and estimated needs

Figure 15 illustrates the funding gap between the financial liabilities of the OSSG in the OSHIS as a result of its commitment to vulnerable groups and public-sector employees in the draft bill and potential resources available to fund it.

[24] The details of the benefit packages and their actuarial pricing is provided in appendix 1.

[25] Based on a basic package that is essentially uniform for everyone insured, fixed for the period of investigation and assumed available at a fixed cost, the growth of insurance costs for each population group and entire insured population is a product of population growth (assumed at 3.25% per annum for the entire population and all component groups) and coverage growth assumed in the estimates (details provided in Table 8).

Figure 15: OSHIS Gap Analysis for premium of N7660/year per person with 1% State CRF as Equity Fund and NHIS Contribution (Millions)



4.3.1.3 Scenario Analysis

The analysis and estimates presented in Table 10 provide the estimated total resources available to the OSSG for the 2018-2022 by revenue source and earmarked target if one exists for the revenue source and estimated total liabilities of the OSSG by population groups for 2018-2022 by coverage targets of 27% of Osun State's population at premium level of ₦7,660. The estimates of the non-vulnerable group including public formal sector are yet to be available due to non-availability of government workforce data.

Table 10 summarizes the needs and revenues for each population group assuming a ₦7,660 per person per year premium with 27% coverage by 2022. Each section on the "Needs" side (left) matches a corresponding "Revenue" side (right). For example, the first section on the left shows the estimated resource needs for covering State Government employees whose premiums would be set at ₦ 7,660 and that the state may choose to subsidize. The corresponding section in the revenue table on the right shows the revenue sources for that population, specifically the currently projected 1% of CRF.

There are some sections on each side that do not have a corresponding section on the other side because either they are needs that can be funded from various sources (not earmarked) or they are revenues that can be used to cover any population or whose use is yet to be determined. Indigent and elderly populations are classified as part of the vulnerable informal groups and are a priority group, but it is not clear that the NHIS makes the same classification, so these populations' premiums may not be covered by the NHIS funding now. However, these population groups have been targets of free medical care in the State. Thus, it is expected that a combination of the NHIS contributions and funds earmarked by OSSG will be applicable to the vulnerable groups.

Table 10: Needs and Sources of Contribution for SSCHS at ₦ 7,660 Premium Scenario

Needs by SSCHS Population Categories	5% 2018	11% 2019	15% 2020	20% 2021	27% 2022		Sources of Contribution/Subsidy for SSCHS (Millions)	2018	2019	2020	2021	2022
Total coverage rate (%)	5%	11%	15%	20%	27%		**NHIS Contribution & State Equity Fund for vulnerable groups**					
Pregnant Women	94	200	320	441	569	← →						
Children Under 5	470	1,214	2,005	2,846	3,740		Equity Fund (1% of CRF)	774	792	809	827	846
Total Needs (A1)	564	1,414	2,325	3,287	4,309	← →						
Elderly	75	154	238	328	424	←	**Sub Total (A)**	774	792	809	827	846
Indigent	133	275	568	1,174	2,272	→	NHIS Contribution from BHCPF (Assuming BHCPF/ 37states) **(B)**	855	950.92	1057.8	1176.7	1309
Total Needs (A2)	208	429	807	1,502	2,695		**Grand Total (X=A+B)**	1,629	1,743	1,867	2,004	2,155
Widows	164	188	211	223	223		**TOTAL REVENUE (X)**	1,629	1,743	1,867	2,004	2,155
OVC	31	32	33	34	35							
Total Needs (A3)	195	220	244	257	258							
Vulnerable group (A1 + A2 + A3)	967	2,063	3,376	5,046	7,263							
Formal Public	172	345	346	348	350							
Public dependent	858	1,724	1,732	1,741	1,750							
Total Needs (B)	1,029	2,069	2,079	2,089	2,100							
Non-vulnerable	160	332	688	1,429	2,779							
Total (C)	160	332	688	1,429	2,779							
Grand Total (A1+A2+B+C)	2,156	4,463	6,143	8,564	12,142							

Sensitivity Analysis

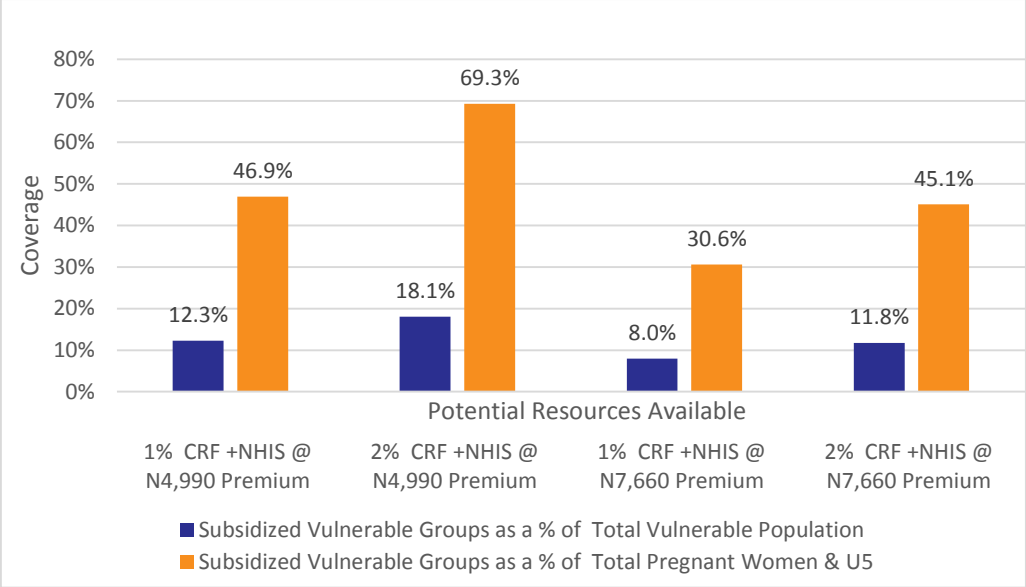
We examine the possibility of Osun state increasing its commitment to equity fund to 2% of CRF and compare resources available with the needs for coverage of the vulnerable population groups.

Table 11: Sensitivity Analysis

Year 2019				
Osun State	1% State CRF Estimates @ N4,990 Premium Cost	2% State CRF Estimates @ N4,990 Premium Cost	1% State CRF Estimates @ N7,660 Premium Cost	2% State CRF Estimates @ N7,660 Premium Cost
State Equity Fund (A)	774,403,849	1,548,807,699	774,403,849	1,548,807,699
Federal BHCPF allocation - NHIS (B)	854,835,016	854,835,016	854,835,016	854,835,016
Total Potential Resources Available for vulnerable population (A+B)	1,629,238,865	2,403,642,715	1,629,238,865	2,403,642,715
Premium Cost Scenarios	4,990	4,990	7,660	7,660
Number of vulnerable population that can be subsidized with potential resources available	326,501	481,692	212,694	313,791
Vulnerable Population Estimates (Children under 5, Pregnant Women, Elderly, Indigent, Widows and OVC)	2,664,548	2,664,548	2,664,548	2,664,548
Children under 5 and Pregnant Women (PwCU5) only	695,440	695,440	695,440	695,440
Subsidized Vulnerable Groups as a % of Total Vulnerable Population	12.3%	18.1%	8.0%	11.8%
Subsidized PwCU5 as a % of Total Pregnant Women & U5	46.9%	69.3%	30.6%	45.1%
Total State Population	5,153,555	5,153,555	5,153,555	5,153,555
Subsidized Vulnerable Groups as a % of Total Population	6.34%	9.35%	4.13%	6.09%
Vulnerable Population as a share of the Total Population	51.70%	51.70%	51.70%	51.70%

In terms of coverage, an increased contribution to the Equity fund of 2% of CRF will raise the coverage of the core priority groups (informal pregnant women and children under 5) from 46.9% to 69.3% in the scenario with premium of N4,990 per annum. Similarly, the coverage is extended from 30.6% to 45.1% in the scenario with premium of N7,660 (Figure 16). Inclusion of more categories of the vulnerable population group (the elderly and the indigent) will reduce these coverage rates significantly as shown in figure 16.

Figure 16: Sensitivity Analysis for subsidizing vulnerable population (%) 2019



4.4 Fiscal Analysis of Osun Health System Solvency Condition

Table 11 examines the solvency of the scheme under the two equity fund scenarios. It shows that earmarking of 2% of CRF cuts the deficits substantially and raises the duration of solvency the scheme until 2021 when cumulative deficit begins to appear, compared to the scenario of 1% CRF in which the fund could cover its current liabilities for only 2018 runs into cumulative deficit in 2021. However, the net effect of increasing CRF contributions from 1% to 2% does not appear to make drastic changes in the deficit profile. Thus, more resources are needed to guarantee solvency of the scheme into the medium-to-long term.

Table 12: Cost and financing dynamics for vulnerable population needs@ N7660 premium (Millions)

Year 2019	**2019**	**2020**	**2021**	**2022**	**2023**
Scenario 1: Vulnerable Populations - 1% State CRF + NHIS @ N7,660 Premium per annum					
Potential Resources Available	1,629	1,743	1,867	2,004	2,155
Vulnerable Population Resource Needs	967	2,063	3,376	5,046	7,263
Gap	**662**	**-320**	**-1,509**	**-3,042**	**-5,108**
Cumulative Funding Gap		**342**	**-1,167**	**-4,208**	**-9,316**
Scenario 2: Vulnerable Populations - 2% State CRF + NHIS @ N7,660 Premium per annum					
Potential Resources Available	2,404	2,534	2,676	2,831	3,001
Vulnerable Population Resource Needs	967	2,063	3,376	5,046	7,263
Gap	**1,437**	**472**	**-699**	**-2,214**	**-4,262**
Cumulative Funding Gap		**1,908**	**1,209**	**-1,005**	**-5,267**
Scenario 3: Pregnant women and Children U5 - 1% State CRF + NHIS @ N7,660 Premium per annum					
Potential Resources Available	1,629	1,743	1,867	2,004	2,155
Pregnant women and children U5 Resource Needs	564	1,414	2,325	3,287	4,309
Gap	**1,065**	**329**	**-458**	**-1,283**	**-2,154**
Cumulative Funding Gap		**1,394**	**936**	**-347**	**-2,501**

Scenario 4: Pregnant women and children U5 - 2% State CRF + NHIS @ N7,660 Premium per annum					
Potential Resources Available	2,404	2,534	2,676	2,831	3,001
Pregnant women and children U5 Resource Needs	564	1,414	2,325	3,287	4,309
Gap	**1,840**	**1,120**	**351**	**-455**	**-1,308**
Cumulative Funding Gap		**2,960**	**3,312**	**2,856**	**1,548**

The solvency challenges will be magnified under more expensive packages and higher-than-anticipated population coverages (See Annex). Efforts to further increase coverage rate beyond approximately 10% of the vulnerable group with 1% CRF will demand additional budgetary allocation.

5. CONCLUSION

The state is fiscally constrained in terms of ability to increase health expenditure owing to weakening capacity to generate IGR. Increased dependence on FAAC allocations and loans to fund its obligations (budget) will imperil sustainable financing of its liabilities for the health sector due to the volatility of earnings from the market for crude oil which is the principal source of federal revenues and debt service charges that usually deflates the FAAC allocation. While it is hard to expect potential increase in fiscal space for health sector through the ordinary and general budgetary processes, we have explored the potentials of extraordinary mechanisms such as those based on CRF.

The vulnerable population groups, which are the primary focus of OSSG's commitment to the OSHIS, represent more than 50% of the state population. Although the analysis shows that commitment of 2% of State CRF to the Equity fund will allow the scheme take off and remain solvent for the first three years under the low premium scenario while limiting OSGs liabilities to the core priority groups (pregnant women and children under 5), any increase in the premium level when the actuarial costing is completed, expansion of the priority population groups or increase in the population coverage levels beyond the projections assumed in this analysis will enlarge the liabilities and lead to insolvency of the scheme almost at take-off.

The State appears to be currently devoting more resources on the infrastructural development such as road construction and education sector - for instance provision and distribution of 'opon-imo' (tablet of knowledge) to 150,000 students in secondary schools and the school feeding program in all primary schools.[26] The health budget witnessed a decline from N11.8 billion in 2015 to N7.9 billion in 2016.

In light of this development and the challenges of funding, there is a critical need to address the weakening capacity for IGR to sustain the state recurrent expenditure which currently cannot be absolved by the state collectible revenue. The limited and unpredictable fiscal space which reflects increased reliance on borrowing is not likely to engender sustainable fiscal policies and economic growth in Osun State including earmarked funds and budget allocations to the health sector.

OSSG needs to court donors for support to identify and activate innovative ways of increasing IGR of the state. There is need for increased engagement and advocacy on the part of OSMoH with development partners to achieve sustainable financing of proposed health insurance scheme and direct programmatic support. Sustained efforts in this direction would gradually widen the fiscal space for health sector.

[26] http://osun.gov.ng/achievements/150000-e-learning-tablets-opon-imo-tablet -of-knowledge-provided-for-senior-secondary-schools/

6. ACTIONABLE RECOMMENDATIONS

Despite limitations, the state has some option for increasing fiscal space to allow for sustainable health financing in Osun State. The colored boxes below reflect the potential of generating additional fiscal space within the five-dimensional frameworks employed in this study. Green connotes high potential while Yellow and Red represent medium and low potential respectively.

Raising IGR: The state should aggressively pursue an internal revenue generation drive by following the guidelines listed below

- Increasing IGR from less than a billion monthly to the targeted N5 billion every month as estimated in a recent study conducted in Osun State. This will support expansion of coverage of the vulnerable population groups and sustain other government initiatives. OSSG needs to institute measures to strengthen revenue collection and create a conducive atmosphere for private sector in order to both widen and diversify its earning base
- All sources of revenue leakage should be eliminated
- Taxpayers should be given adequate enlightenment and education
- Investors in Osun State should be supported as this will increase the internally generated revenue of the state
- Up to date report should be generated showing revenue distribution by revenue types and revenue agency

Earmarking of funds: The State should pass a health bill into law with the following provisions:

- At least 2% of State CRF to be itemized for funding coverage of the vulnerable groups with the expectation that the actual amount will not be constrained by debt service deductions.
- Employer and employee cost-sharing of salary contributions toward purchase of coverage for the public-sector employees.
- Consider LGAs creating an equity fund equivalent to at least 1% of LG CRF

External Funding: OSG should creatively court donor funds by proactive engagement of bilateral and multilateral donors for assistance.

- Strengthening donor coordinating platforms
- Recommend a specific proportion of donor funds to be applied toward the health insurance fund

Reprioritization of Health: The state needs to place the heath sector and its funding as top priorities in its finance and planning activities in addition to pursuing efficiency gains. OSG should consider 15% budget allocation to health which will increase the fiscal room of the health sector. The OSMoH would need to actively engage on this.

Leverage fiscal space: As stated in the SHDP 2010 - 2015, the state government desires to strengthen its relationship with donor partners in its drive to reform the health system. Donor partners can leverage this commitment and stimulate action on the part of the government using a counterpart funding approach. Given funding prospects that are fungible and identified donors can request counterpart funding for their proposed intervention from the state government.

We suggest that that 30% of the additional funded identified by this analysis are available for counterpart funding. This figure is somewhat arbitrary, but we recognize that additional resources will still need to be allocated to addressing issues such as the sub-optimal availability of human resources that remain a priority and responsibility of the state government. The potential

counterpart funding available from the fungible additional fiscal space (based on the recommended 30%) is presented below:

Table 13: Available counterpart funding from fungible fiscal space

Scenario	Potential Additional Funds	Recommended counter-part fund (20% - 30%)
15% Health Expenditure Allocation Rate	NGN7.75billion	NGN2.33billion

Additional reviews: The planning activities should include an empirical update as more information becomes available on the parameters of the evaluations.

ANNEX A

SERVICE PACKAGE			
Beneficiaries	1: Testing and Screening	2: Testing, No Screening	3: No Testing, No Screening
All Nigerians	Wellness checks and facility-based health promotion: Preventive health services Healthy lifestyles education Health promotion and education for primary school children Health promotion for mental health Health promotion for dental health Health promotion for primary eye care Health promotion for primary diabetic care Health promotion for primary hypertensive care SCD Counselling HIV Counselling Family planning education, counseling and services Treatment of uncomplicated malaria Treatment of uncomplicated diabetes Treatment of uncomplicated hypertension Management of uncomplicated UTI, STI Management of uncomplicated pneumonia Referral services Blood tests (promotive, preventive and curative): RDT for malaria Nutrition test Diabetic screening Sickle cell test Cancer screening (breast, prostate and cervical) VDRL	Wellness checks and facility-based health promotion: Preventive health services Healthy lifestyles education Health promotion and education for primary school children Health promotion for mental health Health promotion for dental health Health promotion for primary eye care Health promotion for primary diabetic care Health promotion for primary hypertensive care SCD Counselling HIV Counselling Family planning education, counseling and services Treatment of uncomplicated malaria Treatment of uncomplicated diabetes Treatment of uncomplicated hypertension Management of uncomplicated UTI, STI Management of uncomplicated pneumonia Referral services Blood tests (promotive, preventive and curative): RDT for malaria Nutrition test Sickle cell test RBS Urinalysis Hb/PCV VDRL	Wellness checks and facility-based health promotion: Preventive health services Healthy lifestyles education Health promotion and education for primary school children Health promotion for mental health Health promotion for dental health Health promotion for primary eye care Health promotion for primary diabetic care Health promotion for primary hypertensive care SCD Counselling HIV Counselling Family planning education, counseling and services Treatment of uncomplicated malaria Treatment of uncomplicated diabetes Treatment of uncomplicated hypertension Management of uncomplicated UTI, STI Management of uncomplicated pneumonia Referral services

	HIV screening RBS Urinalysis Hb/PCV		
Children 0-5 years	Newborn Care Resuscitation Cord care with CHX Management of diarrhea diseases including LO-ORS and zinc tablets Treatment for uncomplicated Pneumonia with Amoxicillin Dispersible Tablets Otitis media Conjunctivitis Routine immunizations Management of vaccine preventable diseases Helminthiasis Management of common skin infestations (scabies, fungi, etc.) Sickle cell disease diagnosis, emergency care and referral Minor surgical procedures (male circumcision, burns, I&D, suturing of simple lacerations) Febrile convulsions Growth monitoring and promotion* Management of mild malnutrition Laboratory services Stool and urine microscopy	Newborn Care Resuscitation Cord care with CHX Management of diarrhea diseases including LO-ORS and zinc tablets Treatment for uncomplicated Pneumonia with Amoxicillin Dispersible Tablets Otitis media Conjunctivitis Routine immunizations Management of vaccine preventable diseases Helminthiasis Management of common skin infestations (scabies, fungi, etc.) Sickle cell disease diagnosis, emergency care and referral Minor surgical procedures (male circumcision, burns, I&D, suturing of simple lacerations) Febrile convulsions Growth monitoring and promotion* Management of mild malnutrition Laboratory services Stool and urine microscopy	Newborn Care Resuscitation Cord care with CHX Management of diarrhea diseases including LO-ORS and zinc tablets Treatment for uncomplicated Pneumonia with Amoxicillin Dispersible Tablets Otitis media Conjunctivitis Routine immunizations Management of vaccine preventable diseases Helminthiasis Management of common skin infestations (scabies, fungi, etc.) Sickle cell disease diagnosis, emergency care and referral Minor surgical procedures (male circumcision, burns, I&D, suturing of simple lacerations) Febrile convulsions Growth monitoring and promotion* Management of mild malnutrition

WCBA	ANC visits Routine drugs Facility delivery for low risk & uncomplicated pregnancies (2, 3, 4) PN services Post abortion care Initial management of APH Initial management of PPH ANC investigation blood group determination Early Infant Diagnosis (EID) of HIV	ANC visits Routine drugs Facility delivery for low risk & uncomplicated pregnancies (2, 3, 4) PN services Post abortion care Initial management of APH Initial management of PPH ANC investigation blood group determination	ANC visits Routine drugs Facility delivery for low risk & uncomplicated pregnancies (2, 3, 4) PN services Post abortion care Initial management of APH Initial management of PPH
Elderly	Musculoskeletal disorders e.g. arthritis, arthralgias, neuralgias	Musculoskeletal disorders e.g. arthritis, arthralgias, neuralgias	Musculoskeletal disorders e.g. arthritis, arthralgias, neuralgias

ACTUARIAL PRICING

Risk Premium	N7,123.42	N5,362.70	N4,642.42
Admin Loading	7.5%	7.5%	7.5%
Annual Gross Premium	N7,657.68	N5,764.90	N4,990.60

BOLD THINKERS DRIVING
REAL-WORLD IMPACT