



USAID
FROM THE AMERICAN PEOPLE



KEBBI STATE FISCAL SPACE ANALYSIS FOR HEALTH SECTOR



July 2018

This publication was produced for review by the United States Agency for International Development.
It was prepared by the Health Finance and Governance Project.

The Health Finance and Governance Project

USAID's Health Finance and Governance (HFG) project helps to improve health in developing countries by expanding people's access to health care. Led by Abt Associates, the project team works with partner countries to increase their domestic resources for health, manage those precious resources more effectively, and make wise purchasing decisions. The five-year, \$209 million global project is intended to increase the use of both primary and priority health services, including HIV/AIDS, tuberculosis, malaria, and reproductive health services. Designed to fundamentally strengthen health systems, HFG supports countries as they navigate the economic transitions needed to achieve universal health care.

DATE 2013

Cooperative Agreement No: AID-OAA-A-12-00080

Submitted to: Scott Stewart, AOR
Office of Health Systems
Bureau for Global Health

Recommended Citation: The Health Finance and Governance Project. July 2018. *Kebbi State Fiscal Space Analysis For Health*. Rockville, MD: Health Finance & Governance Project, Abt Associates Inc..



Abt Associates Inc. | 4550 Montgomery Avenue, Suite 800 North | Bethesda, Maryland 20814
T: 301.347.5000 | F: 301.652.3916 | www.abtassociates.com

Avenir Health | Broad Branch Associates | Development Alternatives Inc. (DAI) |
| Johns Hopkins Bloomberg School of Public Health (JHSPH) | Results for Development Institute (R4D)
| RTI International | Training Resources Group, Inc. (TRG)



KEBBI STATE FISCAL SPACE ANALYSIS FOR HEALTH

DISCLAIMER

The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development (USAID) or the United States Government.

CONTENTS

Contents	i
Acronyms	iii
Acknowledgments	v
Executive Summary	vii
1. Introduction	1
1.1 Background	1
1.2 Concept of Fiscal Space for Health	2
1.3 Kebbi State Economy and Health System	3
1.4 Kebbi: Health, Nutrition and Population Status	3
2. Methodology	5
2.1 Stakeholders Meeting	5
2.2 Data Collection	5
2.3 Data Analysis	5
2.4 Scenario Development for KBSCHS Financial Modelling	6
3. Need for Increasing Fiscal Space	8
4. Options for Increasing Fiscal Space	10
4.1 Macfiscal Conditions	10
4.2 Reprioritizing Health	13
4.3 Earmarking of Funds	17
4.4 Mobilizing External Resources	18
4.5 Efficiency Gains	18
5. Fiscal Space Analysis for KBSCHS	21
5.1 Population and Coverage Rates	21
5.2 Resources Available to KBSCHS	22
5.3 Benefits Package and Premium Level Assumptions	23
5.4 Scenario at ₦ 7,660	23
5.5 Fiscal Analysis of KBSCHS Solvency Condition	28
6. Policy Discussion	31
7. Recommendations	32
7.1 Raising IGR	32
7.2 Reprioritization of Health	32
7.3 Earmarking of funds	33
7.4 External Funding	33
7.5 Efficiency Gains	33



List of Tables

Table 1: Kebbi Health Status.....	4
Table 3: Assessment of Fiscal Space available to Kebbi State.....	6
Table 4: Summary costs by HSS categories of Kebbi SHDP II 2017-2021 Essential Package Moderate Scale-up Scenario, (N'Million)	9
Table 5: Summary costs by Programme area of Kebbi SHDP II 2017-2021 Essential Package Moderate Scale-up Scenario, (N'Million)	9
Table 5: Kebbi State Fiscal Profile 2011 - 2017	10
Table 6: Kebbi State Health Sector Prioritization 2011 - 2016.....	13
Table 8: Reprioritization of Health Sector according to Abuja Declaration	14
Table 9: Earmarking through CRF Sources of Contribution/Subsidy for KBCHS	17
Table 10: Population Coverage Rates	22
Table 11: Need by KBCHS Population Categories (Premium at ₦ 7,660)	23
Table 12: Needs and Sources of Contribution for KBCHS at N 7,660 Premium Scenario	25
Table 13: Financing Dynamics for Public Formal & Dependents	26
Table 14: Sensitivity Analysis for Year 2019 at Different Premium Cost Scenarios	27
Table 15: Funding Gap Analysis at 1% and 2% State CRF and ₦ 7,660 Premium.....	29

List of Figures

Figure 1: Trend of Revenue Mix.....	11
Figure 2: Trend of Expenditure Mix.....	11
Figure 3: Sustainability Analysis of Solvency Ratio.....	12
Figure 4: Abuja Declaration Benchmarks	14
Figure 5: Health Budget Performance	15
Figure 6: Health Budget and Expenditure per capita	15
Figure 7: Kebbi State Health Budget Allocation	16
Figure 8: Kebbi State Health Actual Expenditure	16
Figure 9: Raising Percentage from CRF.....	18
Figure 10: Health Budget Expenditure Performance	19
Figure 11: Kebbi State Population Categories.....	21
Figure 12: Gap Analysis @ ₦ 7,660/yr. with 1% CRF & NHIS Contribution (Millions)...	26
Figure 13: Sensitivity Analysis for Subsidizing Vulnerable Population 2019	27

ACRONYMS

BHCPF	Basic Health Care Provision Fund
CHECOD	Centre for Health Economics and Development
FAAC	Federation Account Allocation Committee
DHS	Demographic and Health Studies
FSA	Fiscal Space Analysis
HFG	Health Financing and Governance
HSS	Health Systems Support
IGR	Internally Generated Revenue
KBCHS	Kebbi State Contributory Health Scheme
KBSG	Kebbi State Government
KBHIS	Kebbi State health Insurance Scheme
KBHS	Kebbi State Health System
KBMOH	Kebbi State Ministry of Health
LGAs	Local Government Areas
LMIC	Lower-Middle Income Country
MDAs	Ministries/Departments/Agencies
MDGs	Millennium Development Goals
MICS	Multiple Indicator Cluster Study
MoH	Ministry of Health
OOP	Out-of-Pocket
NCDs	Non-Communicable Diseases
NHA	National Health Act
NHIS	National Health Insurance Scheme
PHC	Primary Health Care
SDGs	Sustainable Development Goals
SGDP	State Gross Domestic Product
SGHE	State Government Health Expenditure
UHC	Universal Health Coverage
USAID	United States Agency for International Development

VAT

Value Added Tax

WHO

World Health Organization

ACKNOWLEDGMENTS

This study was made possible through funding from USAID Health Finance and Governance (HFG) Project in support of Kebbi State Ministry of Health on Fiscal Space Analysis for Health Sector. The authors are grateful to Dr. Gafar Alawode, Sylvester Akande and Frances Illika of HFG Projects for their guidance on the focus of the study. We thank Alhaji Umar Kambaza, the Commissioner for Health and his team for their input and encouragement during the study.

We equally recognize the efforts and enthusiasm of all the public officials of ministries, departments and agencies interviewed at state and local government levels in providing useful information and data collection. These include but not limited to:

1. Director Health Planning, Research and Statistics
2. Deputy Director and Health Financing Desk Officer
3. Abubakar Ahmed Jega – Deputy Director Planning, Ministry of Budget and Economic Planning
4. Director, Main Account, Ministry of Finance
5. Alhaji Umar Ahmed - Director PHC Ministry of Local Government
6. Chairman, Kebbi State Internal Revenue Service
7. Alhaji Kangiwa - Director Social Security Welfare Fund

The contributions of Centre for Health Economics and Development (CHECOD) Staff are well appreciated. Quality assurance was carried out by Dr Elaine Baruwa and Xi Cheng of Abt Associates. Inc.

Regardless of the assistance received and acknowledged above, the opinions expressed in this report do not necessarily represent the views of any of the institutions and individuals mentioned but are entirely the responsibility of the authors.



EXECUTIVE SUMMARY

Achieving adequate access to health care through universal health coverage concepts had remained a predominant goal in regional settings and within countries. Hence, development partners are putting efforts in place to support state governments in Nigeria to further strengthen their health system and financing. This study presents an assessment of the fiscal space available to Kebbi State health sector. The analysis will provide decision-makers with options for informed choices. The findings will help to inform the target setting, advocacy and planning needs of the Kebbi State Ministry of Health (KBSMoH) as well as Kebbi State Health Contributory Scheme. In addition, an assessment of the fiscal capacity of Kebbi State government to implement and ensure the sustainability of health contributory scheme was conducted.

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 Kebbi state engages in the implementation of its new strategic health development plan (SHDP), fiscal space analysis was recommended to explore ways to increase resources for the sector, even in a constrained macro-fiscal condition.

Need for Increasing Fiscal Space

Kebbi State has recently developed a Kebbi State Strategic Health Development Plan (SHDP) II in line with national framework. The framework established common approach for planning and implementation time frame for health sector needs over a period of five years. In the recent stakeholder's validation conducted by KBSMoH, the moderate scale up scenario of SHDP II was adopted with a total cost of N155 billion in 5 years, average of N31 billion per year. About 38% of this amount is expected to fund medicines, commodities and supplies while 30% will be used to fund human resources for health. However, actual government health expenditure in 2017 was N6.5 billion leaving a potential gap of N25 billion on the cost of SHDP II - about 400% of the actual expenditure. Hence, mobilizing resources to fund this strategic plan cannot be overstretched.

Options for Increasing Fiscal Space

Macro-fiscal conditions are main determinants of budgetary allocations to any sector. In Kebbi State, the statutory allocations from FAAC steadily decreased, from 33 billion in 2011 to 21 billion in 2016 due to fall in international oil price. Data from 2017 and 2018 FAAC allocations have shown progressive and favourable macro-fiscal conditions due to the steady increase in international oil price. This increase in statutory revenue has a potential to yield additional N17.6 billion to the state fiscal room by the end of 2018. Meanwhile, the state IGR decreased substantially by 50% from N6.4 billion in 2011 to N3.1 billion in 2016. Kebbi state credit profile started rising in 2014 as result of declining revenue and several loans obtained by the state government such as Budget Support Facility Loans, Commercial Agric Loans, Excess Crude Account (ECA) loans payable in 20 years and some bailout funds obtained from Federal Government. There was a twist in 2017 as IGR grew by 40% growth and it is expected that it will increase by 20% in 2018. Increasing IGR with this rate will potentially accrue about N880 million by the end of 2018. This implies that not less than additional N180 million naira to the health contributory

equity fund and about N1.3 billion naira¹ to the health sector allocation given an ideal situation where increase in government revenue translate to increase in health spending.

Reprioritizing Health: An examination of budget allocations to the various sectors in Kebbi state shows that the relative share of the health sector fell from 8.7% in 2012 to 7.1% in 2015 but rose to 9.0% in 2016 before returning back to 7% in 2017, it reached an average of 7.9 percent of government spending within this period which fell short of the Abuja declaration benchmarks of 15 percent. If the state meets up with Abuja Declaration benchmarks, an average of N4.47 billion per year would have accrued to the health sector. Furthermore, health expenditure per capita decreased as population increased within the same period averaging N1291 (US\$6.8). As historical data shows that in difficult economic times, lower priority is given to the health sector, limited opportunities to improve prioritization of the health sector exist.

Earmarked funds: Earmarking 1% CRF will provide additional N481 million in 2019 while raising it to 2% will generate additional N962 million funding for the health sector. A component of earmarked funds is the basic healthcare provision fund (BHCPF) from federal government as stipulated in the National Health Act – 1% from Federal Government CRF estimated at N54.02 billion in 2018. The expected funds from BHCPF to each state, if distributed equally among states, is N1.46 billion. In addition, exploring 1% of LG revenue fund, which has a potential of generating up to N450 million per year to the equity fund should also be considered.

External Grants/Donors Contributions: Another way to generate fiscal space for health is for governments to utilize external resources in the form of foreign aid and grants from international donors. The predictability, flexibility and composition of the assistance are equally important. A highly unpredictable inflow of foreign aid renders long-term planning a challenge. Data limitations preclude analysis of resources from the external grants in this study due to the ineffective planning, budgeting and reporting systems for donor-funded programs and interventions. However, World Bank Supported Save one million lives project up to a tune of 540 million naira is additional resources to health sector in the state. Kebbi state should actively court donors and external partners, as well as include such potential sources of income in their budgeting process through effective donor coordination mechanism.

Efficiency Gains: KBSG could save money by demonstrating commitment towards ensuring increased budget performance for capital expenditure relative to recurrent expenditures. Intra-sectorial analysis of the state's health budget into its recurrent and capital components shows that budget performance was 94% for recurrent expenditure and 53% for capital spending in 2012. The performance on recurrent component reduced significantly up from 2012 to 2016 where budget performance was 74% and 8% for recurrent and capital expenditures respectively. The reduction in capital expenditure is not only worrisome but it can hardly meet the investments for high impact health interventions required for its systems development. Other analysis of efficiency gains is highly demanding in terms of operational and financial data but limited within this scope of work.

Fiscal Space Analysis for KBSHIS

The population of Kebbi State is estimated at 4.9 million in 2019 based on an annual growth rate of 3.25% and will reach 5.6 million by 2023. The core priority (vulnerable) groups comprising the informal pregnant women and children under-5, and the informal elderly and indigent, account for 72% 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 account for just 4% and the non-vulnerable informal sector is estimated to be 16% of the population, at total of 28%.

The total estimated liability (premium cost) for state government workers only is N951 million, about 8.4% of the total basic salary. There is currently no earmarked funding to pay for coverage of public employees. Employers and employees for both public and organized private sector are expected to contribute salary deductions or its equivalence to receive coverage under the basic package adopted by KBSHCS. The feasibility of KBSG increasing

¹ Using current share of health expenditure to total government expenditure

its commitment to equity fund from proposed 1% to 2% of CRF was examined. An increase of Equity fund to 2% of CRF will raise the coverage of the core priority groups - pregnant women and children under 5 populations - from 13% to 16% in the scenario with premium of N7,660 and reduces the deficits in 2020. In the scenario for total vulnerable populations, earmarking of 2% of Consolidated Revenue Fund (CRF) increases the coverage from 4% to 5% cuts the deficits substantially and raises the duration of solvency the scheme until the year 2020.

Overall, prospects for increasing fiscal space are limited in the short term. Earmarking of 1% CRF, external grants 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 which currently cannot be absolved by the state collectible revenue. There is need for increased engagement and advocacy on the part of KBStMoH with development partners to achieve sustainable financing of proposed health contributory scheme. Sustained efforts in this direction would gradually widen the fiscal space for health sector.

Recommendations

Raising IGR

- The state should aggressively pursue an internal revenue generation drive by implementing the proposals of the revenue generating MDAs currently at State Ministry of Justice. The proposed initiatives have potential to double the current IGR which is estimated at N4.3 billion in 2017.
- Increasing IGR to the proposed target of N10 billion will support expansion of coverage of the vulnerable population groups and sustain other government initiatives. It further has positive fiscal implication for KBStCHS by providing health coverage for additional 10,000 vulnerable individuals.
- Kebbi state needs to focus on expanding the tax base to include nonpayers such as Lake Rice Investments, farmers (Rice, Onions, Guinea corn, etc) and import duties from fabric as well as increasing the very low contribution rates from existing corporations.
- KBStG 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.
- The State's Internal Revenue Service needs to embark on aggressive posture in mobilizing revenue in the state.
- All sources of revenue leakage should be eliminated by employing technology in tax collection, generation of receipts, etc
- Taxpayers should be given adequate enlightenment and education. Kebbi State IRS requested the Governor to lead the awareness creation.
- Investors in Kebbi State should be supported as this will increase the internally generated revenue of the state as well as ensuring compliance to tax payment including the existing Lake Rice Investment.
- Up to date report should be generated showing revenue distribution by revenue types and revenue agency.

Reprioritization of Health

- The state needs to place the health sector and its funding as top priorities in its finance and planning activities in addition to pursuing efficiency gains.
- Ministry of Health and its MDAs need to sensitize and educate program officers to explore and utilize approved budget allocations. Low budget performance is one of the metrics by Ministry of Budget and Economic Planning for reducing budget allocations in the state including health sector. There were instances where health sector budget was reduced as a result of low performance.
- KBStG should consider 15% budget allocation and at least 15% expenditure share to health out of total government expenditure which will increase the fiscal room of the health sector.
- Budgeting for health should be sensitive to population growth as it will help to alleviate the widening of existing gaps.

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.
- Create a budget line for the provisions of Government contribution to KBSCHS on behalf of the public-sector employees.
- Consider LGAs creating an equity fund equivalent to at least 1% of LG CRF
- Consider a percentage of funds for disabled and other vulnerable, assuming 20%, that accrue to Kebbi State Social Security Welfare Fund and Zakat Committee.

External Funding

- KBSG should creatively coordinate donor funds by proactive engagement of bilateral and multilateral donors for assistance
- KBSG needs to strengthen Development Partners Forum under the chairmanship of Deputy Governor as well as revive and strengthening the Steering Committee on Counterpart Fund under the chairmanship of Commissioner of Finance. Recommend a specific proportion of Donor funds to be applied toward the health contributory fund.

Efficiency Gains

- Demonstrating commitment towards ensuring increased budget performance for capital expenditure relative to recurrent expenditures
- Addressing health worker absenteeism
- Ensuring that most Kebbi State health sector financing is allocated to highest causes of deaths
- Delivering more services at the primary care and implementing a sound referral system.



I. INTRODUCTION

I.1 Background

Sustainable Development Goals (SDGs) adopted by the United Nations General Assembly in 2015 under the Goal 3 seeks to “Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.”² Policies targeted at UHC, from wider health systems approaches to specialized programs and interventions, must be assessed in terms of their effect on equity of access, which requires that their design and management specifically facilitate and enable access across the social gradient, particularly by vulnerable groups.

One of the basic objectives of UHC is how to ensure that all have equitable access to their health care needs without having to make significant Out-of-Pocket (OOP) at the centre of care.³ An important means to achieving this is spreading financial risk via tax-funded or social health insurance (SHI)⁴. Achieving adequate access to health care through universal SHI coverage had remained a predominant goal in regional settings and within countries because of its measurable improvements in health and productivity as well as its potential to bring life-saving health care to those who need it most. SHI is aimed at providing easy access to healthcare for all Nigerians at an affordable cost through various prepayment systems and thus significantly reduce the out-of-pocket health care expenditure of households, especially the poorest.

The World Health Organization states that 'the main aim of health financing is to make funding available, and also to set the right financial incentives for providers, to ensure that all individuals have access to effective public health and personal health care'.⁵ In this regard, health financing in Kebbi State remains a key priority area and its effectiveness must be achieved. In order to fully understand and improve financing of health services in the state in line with UHC, the Health Financing and Governance (HFG) Project of the United States Agency for International Development (USAID) in collaboration with Centre for Health Economics and Development (CHECOD) were asked to conduct a fiscal space analysis (FSA). This is to assess the capability of government to provide further budgetary resources for a desired purpose without any partiality to the sustainability of its financial position. The intention is to identify the level of additional financial resources that can be assumed to be available for the health systems in the short and medium term in a way that is consistent with Kebbi State macroeconomic fundamentals such that there is no adverse effect on long-term solvency of the government and its economic potential. This analysis will provide decision-makers with options for informed choices while the actuarial analyses are being conducted. The purpose is not to define a single pathway but rather to provide evidence that can support the discussion of the financial, political and implementation feasibility of the different possible pathways leading to evidence decision making on the approach that state will take to scaling up coverage through the scheme.

The analysis focused on four sets of policy questions that the three sections of this paper will give a report on.

² <http://www.who.int/sdg/targets/en/> accessed 6th May 2018

³ World Health Organization. World Health Report 2010, Health Systems Financing - The Path to Universal Coverage. Geneva: World Health Organization; 2010.

⁴ Kutzin J. Myths, instruments, and objectives in health financing and insurance. In Extending social protection in health: Developing countries' experiences, lessons learnt and recommendations. Eschborn, Germany: Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ); 2007. p. 87-95

⁵ World Health Organization (WHO) The World health report, 2000. Health systems: improving performance. Geneva: WHO; 2000.

- What is the current fiscal space available for health now?
- What is the current fiscal space available for the Kebbi State Contributory Health Scheme (KBCHS) now?
- How is that fiscal space going to change over time?
- What financial resources are required to cover the population groups that need full/partial government subsidy?

This paper is organized into three sections: Section 1 provides background on the concept of fiscal space analysis as well as Kebbi state's economic, administrative and health-system context. Section 2 assesses the various options available for the state for increasing fiscal space in the context of Kebbi state. In section 3, we look at illustrative scenarios and seek to address the question How much is the fiscal space? An additional section draws conclusions and recommendations.

1.2 Concept of Fiscal Space for Health

The notion of fiscal space for health has gained increased prominence in policy discussions at local and global levels, where it is recognised as a crucial issue that all countries must take into consideration as they seek to make progress toward achieving universal health coverage (UHC). The subject has become prominent for many low- and middle-income countries (LMICs) such as Nigeria, as they try to expand fiscal space for the sector to meet health coverage goals in the context of structural revenue and financing constraints⁶.

Initially, defined by Heller in 2005⁷, “fiscal space is the budgetary room allowing a government to provide resources for public purposes without impacting fiscal sustainability or threatening government solvency given existing fiscal conditions and long-term requirements”⁸. Building on Heller's (2006) theoretical framework⁹, Tandon and Cashin expounded on five pillars that could be explored to generate fiscal space for health namely:¹⁰

- i. Conducive macroeconomic conditions,
- ii. Reprioritization of health within the government budget
- iii. Earmarking of funds i.e. an increase in health sector-specific resources
- iv. Health sector specific grants and foreign aid, and
- v. Increased efficiency of existing health expenditure.

The first three options (possibly including earmarking of funds) usually lie outside of the domain of the health sector and are linked to general macroeconomic and political conditions, and trade-offs between various sectors. However, it is important to investigate what the implications are for the health sector due to the changes in the general macroeconomic and political environment within which it operates. Options

⁶ Thomson S, Figueras J, Evetovits T, Jowett M, Mladovsky P, Maresso A, et al. Economic crisis, health systems and health in Europe. European Observatory on Health Systems and Policies, editor. New York: World Health Organization; 2015.

⁷ Heller P. Understanding fiscal space. Washington, DC: International Monetary Fund, 2005.

⁸ Burnside C, editor. Fiscal sustainability in theory and practice. Washington, DC: World Bank; 2005.

⁹ Heller, P (2006), The Prospect of Creating Fiscal Space for the Health Sector, II *Health Policy and Planning*, 21(2): 75- 79.

¹⁰ Tandon A, Cashin C. Assessing Public Expenditure on Health from a Fiscal Space Perspective. Washington, DC: World Bank, 2010.

(iv) and (v) are more within the domain of the health sector, given that they provide the potential for resources that are sector-specific¹¹.

The fiscal space analysis for the health sector in Kebbi is timely and the need for such analysis has been strongly expressed by government and its development partners. This becomes imperative as the country (and by extension, states) is hit by an economic crisis resulting in lower revenues and cuts in expenditures. Understanding the consequences and assessing coping strategies for the health sector is of critical importance. As the country engages in the implementation of its new strategic health development plan (SHDP), fiscal space analysis was recommended to explore ways to increase resources for the sector, even in a constrained macro-fiscal condition. It is also important to highlight the major sources of inefficiencies currently affecting health systems to identify areas for improvement and increase the value for money.

1.3 Kebbi State Economy and Health System

Kebbi State is in the northwest geopolitical zone of Nigeria, with Birnin Kebbi as its capital. It has a total land area of about 36,309 square kilometres. The state was created out of a part of the former Sokoto State in 1991 and consists of 21 Local Government Areas (LGAs), four emirate councils (Gwandu, Argungu, Yauri And Zuru) and 35 districts¹². With regard to the health sector, ownership of public health facilities (health centres and general hospitals) and responsibility for delivering health services are shared between the state and local governments. The Ministry of Health (MoH) is responsible for core functions of policy and standards formulation, quality assurance, and resource mobilization. It is also responsible for managing general hospitals.

Kebbi State operates a mixed health economy of public and private healthcare delivery system which is funded by government, donors, corporations and households. The health facilities include 544 Public Healthcare facilities out of which 529 are PHCs; 14 secondary and 1 Tertiary health facilities¹³. There are 24 private secondary health facilities and no private tertiary health facility in the state.

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 FAAC and loans for provision of public good services including public health. Budget allocation to the health sector is very low compared to the Abuja target of 15% and has been declining over time. At 8.7% of health budget allocation in 2012, KBSG financing of health reached its peak within last six years but had declined to 7% in 2016. Given that government health spending is mostly targeted at advancing equitable healthcare by focusing on the vulnerable population groups, the declining allocations to health needs to be reversed if the ambitions of UHC are to be realized.

1.4 Kebbi: Health, Nutrition and Population Status

Currently, Nigeria suffers the loss of almost one million deaths in children under-five years of age and thousands of maternal deaths, mostly from mainly preventable causes¹⁴. The efforts and commitment of development partners towards addressing these major challenges within the health system 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.

Kebbi State Government (KSG) has made considerable progress towards improving the health status of its residents. However, the state underperforms relative to the northwest and national averages of crucial RMNCH health indicators as indicated from data from MICS 2016/2017 (Table I). In addition, Kebbi State

¹¹ Although, even for health-specific grants and foreign aid, final decisions are often made within Ministries of Finance and not Ministries of Health.

¹² INEC. Information Kit for 2015 General Elections

¹³ NBS. <http://nigeria.opendataforafrica.org> accessed 20th April 2018

¹⁴ https://www.unicef.org/nigeria/children_1926.html accessed 25th April 2018

has the lowest number of HIV population in the country (1.1%) despite being one of the states with the lowest reported residents with knowledge of HIV status.^{15,16} Data from the National Nutritional and Health Survey of 2015 indicates that median age at first birth among women age 15-49 stands at 17.9. Among the states, knowledge of contraceptive methods is lowest for women in Kebbi (51 percent).¹⁷

Table 1: Kebbi Health Status

Selected health indicators	Kebbi State	North West	National
Neonatal Mortality rate per thousand live births	55	45	39
Infant Mortality rate per thousand live births	111	87	69
Under-Five Mortality rate per thousand live births	174	162	120
Moderate and severe underweight	44.9	42.6	31.5
Moderate and severe stunting	60.3	58.5	43.6
Moderate and severe wasting	13.7	12.9	10.8
Children with diarrhoea	23.6%	19.2%	14.3%
Skilled attendance at birth, percentage	17.9%	23.6%	43%
Antenatal care from skilled providers	45.4%	53.6%	65.8%
Modern contraceptive prevalence rate	5.0%	7.4	10.8%
Source: Multiple Indicator Cluster Survey 2016-17			

¹⁵ Spectrum/EPP, National Agency For The Control Of AIDS/HIV(NACA) 2012

¹⁶ Annual Abstract of Statistics 2016 Volume 2

¹⁷ NBS, National Nutrition and Health Survey 2015

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 Kebbi State Health Sector was held to achieve common understanding and agree 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 including Department of Statistics and Donor Coordination Units, State Ministry of Finance, State Ministry of Local Government and Chieftaincy affairs, Social Security Welfare Fund, – 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 with public officials in the state regarding their experience implementing similar laws with earmarked funds and working with federal agencies in addition to 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 Kebbi State.

2.3 Data Analysis

Using the five fiscal space dimensions¹⁸, this study presents an assessment of the fiscal space available to Kebbi State health sector. This analysis will provide decision-makers with options for informed choices. The purpose is not to define a single pathway but rather to provide evidence that can support the discussion of the financial, political and implementation feasibility of the different possible pathways 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 KBMoH as well as Kebbi State Health Insurance Agency. In other words, this will also be a guide to determine fiscally optimal trajectories of health insurance coverage expansion.

An assessment of the fiscal capacity of Kebbi 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 KBHIS 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

¹⁸ Regondi I. and Whiteside A. (2012), 'Fiscal Space for Health: Assessing Policy Options in South Africa', Journal of Contemporary Management

milestone approach.¹⁹ In the simulation, which used 2019 as base year, the dynamic population in the state was taken into cognizance 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 analysed.

- Funding gaps estimated: gaps were calculated based on several scenarios and are presented alongside a discussion of options to fund them.
- Macro-fiscal analysis of additional space for KBHIS: this analysis is based on revenues accruing to the state, internally generated revenue, debt profile, budget and actual expenditure over a 5-year period.

Table 2: Assessment of Fiscal Space available to Kebbi State

Dimension	Analytical Framework	Examples
1	Macrofiscal Conditions	Sources of government revenue, Trend of revenue mix, Government solvency conditions, Economic outlook
2	Health sector reprioritization	Allocation to Health, Share of government health expenditure out of total government expenditure, and Population Growth
3	Earmarking of Funds	Available earmarked funds e.g. through CRF or Taxation, Other health sector-specific resources
4	External Grants	Donor Contributions, Philanthropists, Other private sources
5	Efficiency Gains	Input versus Output, Sources of inefficiency

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

2.4 Scenario Development for KBSCHS Financial Modelling

There will be many combinations of coverage targets, premium levels and prioritisation of populations that the government of Kebbi State could use to guide the scale up of health insurance coverage by the KBHIS. 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. However 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 KBMoH 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

¹⁹ Milestone approach was employed to set the target coverage per year for each defined population categories over the projection period.

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 possibly rapid enrolment for this population that exceeds conservative estimates and resource available. On the other hand, the informal sector will be more challenging to reach and enroll 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 Kebbi 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. NEED FOR INCREASING FISCAL SPACE

Kebbi State is of the 36 states and Federal Capital Territory (FCT) that participated 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. 1. Leadership and Governance
2. 2. Community Participation and Ownership
3. 3. Partnerships for Health
4. 4. Reproductive, Maternal, Newborn, Child, Adolescent Health Services & Nutrition
5. 5. Communicable Diseases (Malaria, TB, Leprosy, HIV/AIDS) And Neglected Tropical Diseases
6. 6. Non-Communicable Disease, Care of The Elderly, Mental Health, Oral Health, Eye Healthcare
7. 7. General and Emergency Hospital Services
8. 8. Health Promotion and Social determinants of Health (Environmental Health)
9. 9. Human Resource for Health
10. 10. Health Infrastructure
11. 11. Medicines, Vaccines and Other Health Technologies and Supplies
12. 12. Health Information System
13. 13. Research for Health
14. 14. Public Health Emergencies: Preparedness and Response
15. 15. Health Financing

In the recent stakeholder's validation of the SHDP 2017 – 2021 conducted by Kebbi State Ministry of Health, the moderate scale up scenario was adopted for both programmed areas and Health Systems Support (HSS) cost categories of Kebbi State SHDP as shown in Table 3 and 4 below. The cost below excludes the financial liabilities of KBSG towards providing health contributory coverage for vulnerable groups under KBSCHS as described in section 5 of this report.

Table 3: Summary costs by HSS categories of Kebbi SHDP II 2017-2021 Essential Package Moderate Scale-up Scenario, (N'Million)

HSS Cost Categories	2017	2018	2019	2020	2021	Total	% of total cost
Programme Activity costs	N493M	N484M	N426M	N395M	N381M	N2180M	1.40%
Human Resources	N7262M	N8131M	N9077M	N10071M	N11126M	N45667M	29.50%
Infrastructure	N3591M	N3591M	N3591M	N3591M	N3591M	N17954M	11.60%
Logistics	N2844M	N3794M	N5040M	N5952M	N6991M	N24621M	15.90%
Medicines, commodities and supplies	N6714M	N8959M	N11902M	N14058M	N16514M	N58148M	37.50%
Health Financing	N43M	N44M	N44M	N43M	N42M	N216M	0.10%
Health Information Systems	N357M	N372M	N1014M	N369M	N362M	N2474M	1.60%
Governance	N737M	N766M	N744M	N752M	N744M	N3743M	2.40%
SGDP II Total cost	N22,042M	N26,141M	N31,838M	N35,229M	N39,752M	N155,022M	

Table 4: Summary costs by Programme area of Kebbi SHDP II 2017-2021 Essential Package Moderate Scale-up Scenario, (N'Million)

SHDP II 2017-2021 Programme Areas	2017	2018	2019	2020	2021	Total	% of total cost
Maternal/new born and reproductive health	N438M	N471M	N519M	N542M	N581M	N2552m	16.50%
Child health	N289	N324M	N371M	N400M	N438M	N1822M	11.80%
Immunization	N95M	N120M	N145M	N169M	N193M	N723M	4.70%
Malaria	N59M	N44M	N118M	N72M	N59M	N351M	2.30%
TB	N483M	N626M	N779M	N902M	N1036M	N3826M	24.70%
HIV/AIDS	N117M	N132M	N144M	N159M	N178M	N731M	4.70%
Nutrition	N232M	N285M	N348M	N401M	N466M	N1733M	11.20%
WASH	N52M	N53M	N56M	N56M	N59M	N275M	1.80%
Non-communicable diseases	N295M	N387M	N491M	N573M	N675M	N2412M	15.60%
Mental, neurological, and substance use disorders	N36M	N43M	N51M	N57M	N65M	N253M	1.60%
Adolescent health	N78M	N109M	N142M	N175M	N209M	N713M	4.60%
Neglected tropical diseases	N4M	N4M	N3M	N4M	N3M	N17M	0.10%
Health promotions and social determinant	N2.4M	N4M	N4M	N4M	N4M	N18M	0.10%
General and emergency hospital services	N17.90M	N5M	N6M	N3M	N3M	N35M	0.20%
Public Health Emergencies, Preparedness and response	N6.4M	N6.4M	N6.4M	N6.4M	N6.4M	N31.8M	0.20%
SSHDP II Total cost	N22,042M	N26,141M	N31,838M	N35,229M	N39,752M	N155,002M	



4. OPTIONS FOR INCREASING FISCAL SPACE

4.1 Macrofiscal Conditions

Rising income leads to a greater demand for, and supply of healthcare services. Newhouse (1977) stated that national income is the biggest determinant of public health spending across countries.²⁰ Periods of robust economic growth and macro-fiscal stability result in increases not only in the level but also in the share of the public sector in the economy, including for health.²¹ A conducive macro-fiscal environment is important for considering fiscal space for health. These include a positive economic growth, increases in internally generated revenue, manageable levels of debt and budget deficits, and favourable inflation and labour market indices.

An analysis of Kebbi State's Fiscal Profile (Table 5) indicates that statutory allocations from FAAC have steadily decreased, from 33 billion in 2011 to 21 billion in 2016 while Value Added Tax (VAT) increased albeit slightly during the period. The state Internally Generated Revenue (IGR) decreased substantially by 50% from N6.4 billion in 2011 to N3.1 billion in 2016. Kebbi state credit profile started growing in 2014 as result of several loans obtained by the government such as Budget Support Facility Loans, Commercial Agric Loans, Excess Crude Account (ECA) loans payable in 20 years and some bailout funds obtained from Federal Government.

Table 5: Kebbi State Fiscal Profile 2011 - 2017

	2011	2012	2013	2014	2015	2016	2017
Revenue (Billion Naira)							
Statutory Allocation	33	35	39.5	42.6	29.7	21.5	29.6
Internally Generated Revenue	6.4	4.4	3.8	3.8	3.6	3.1	4.4
Value Added Tax	6.8	7.5	8.3	8.4	8.0	8.3	9.9
External and Internal Loans	0.0	0.0	0.0	1.0	22.9	21.5	9.3
Others (inc. Dividends, Grants)	20.3	19.9	20.6	12.2	7.4	4.6	28.8
Sure-P	0.0	1.3	2.7	2.8	0.0	0.0	0.00
Total Revenue	66.5	68.1	74.9	70.7	71.6	59.1	81.9
Expenditure (Billion Naira)							
Personnel Cost	15.6	19.5	18.3	20.0	20.9	18.6	36.5
Overhead	5.3	8.9	6.4	7.9	10.5	5.1	
Capital Expenditure	43.0	39.1	50.0	39.7	10.7	31.8	45.3
Subtotal Expenditure	63.9	67.5	74.7	67.5	42.1	55.5	81.8
Debt Service Charges	0.4	0.3	0.2	1.9	3.4	3.5	-
Total Expenditure	64.4	67.9	74.9	69.4	45.5	59.0	81.8
Net Cash Balance	2.1	0.2	-0.004	1.3	26.1	0.04	0.1
Source: Accountant General Financial Statements. 2017 Data from Ministry of Budget and Economic Planning							

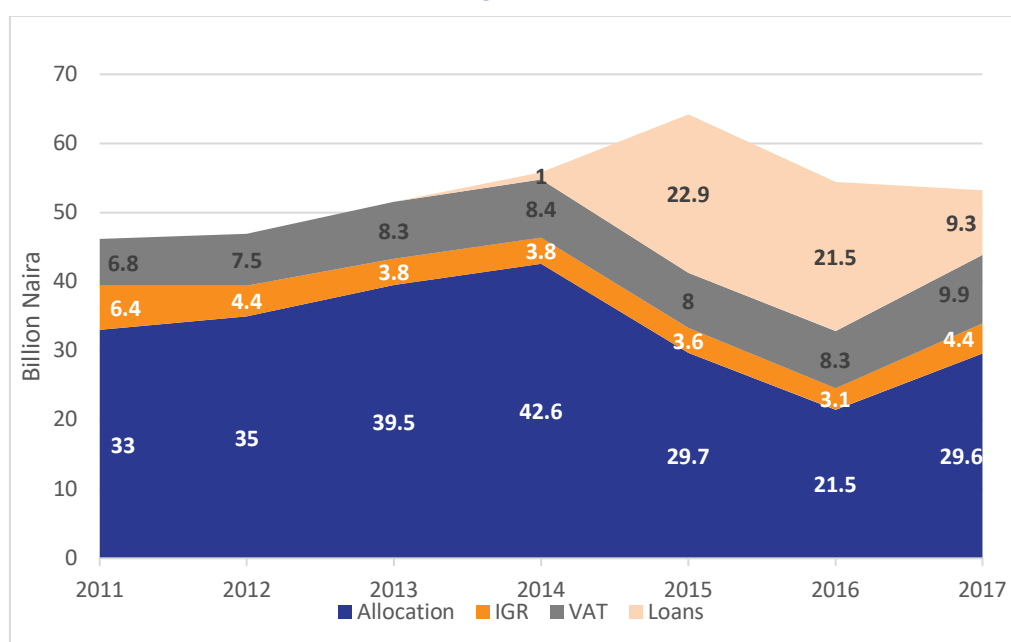
²⁰ Newhouse, JP (1977), "Medical Care Expenditure: A Cross-National Survey," *Journal of Human Resources*, 12(1): 115-125.

²¹ ADB (2006), *Measuring Policy Effectiveness in Health and Education*, Manila: Asian Development Bank

Overall, the state's total revenue showed net growth over the seven-year period from 2011 to 2017 except for a sharp decline in 2016. The state's expenditure increased in tandem with revenue, but fell sharply in 2015, the same year with a moderate net cash balance.

Figure 1 shows the trend of revenue mix of the State and the relative allocations to recurrent and capital expenditures are illustrated in Figure 1. There was a net increase in the debt stock from 2013 to 2016, which reflects increased reliance on borrowing by the state as IGR dropped between 2014 and 2016. The IGR trend may be attributed to the non-aggressive posture of the State's Internal Revenue Service in mobilizing revenue in the state. VAT contribution increased from N6.8 billion in 2011 to N9.9 billion in 2017 and its proportion as share of the total revenue has slightly increased steadily from 10.2% in 2011 to 14.0% in 2016. However, the state is limited to control the extent to which VAT can influence its revenue generation as it is under purview of federal government.

Figure 1: Trend of Revenue Mix

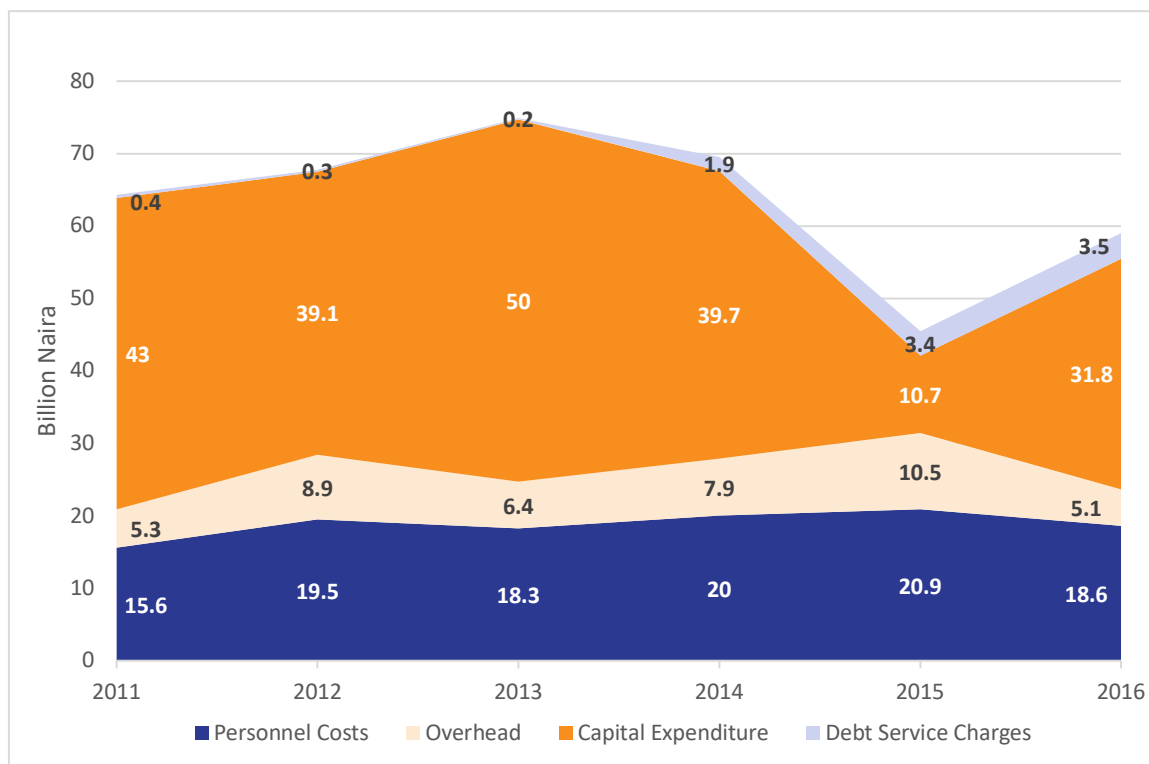


Source: Accountant General Financial Statements.

The share of aggregate expenditure allocated to infrastructure spending was a high of 66.8% in 2013 but experienced a severe dip to 23.7% in 2015 (Figure 2). The shift in the expenditure profile toward recurrent expenditure is driven by net growth of personnel cost, which increased from N15.6 billion in 2011 to N20.9 billion in 2015. There is a critical need to address the states declining capacity for IGR to sustain the state recurrent expenditure which currently absolved the state collectible revenue.

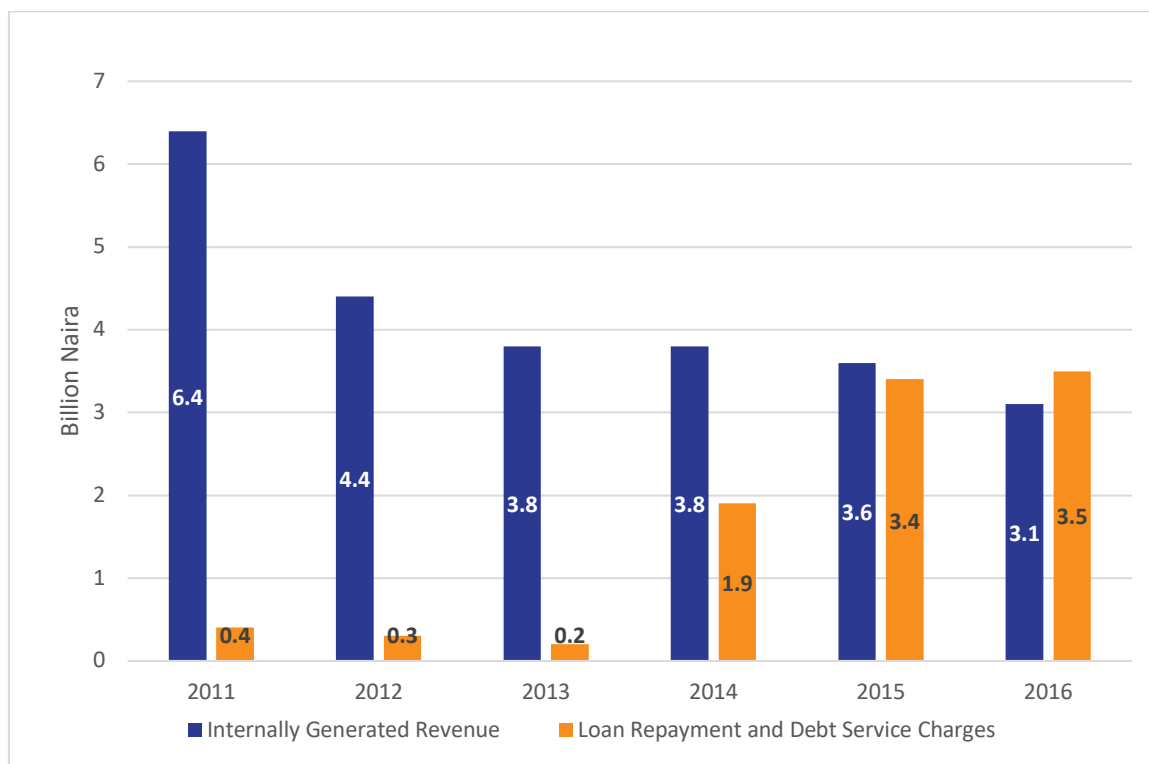
Kebbi's increasing public debt burden is a significant constraint on economic growth (Figure 3). High levels of deficit and debt pose a threat to fiscal sustainability (i.e. a government's ability to maintain current fiscal policies, such as spending and tax policies, without any major future adjustments). Kebbi is currently servicing its domestic public debt but an increase in personnel and overhead costs may suffer on the long run if adequate measures are not put in place. KSG needs to institute measures to strengthen revenue collection and create conducive atmosphere for private sector in order to both widen and diversify its earning base.

Figure 2: Trend of Expenditure Mix



Source: Accountant General Financial Statements.

Figure 3: Sustainability Analysis of Solvency Ratio



Source: Accountant General Financial Statements.

Kebbi state needs to focus on expanding the tax base to include nonpayers such as lake rice investments, farmers (Rice, Onions, Guinea corn, etc) and import duties from fabric as well as increasing contribution rates from existing corporations.²² Improving efficiency of tax administration becomes imperative in the face of dwindling oil revenue by simplifying procedures and employing use of technology to improve revenue collection.

However, the growth of the informal economy hinders broadening the tax base. In Nigeria, unemployment has been rising in recent years, and employment is largely informal. In third quarter of 2017, the unemployment and underemployment rate were 31.5 percent²³. Of the 465,815 employed, half may be in informal employment²⁴. Moving forward, it is necessary to encourage and incentivize the informal sector to transition from informality to formality to increase contributions to the state treasury.

To summarize, from a macro fiscal perspective, the current financial situation of Kebbi State makes prospects of availability of additional public resources for health to be relatively low due to irregular growth, increasing debt and low taxation levels. Rising unemployment and growth of the informal sector can further impede the already restricted fiscal space. Concerted efforts to improve efficiency²⁵ in revenue collection and expenditure will make better use of existing resources in the medium term.

4.2 Reprioritizing Health

In theory, the limited fiscal space for health generated from economic growth and revenue collection can be supplemented by increasing the budget share allocated to health. There may be scope for raising health's share of overall government spending in some states, particularly if the share of health in the government budget is lower than comparator states in the same region or those with similar income levels as well as if certain expenditure categories can be identified that are deemed unproductive or unnecessary and could be replaced by additional health spending. Government spending on health often reflects overall government commitment to and prioritization of health—the budget for which competes with other sectors such as education, infrastructure or agriculture.

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 various sectors in Kebbi state shows that the relative share of the health sector fell from 8.7% in 2012 to 7.1% in 2015 but oscillated to 9.0% in 2016 before returning to 7% in 2017 (Table 6). In the past five years, it reached an average of 7.9 percent of government spending which has fallen short of the Abuja declaration benchmarks of 15 percent. This indicates that there is a lot of room for increasing the current allocation towards achieving the target.

Table 6: Kebbi State Health Sector Prioritization 2011 - 2016

	2012	2013	2014	2015	2016	2017
Health Budget Allocation (Billion Naira)	10.1	10.6	10.5	11.9	9.9	10.1
Total Govt. Budget (Billion Naira)	116.6	125.5	151.1	166.8	109.8	143.8
Budget Allocation to Health	8.7%	8.4%	7.0%	7.1%	9.0%	7.0%
Abuja Declaration Benchmark	15%	15%	15%	15%	15%	15%
Health Expenditure (Billion Naira)	7.3	4.9	5.3	4.7	4.3	6.5
Total Govt. Expenditure (Billion Naira)	67.8	74.9	69.4	45.5	59.0	81.8
Govt. Expenditure on Health (%)	10.8%	6.5%	7.6%	10.3%	7.2%	7.9%
Total Population (Millions)	3.95	4.07	4.21	4.34	4.48	4.63
Health Expenditure per capita (Naira)	1,840	1,198	1,269	1,081	953	1,404

²² Currently, all the state MDAs have submitted proposals to Ministry of Justice on increasing revenue generating options. It is estimated by anecdotal evidence that these efforts have potential to double the current IGR which is around N4.4 billion naira in 2017.

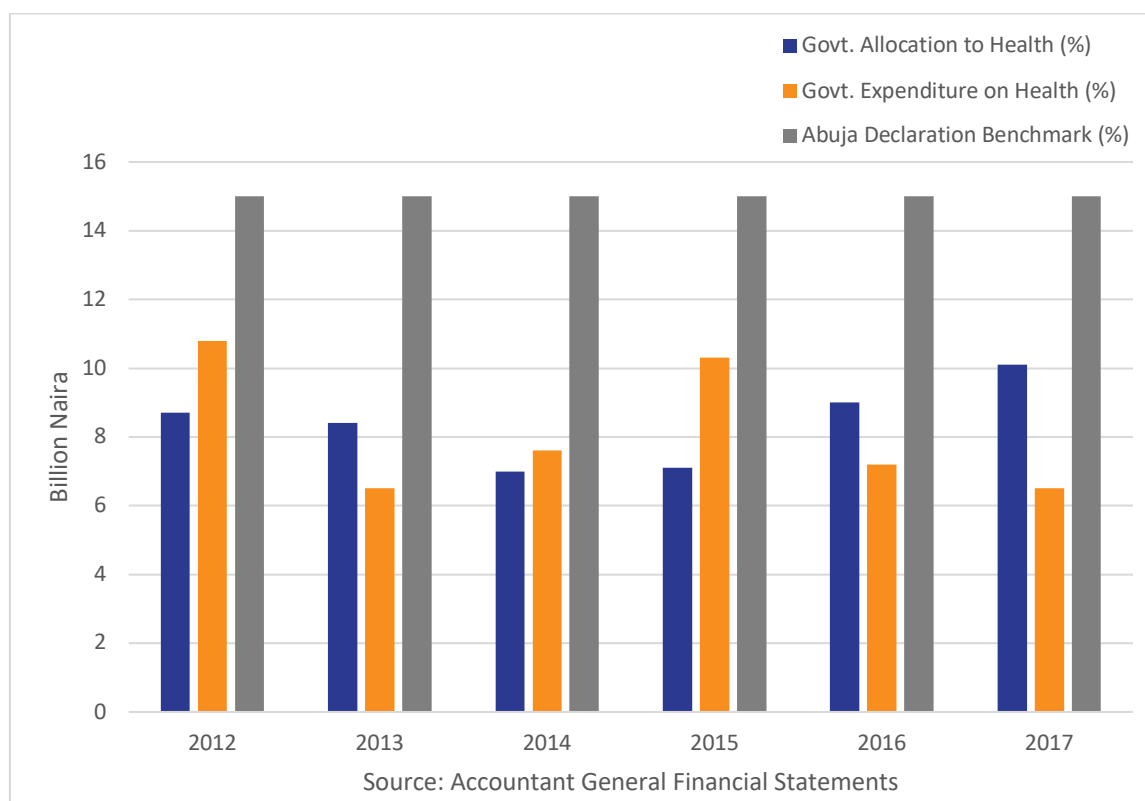
²³ NBS (2017) Labour Force Statistics Vol. 1: Unemployment and Underemployment Report

²⁴ NBS and National Pension Commission (2017) Retirement Savings Account (RSA) 2016 Q4 Membership Distribution Report

²⁵ Manual collection of dues still exists in Kebbi state which makes the process of revenue collection vulnerable to inefficiencies. Automated process is highly encouraged.

Health Budget per capita (Naira)	2,561	2,603	2,504	2,745	2,208	2,181
Health Expenditure per capita (USD)	11.7	7.6	8.0	5.5	3.1	4.6
Health Budget per capita (USD)	16.3	16.5	15.8	13.9	7.2	7.1
Sources: Accountant General Financial Statements, Authors Estimates, Kebbi State Bureau of Statistics						

Figure 4: Abuja Declaration Benchmarks



Re-prioritizing health could yield some benefits in the medium to long term as noted from the funding gaps. If Kebbi state implements the prioritization of health along those lines, the additional resources that would have accrued to the health sector amounts to N2.87 billion in 2012, N5.11 billion in 2014 and N5.8 billion in 2017 (Table 5). The average gap of N4.47 billion per year between 2012 and 2017 is adequate to build and equip 1 standard public health Laboratory in each 21 LGAs and address other priorities as identified in the strategic health plan.

Table 7: Reprioritization of Health Sector according to Abuja Declaration

	2012	2013	2014	2015	2016	2017
Total Govt. Expenditure (Billion Naira)	67.8	74.9	69.4	45.5	59.0	81.8
15% Equivalent of TGE (Billion Naira)	10.2	11.2	10.4	6.8	8.9	12.3
Actual Health Expenditure (Billion Naira)	7.3	4.9	5.3	4.7	4.3	6.5
Funding Gap (Billion Naira)	2.87	6.34	5.11	2.13	4.58	5.8
Sources: Accountant General Financial Statements, Authors Estimates						

Budgeting allocation for health is meaningless without consideration of budget release and utilization in the sector. Figure 5 shows that budget performance in the health sector (ratio of actual expenditure to budget allocation) showed a net decline between 2012 (72%) and 2015 (39%) but has been on the rise since then to 64% in 2017. Health expenditure per capita and budget per capita decreased as population increased within the same period (Figure 6).

Figure 5: Health Budget Performance

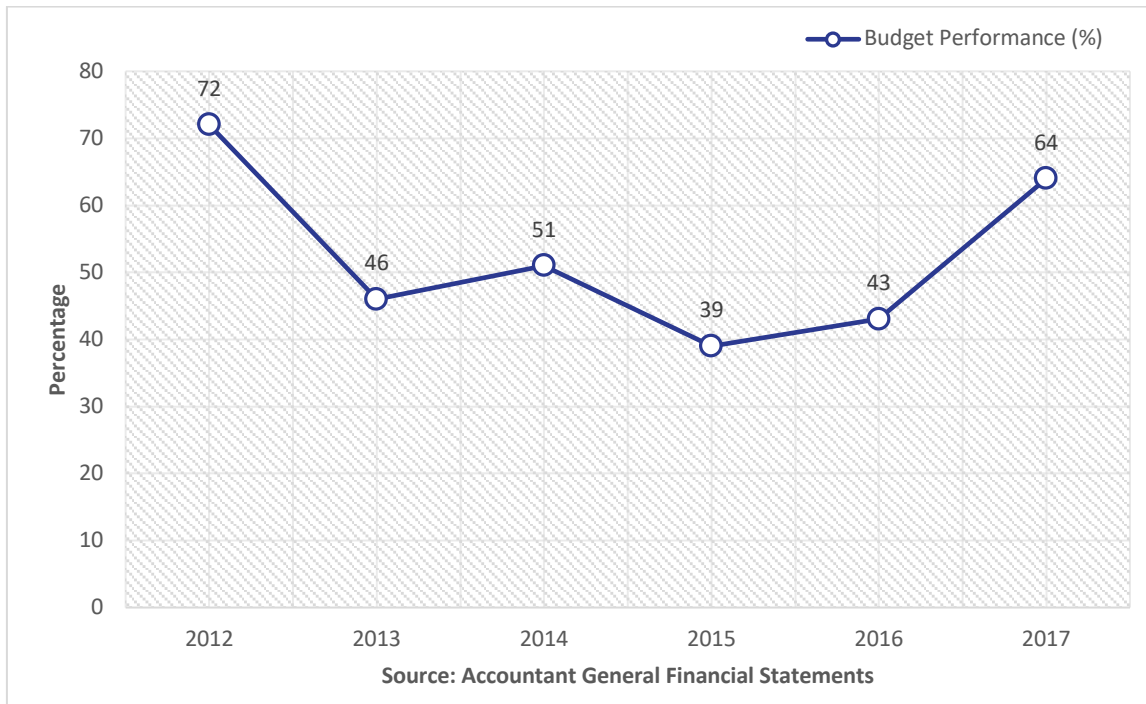
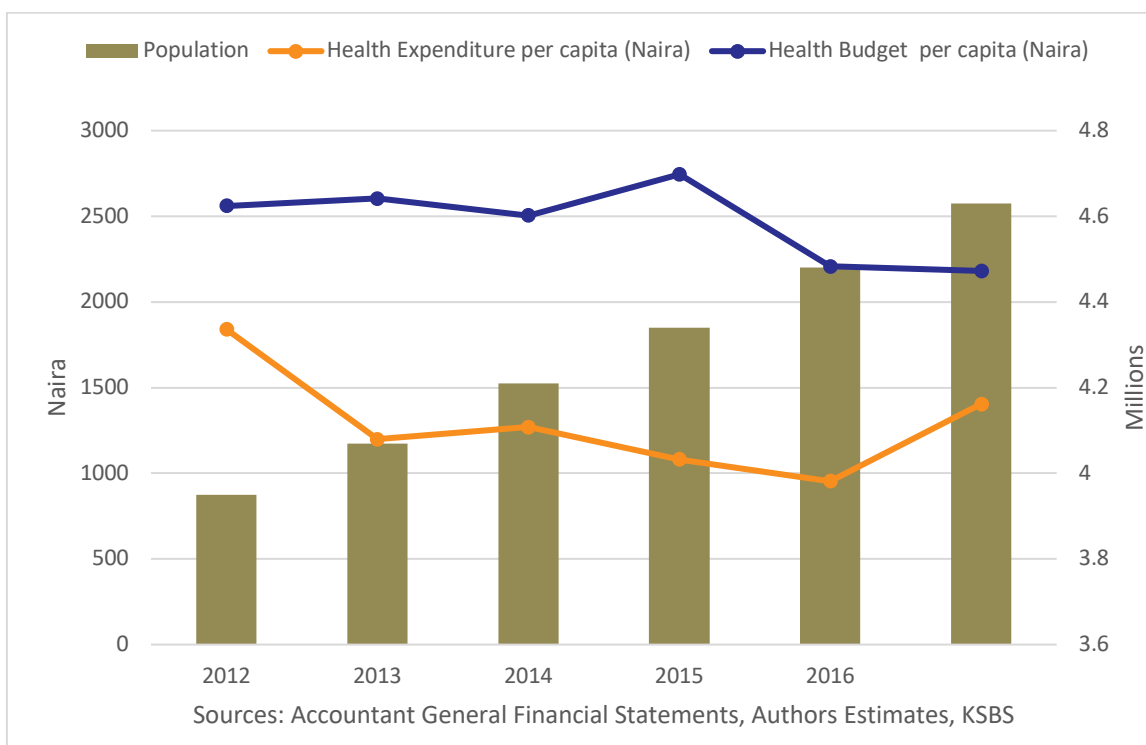


Figure 6: Health Budget and Expenditure per capita



Intra-health sector allocations and expenditure as revealed in figure 7 and 8 indicate that Kebbi state allocates more to capital expenditure relative to recurrent expenditure. However, reverse is the case in terms of implementation - actual expenditure – where the state spends substantially higher on recurrent expenditure than capital expenditure.

Figure 7: Kebbi State Health Budget Allocation

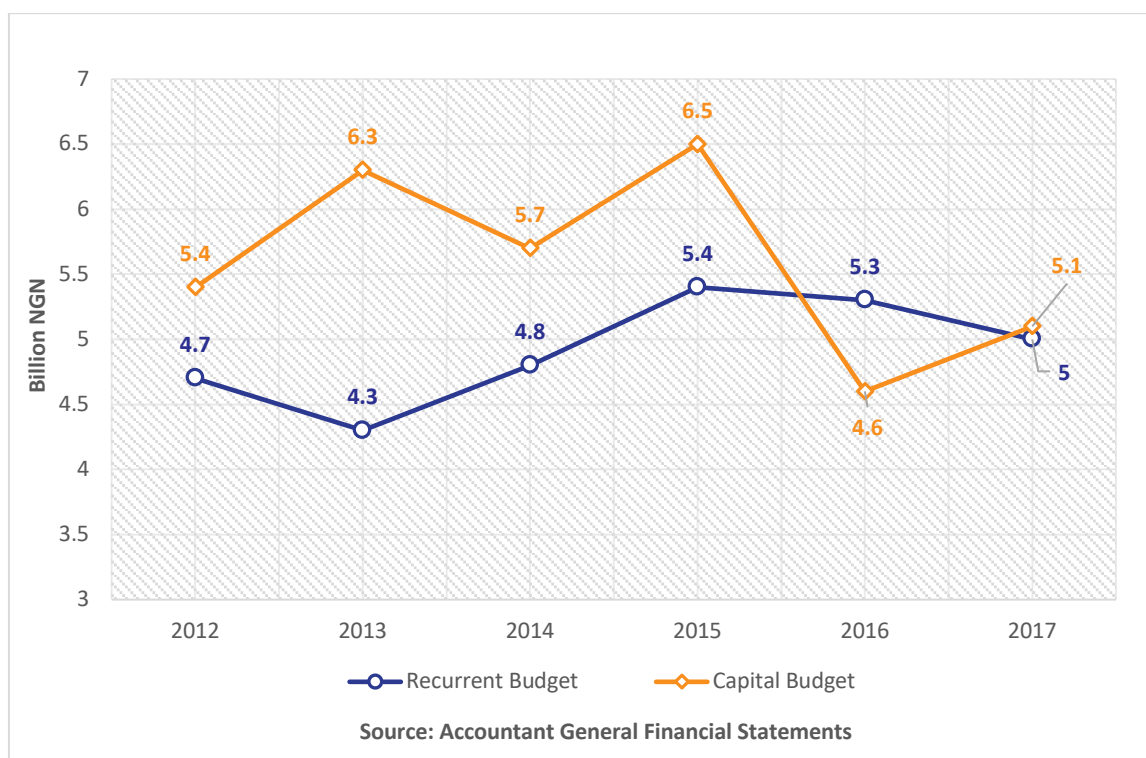
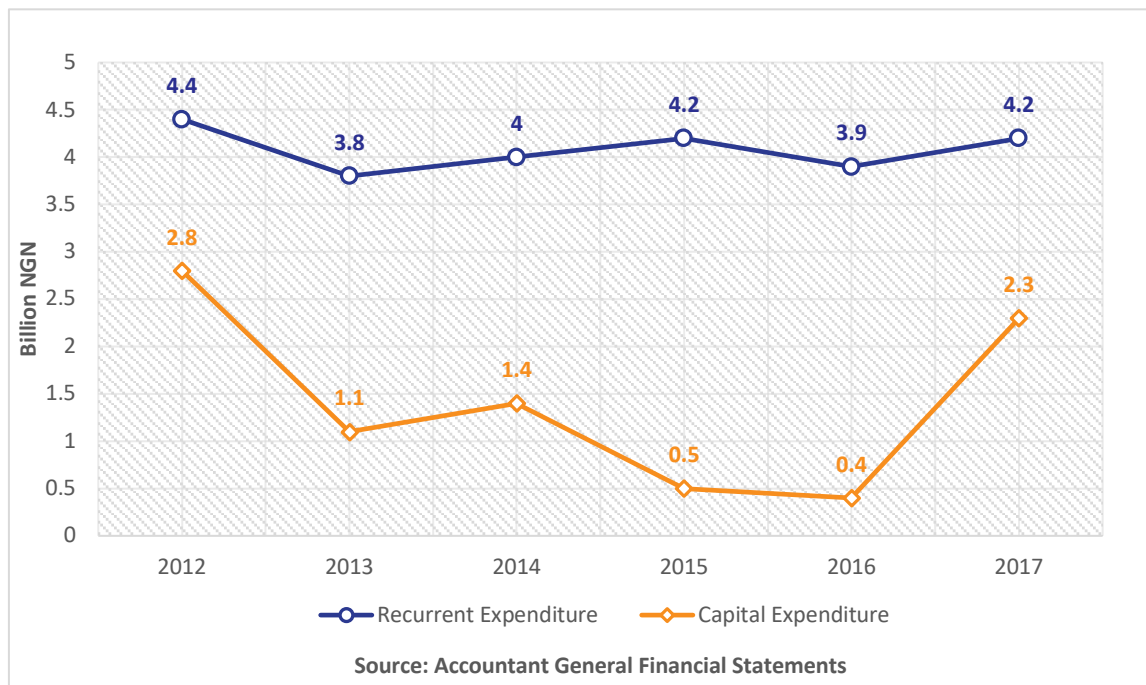


Figure 8: Kebbi State Health Actual Expenditure



Current trends suggest limited opportunities to improve prioritization of the health sector despite the need for increased resources to implement the state SHDP. Historical data shows that in difficult economic times lower priority is given to the health sector, and an increased share of the budget is used for debt servicing (interest payment). Therefore, despite the stated objective of health financing strategies to

mobilize adequate resources for predictable sustainable funding for the health care sector and increase public spending on health to 15 percent of government spending is unfeasible.

4.3 Earmarking of Funds

One of the most intuitive options when considering fiscal space for health is to introduce new taxes or percentage of revenue which could be earmarked for financing health care²⁶. 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, this include improving access to quality health services. Earmarking can involve dedicating an entire tax to fund a particular program (e.g. dedicated payroll tax earmarked for social health insurance) or setting aside a fixed portion of a particular tax to fund the program (e.g. a fixed proportion of the consolidated revenue fund allocated to the health)²⁷. From the perspective of the health sector, earmarked taxes are useful because they can insulate health spending from other competing publicly funded activities and this can be particularly important for countries with low or unstable spending in health. The evidence on earmarking is indeed mixed and depends on country specific context and political economy. Furthermore, it is worth mentioning that revenues earned from earmarked sources may not be 'additional' in the medium to long term since the Ministry of Finance can lower the trajectory of funding from traditional revenue sources. Exploring the scope for increased domestic funding from tax revenues is however critical for a fiscal space analysis²⁸.

A direct allocation from Consolidated Revenue Fund (CRF) is an option that states are currently exploiting in order to provide reliable earmarked funds for the health sector. Following the action at the federal level as contained in the National Health Act (NHAAct), the state is considering legislation to charge not less than 1% of the state CRF into equity fund for health insurance. In order to expand more budgetary space for KBCHS, LGAs are being encouraged to emulate what is obtainable at the federal and state levels – contribution of not less than 1% of CRF at each level. Equity funds at LGA level are not considered in the priority scenarios but rather might be considered as a recommendation.

Table 8: Earmarking through CRF Sources of Contribution/Subsidy for KBCHS

Sources of Contribution (Millions)	2019	2020	2021	2022	2023
State Equity Fund (1% of CRF)	481	503	526	550	576
NHIS Contribution from BHCPF*	855	951	1058	1177	1309
Total	1,336	1,454	1,584	1,727	1,885
State Equity Fund (2% of CRF)	962	1006	1052	1100	1152
State Equity Fund (3% of CRF)	1443	1509	1578	1650	1728

Source: Author's Estimates based on State Approved Budget and NHIS Reports.

*NHIS Contribution from BHCPF to the State is assumed to be 1/37 of 0.5% of Federal Consolidated Revenue Fund

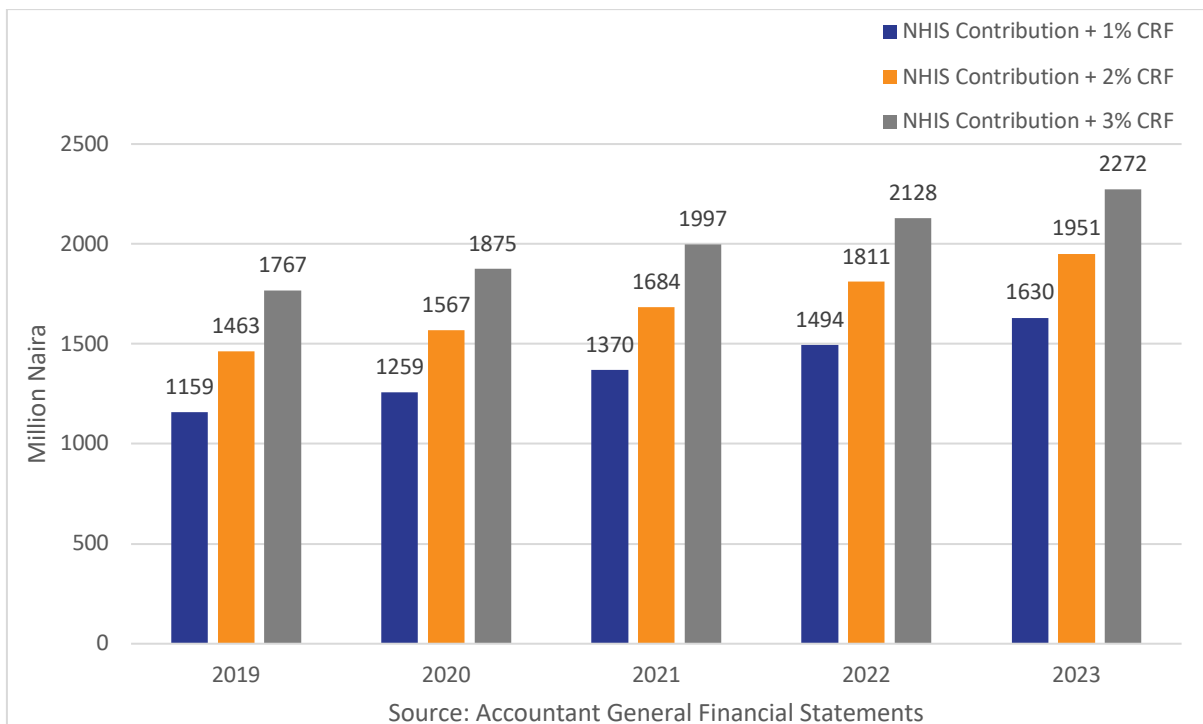
Figure 9 shows that Kebbi State can improve health financing substantially by raising the percentage of CRF to health. For example, raising the allocation to 2% will provide additional N481 million in 2019 while raising it to 3% will generate additional N855 million funding for the health sector.

²⁶ World Bank (2017) Analyzing Fiscal Space Options for Health in Zimbabwe (Final Report)

²⁷ Tandon A, Cashin C. Assessing Public Expenditure on Health from a Fiscal Space Perspective. Washington, DC: World Bank, 2010.

²⁸ World Bank (2017) Analyzing Fiscal Space Options for Health in Zimbabwe (Final Report)

Figure 9: Raising Percentage from CRF



4.4 Mobilizing External Resources

Another way to generate fiscal space for health is for governments to utilize external resources in the form of foreign aid and grants from international donors. Donor funding i.e. Developmental Assistance for Health (DAH) is a vital source of health expenditure and Nigeria's health sector is already quite dependent on external resources. 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.

While the level of such assistance is important, the predictability, flexibility and composition of the assistance are equally important. A highly unpredictable inflow of foreign aid renders long-term planning a challenge, and foreign aid that comprises primarily of loans increases debt-servicing costs. Similarly, foreign aid that is tied to specific programs (such as immunization or HIV/AIDS) may lack the flexibility to meet to country's changing demand for overall health resources. External funding is skewed towards a few health programs, generating heavy reliance on DAH for those programs and a potential risk of funding gap in the event of decreasing DAH. HIV, vaccines, malaria, reproductive and maternal, neonatal and child health (MNCH) and TB programs are highly donor dependent and there is no effective graduation plan for decreasing external funding. Kebbi state should actively court donors and external partners, as well as include such potential sources of income in their budgeting process through effective donor coordination mechanism.

4.5 Efficiency Gains

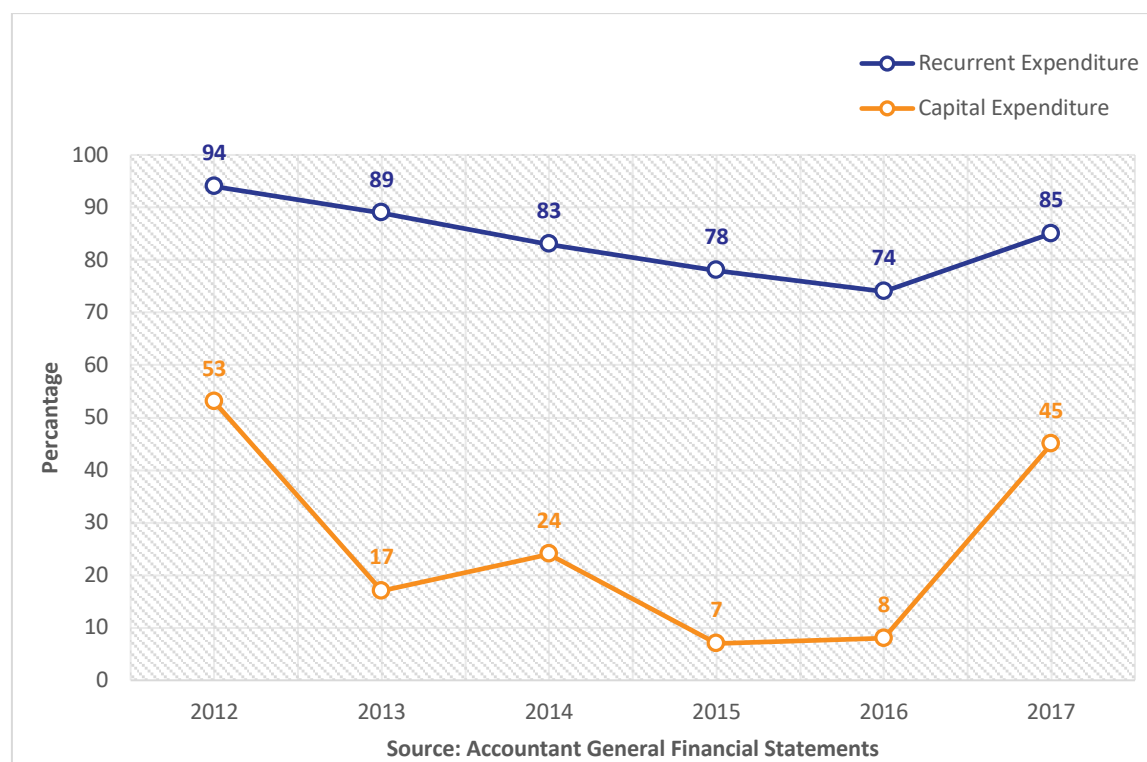
Fiscal space for health could be improved through actualization of efficiency gains in the health sector. Analysis of efficiency gains is highly demanding in terms of operational and financial data. Data limitations preclude the analysis at the moment. Increased efficiency creates fiscal space by increasing savings within the existing envelope rather than by expanding the resource envelope. The World Health Report (2010) identifies ten major sources of inefficiency: underuse of generic medicines and higher than necessary prices for medicines; use of substandard and counterfeit medicines; inappropriate and ineffective use of medicines; supplier-induced demand and overuse of some services; inappropriate staff mix and unmotivated workers; inappropriate hospital admissions and length of stay; low use of infrastructure such as hospital beds; medical

errors and suboptimal quality of care; waste and fraud; and inefficient mix and inappropriate level of intervention²⁹

KBSG could save money by demonstrating commitment towards ensuring increased budget performance for capital expenditure relative to recurrent expenditures. Intra-sectorial analysis of the state's health budget into its recurrent and capital components shows that budget performance was 94% for recurrent expenditure and 53% for capital spending in 2012 (Figure 10). The performance on recurrent component reduced significantly up to 2016 where budget performance was 74% and 8% for recurrent and capital expenditures respectively. The reduction in capital expenditure is not only worrisome but it can hardly meet the investments for high impact health interventions required for its systems development. 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.

Human resources typically represent the single largest cost in most health system and therefore have an important impact on overall efficiency. In general, excessive spending on wages and salaries suggests an imbalance in the use of inputs and translates into less resources being available for other health programs and activities. The share of employment costs to total KBMoH expenditure indeed grew consistently between 2011 and 2016. Reducing excessive expenditures on wages and salaries could free up resources for other health activities.

Figure 10: Health Budget Expenditure Performance



Gains from addressing health worker absenteeism alone would cover more than the cost of one year's worth of family planning commodities in Kebbi State. Salaries and benefits cost Kebbi State Government about 20 billion annually, starting from 2014. It needs to be ensured that services for which these payments are made, are being carried out. Routine workers biometric verification exercises, for example, to screen out ghost workers, and spot checks in health facilities to ensure presence of crucial health professionals is important in increasing efficiency savings.

²⁹ (2010). Health Systems Financing: The Path to Universal Health Coverage. World Health Report.

The burden of disease in Nigeria, like developing countries is largely dominated by communicable diseases that can be addressed at low cost at the lowest level of care. Improving allocative efficiency in that context would require ensuring that most Kebbi State health sector financing is allocated to these causes of deaths and to preventative measures to reduce the incidence of these conditions. Inefficiency arises if the majority of the disease burden can be addressed through primary level care but public spending is largely geared towards hospitals. Productive efficiency gains could be achieved by delivering more services at the lower levels of care and implementing a sound referral system.

5. FISCAL SPACE ANALYSIS FOR KBSCHS

5.1 Population and Coverage Rates

The population of Kebbi State is estimated at 4.9 million in 2019 at annual growth rate of 3.25% to reach 5.6 million by 2023. Figure 11 provides the breakdown of the population into the individual categories that are relevant to analysing the resource needs of the KBSCHS. The core priority population groups comprising the informal pregnant women and children under-5 constitute about 25% of the state population and the remaining priority groups, the informal elderly and the indigent population, constitute roughly 47% of the population. Together the broadly defined priority population groups account for 72% 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 accounts for 4% and the non-vulnerable informal sector is estimated to be 24% of the population. These population groups account for a total of 28% of the population.

Figure 11: Kebbi State Population Categories

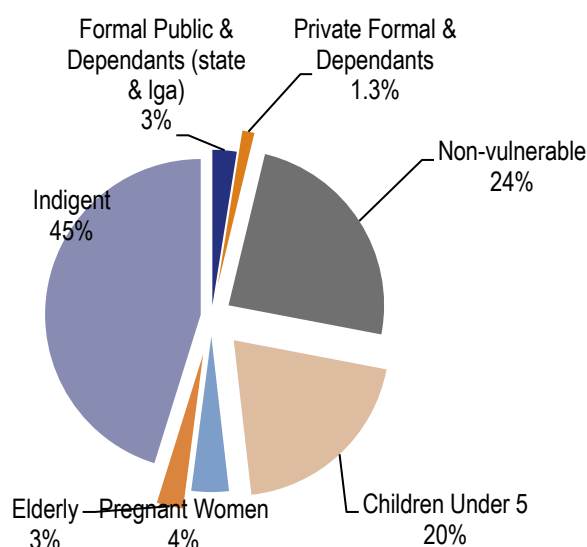


Table 8 shows the possible scenario of coverage scale up where 31% of the state's population is covered by 2023. Coverage of the subgroups of pregnant women and young children is expected to begin at 15% and 10% respectively in 2019 while coverage of the elderly is expected to begin at 5%. The rationale for the rapid scale up for pregnant women to 80% in 2023 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 2023. These two groups are also expected to remain in the program since their premiums will be subsidized. The lower coverage of indigent population starting at 1% in 2019 and reaching mere 15% in 2023 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 2019 to 100% by 2020, the remaining segments of the population that will not be subsidized are expected to gain coverage at the lowest rates.

Table 9: Population Coverage Rates

Categories	2019	2020	2021	2022	2023
	Coverage Rate Coverage Population				
Children Under 5	10% 99,626	25% 257,159	40% 424,826	55% 603,121	70% 792,556
Pregnant Women	15% 28,730	31% 61,305	48% 98,009	64% 134,925	80% 174,138
Elderly	5% 6,783	10% 14,007	15% 21,693	20% 29,864	25% 38,543
Indigent	1% 22,301	2% 46,051	4% 95,096	8% 196,372	15% 380,165
Formal Public	50% 10,345	100% 20792	100% 20,896	100% 21,001	100% 21,106
Formal Public Dependents	50% 51,723	100% 103,962	100% 104,482	100% 105,004	100% 105,529
Formal Private	1% 103	2% 209	4% 422	8% 853	15% 1,615
Formal Private Dependents	1% 517	2% 1,045	4% 2,110	8% 4,263	15% 8,073
Non-vulnerable	1% 11,957	2% 24,788	4% 51,381	8% 106,491	15% 206,896
Total Coverage Rate Total Coverage Population	5% 232,084	10% 529,318	16% 818,916	22% 1,201,895	31% 1,728,621

Source: Author's Modelling from Kebbi Bureau of Statistics

5.2 Resources Available to KBSCHCS

Kebbi State Government is currently in the process of formally establishing the Kebbi State Contributory Health Care Scheme through Legislation (update: passed July 2018). 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 (Table 2) 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 possibly 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 (Table 2). 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.

Local Government Equity Fund: In order to expand more budgetary space for KBSCHS, LGAs are being encouraged to emulate what is obtainable at the federal and state level – contribution of not less than 1% of CRF at each level. These funds are not considered in the priority scenarios but rather might be considered to be a recommendation.

5.3 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%)³⁰

5.4 Scenario at ₦ 7,660

Based on population estimates and assumed coverage rates (Table 10)³¹, the liabilities of KBSG are estimated based on the basic health package (including screening and testing), and estimates are summarized by population groups for each year from 2019 to 2023.

Category A: With anticipated support from the NHIS, KBSG plans to fully fund the coverage of the vulnerable groups. These groups are split into two subgroups A1 – informal pregnant women and children under 5, and A2 – informal elderly and the indigent population. Subgroup A1 is regarded as the priority group from NHIS' perspective. Under the assumption of NHIS suggested premium of N7,660 per year, KBSG's liabilities toward coverage of these groups are valued at N983 million (A1) and N223 million (A2) respectively in 2019 at projected coverage rates of 15% for informal pregnant women, 10% for children under 5, 5% for the informal elderly, and 1% for the indigent population. The coverage liabilities for groups A1 and A2 rise to N7.4 billion and N3.2 billion respectively by 2023. At that time, projected coverage rates are 80% for informal pregnant women, 70% for children under 5, 25% for informal elderly group and 15% for the indigent population.

Category B: On behalf of state employees, KBSG's obligation of 50% of premium is valued at N333 million in 2019, rising to N669 million when coverage of the group is fully at 100%. Using these cost estimates as baseline, the cost of the scheme for different premium scenarios are obtainable simply by scaling up or down the implied costs by the relative premium rate.

Table 10: Need by KBCHS Population Categories (Premium at ₦ 7,660)

Categories	2019 (5%)	2020 (10%)	2021 (16%)	2022 (22%)	2023 (31%)
Pregnant Women	220	470	751	1,034	1,334
Children Under 5	763	1,970	3,254	4,620	6,071
Total (A1)	983	2,439	4,005	5,653	7,405
Elderly	52	107	166	229	295
Indigent	171	353	728	1,504	2,912
Total (A2)	223	460	895	1,733	3,207
Total Vulnerable (A1+A2)	1,206	2,899	4,900	7,386	10,612
Formal Public	55	111	112	113	113
Public Dependents	277	557	560	563	566
Total Public (B)	333	669	672	676	679
Non-vulnerable	92	190	394	816	1,585
Total Non-vulnerable (C)	92	190	394	816	1,585
Grand Total (A1+A2+B+ C)	1,630	3,758	5,965	8,878	12,876

³⁰ The details of the benefit packages and their actuarial pricing is provided in appendix I.

³¹ 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).

The analysis and estimates presented to this point provide the estimated total resources available to the KBSG for the 2019-2023 by revenue source and earmarked target if one exists for the revenue source and Estimated total liabilities of the KBSG by population groups for 2019-2023 by coverage targets of 31% of Kebbi State's population at premium level of ₦7,660.

Table 11 summarizes the needs and revenues for each population group assuming a ₦7,660 per person per year premium with 31% coverage by 2023. 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 KBSG will be applicable to the vulnerable groups.

Table 11: Needs and Sources of Contribution for KBCHS at N 7,660 Premium Scenario

Needs by KBCHS Population Categories (Millions)							Sources of Contribution for KBCHS (Millions)					
	5% 2019	10% 2020	16% 2021	22% 2022	31% 2023			2019	2020	2021	2022	2023
Pregnant Women	220	470	751	1,034	1,334	↔	NHIS Contribution & State Equity Fund					
Children Under 5	763	1,970	3,254	4,620	6,071	↔	Equity Fund (1% of CRF)	481	503	526	550	576
Total Needs (A1)	983	2,439	4,005	5,653	7,405		Others	0	0	0	0	0
Elderly	52	107	166	229	295		Sub Total (A)	481	503	526	550	576
Indigent	171	353	728	1,504	2,912		NHIS Contribution from BHCPF (BHCPF/ 37states)	855	950	1058	1177	1309
Total Needs (A2)	223	460	895	1,733	3,207		Grand Total	1,336	1,454	1,584	1,727	1,885
							NHIS & State Equity Funds	1,336	1,454	1,584	1,727	1,885
Vulnerable group (A1 + A2 + A3)	1,206	2,899	4,900	7,386	10,612		Public Sector (State & LGA/LCD) Contributions					
Formal Public	79	159	160	161	162		Government contribution of employee's salary/wages	0	0	0	0	0
Public dependent	396	796	800	804	808	↔	Employee's contribution of basic salary	0	0	0	0	0
						↔						
						↔						
Total Needs (B)	475	956	960	965	970		Total	0	0	0	0	0
Non-vulnerable	92	190	394	816	1,585							
Total (C)	92	190	394	816	1,585							
GrandTotal (A1+A2+B+C)				1,773	4,045	6,253		9,167	13,167			

As illustrated in figure 12, the period during which inflows are sufficient to cover outflows of core priority group – pregnant women and children under 5 – is limited to only 2019. Total estimated liability of N475 million in 2019 by public formal and dependents remains unfunded as there is currently no earmarked funding to pay for coverage of public employees. Instead, funding depends on contributions from both government and employees. To this end, employers and employees for both public and organized private sector are expected to contribute salary deductions or its equivalence to receive coverage under the basic package adopted by KBSCHS.

Figure 12: Gap Analysis @ ₦ 7,660/yr. with 1% CRF & NHIS Contribution (Millions)

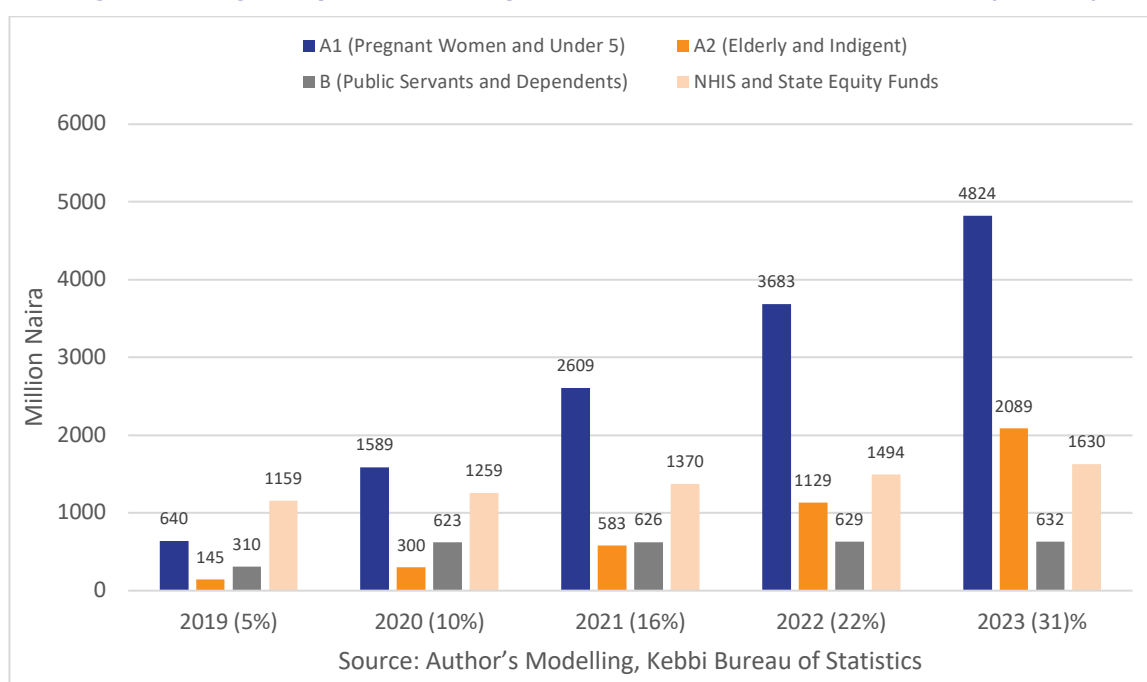


Table 11 presents estimates of the funding and expenses related to public formal sector of enrollees. Based on the assumption of 50:50 share³² of employees' premium payments between the government and employees respectively, the figures imply effective deductions of 8.4% of basic salaries, with government paying 4.2% while employees are responsible for the remaining 4.2%.

Table 12: Financing Dynamics for Public Formal & Dependents

Needs @ ₦ 7,660 Premium	2019
Health Insurance Spending (Millions)	951
Total Basic Salary (State) per year (Millions)	11,306
50% share of Employer Contribution (Millions)	475
50% share of Employee Contribution (Millions)	475
Equivalent % of Basic Salary across all levels	8.4%
50% share of Employer Contribution (% of Basic salary)	4.2%
50% share of Employee Contribution (% of Basic salary)	4.2%

Source: Ministry of Finance, Author's Estimate

5.5 Sensitivity Analysis

³² This ratio was suggested by the respondents during the in-depth interview. Hence, it is not yet a fixed rate at the state level.

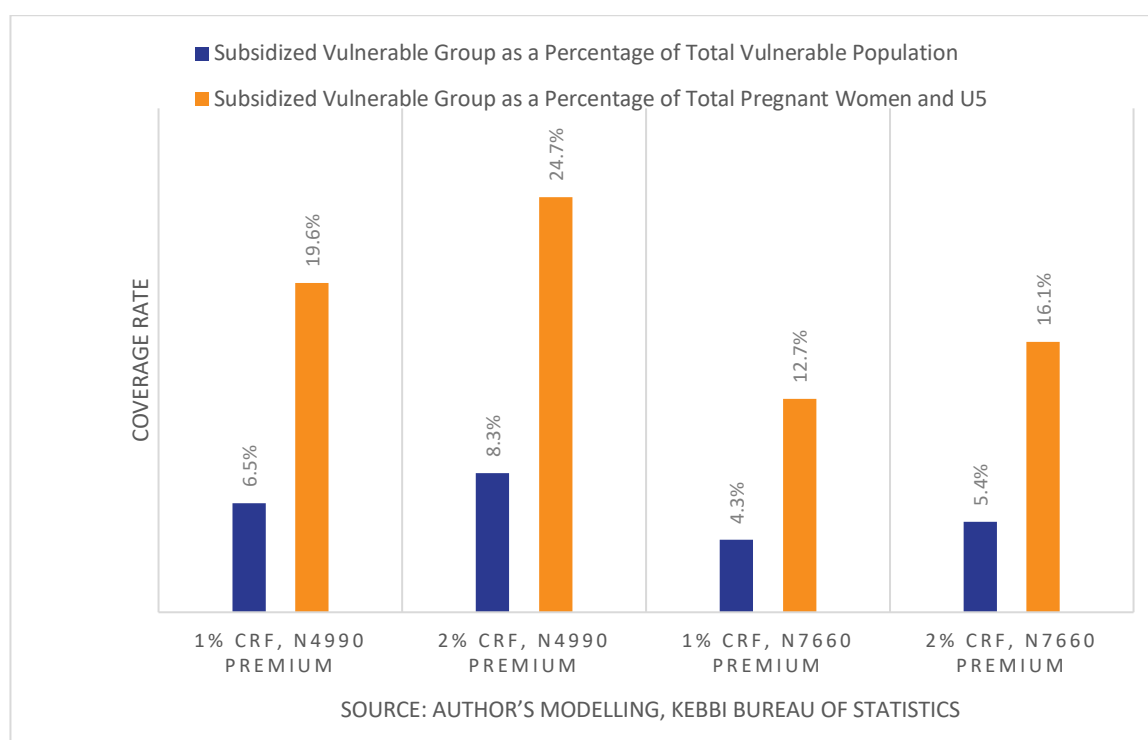
We examine the possibility of KBSG increasing its commitment to equity fund to 2% of CRF and compare resources available with the needs for coverage of the vulnerable population groups.

Table 13: Sensitivity Analysis for Year 2019 at Different Premium Cost Scenarios

Kebbi State FSA	1% CRF, N4,990 Premium	2% CRF, N4,990 Premium	1% CRF, N7,660 Premium	2% CRF, N7,660 Premium
Number of vulnerable population that can be subsidized with potential resources available	267,743	364,177	174,418	237,238
Number of Children under 5 and Pregnant Women (PwCU5) only	972,351	972,351	972,351	972,351
Subsidized Vulnerable Groups as a % of Total Vulnerable Population	9.6%	13.0%	6.2%	8.5%
Subsidized PwCU5 as a % of Total Pregnant Women & U5	27.5%	37.5%	17.9%	24.4%
Subsidized Vulnerable Groups as a % of Total Population	6.90%	9.38%	4.49%	6.11%
Vulnerable Population as a share of the Total Population	72.0%	72.0%	72.0%	72.0%

An increase of Equity fund to 2% of CRF will raise the coverage of the core priority groups (informal pregnant women and children under 5) from 27.5% to 37.5% in the scenario with premium of N 4,990 per annum. Similarly, the coverage is extended from 17.9% to 24.4% in the scenario with premium of N 7,660 (Table 11, Figure 13). Inclusion of more categories of the vulnerable population group (the elderly and the indigent) will reduce these coverage rates significantly.

Figure 13: Sensitivity Analysis for Subsidizing Vulnerable Population 2019



5.5 Fiscal Analysis of KBSCHS Solvency Condition

Table 14 examines the solvency of the scheme under the two equity fund scenarios. It shows that in the scenario for *vulnerable populations*, earmarking of 2% of Consolidated Revenue Fund (CRF) cuts the deficits substantially and raises the duration of solvency the scheme until 2020, compared to the scenario of 1% CRF in which the scheme is solvent almost at take-off and runs into huge cumulative deficit in 2020. In the scenario for *pregnant women and children under 5 populations*, earmarking of 2% of CRF merely reduces the deficits in 2020, compared with earmarking of 1% of CRF.

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. Earmarking of 3% of Consolidated Revenue Fund may not be feasible due to pressure from needs of other sectors. Of course, the solvency challenges will be less daunting under the scenario with premium of ₦ 4,990³³. However, this comes with a price to pay by the citizens, as premium of ₦ 4,990 does not cover the fees for important laboratory tests.

³³ Scenario and funding gap analysis at a premium of ₦ 4,990 is presented in appendix 2 to 5

Table 14: Funding Gap Analysis at 1% and 2% State CRF and ₦ 7,660 Premium

Cumulative Funding Gap		984	-175	-2,516	-6,106
Year	2019	2020	2021	2022	2023
Scenario 1: Vulnerable Populations - 1% State CRF + NHIS @ ₦ 7,660 Premium per annum					
Potential Resources Available	1,336	1,454	1,584	1,727	1,885
Vulnerable Population Resource Needs	972	2,346	3,960	5,954	8,522
Gap	364	-891	-2,376	-4,227	-6,638
Cumulative Funding Gap		-527	-2,903	-7,129	-13,767
Scenario 2: Vulnerable Populations - 2% State CRF + NHIS @ ₦ 7,660 Premium per annum					
Potential Resources Available	1,817	1,957	2,111	2,278	2,461
Vulnerable Population Resource Needs	972	2,346	3,960	5,954	8,522
Gap	846	-388	-1,849	-3,676	-6,062
Cumulative Funding Gap		457	-1,392	-5,068	-11,130
Scenario 3: Pregnant women and Children U5 - 1% State CRF + NHIS @ ₦ 7,660 Premium per annum					
Potential Resources Available	1,336	1,454	1,584	1,727	1,885
Pregnant women and children U5 Resource Needs	800	1,991	3,270	4,618	6,050
Gap	536	-537	-1,686	-2,891	-4,166
Cumulative Funding Gap		0	-1,686	-4,577	-8,743
Scenario 4: Pregnant women and children U5 - 2% State CRF + NHIS @ ₦ 7,660 Premium per annum					
Potential Resources Available	1,817	1,957	2,111	2,278	2,461
Pregnant women and children U5 Resource Needs	800	1,991	3,270	4,618	6,050
Gap	1,017	-33	-1,159	-2,340	-3,590



6. POLICY DISCUSSION

Kebbi State is fiscally constrained in terms of ability to increase health expenditure owing to weakening capacity to generate IGR and increasing debt service deductions. Increased dependence on FAAC allocations and the normal budgetary process to fund its obligations will imperil sustainable financing of its liabilities under KBCHS due to the volatility of earnings from the market for crude oil which is the principal source of federal revenues. Kebbi is currently servicing its domestic public debt but an increase in personnel and overhead costs may suffer on the long run if adequate measures are not put in place. The KSG needs to institute measures to strengthen revenue collection and create conducive atmosphere for private sector in order to both widen and diversify its earning base. There is need to focus on expanding the tax base to include nonpayers such as lake rice investments, farmers (rice, onions, guinea corn, etc.) and import duties from fabric as well as increasing contribution rates from existing corporations.

Ministry of Health and its MDAs need to sensitize and educate program officers on how to explore and utilize approved budget allocations. Low budget performance is one of the metrics by Ministry of Budget and Economic Planning for reducing budgetary allocations to sectors in the state including health sector. There were instances where health sector budget was reduced as a result of low implementation performance.

While it is hard to expect potential increase in fiscal space for KBCHS through the ordinary and general budgetary processes, earmarking a percentage of consolidated revenue fund was explored from 1% to 3%. KSG needs to decide which scenario is feasible within the context of fiscal space and addressing the inequity. An increase in internally generated revenue would invariably increase funding available to the health sector.

Local Government Areas are being encouraged to emulate what is obtainable at the federal and state level. Thus, more resources are needed to guarantee solvency of the scheme into the medium-to-long term. Thus, more resources are needed to guarantee solvency of the scheme into the medium-to-long term.

We have considered the basic package costed at a premium of ₦ 7,660 per annum per person. By the time the actuarial costing of the basic package is completed, there has to be a revaluation of the liabilities and funding options available to KBSG in ensuring that the vulnerable population groups can receive coverage to access the basic health services they require. In line with the goals of UHC, a successful take-off and sustainable financing of the contributory health scheme is imperative.

The priority groups, which represent the primary focus of KBSG's commitment to the BSCHS, represent 72% of the state population. This extremely high burden of vulnerability demands enormous resource commitments. 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 coverage of about 200,000 vulnerable persons under the ₦ 7,660 premium scenario. 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.

7. RECOMMENDATIONS

7.1 Raising IGR

- The state should aggressively pursue an internal revenue generation drive by implementing the proposals of the revenue generating MDAs currently at State Ministry of Justice. The proposed initiatives have potential to double the current IGR which is estimated at N4.3 billion in 2017.
- Increasing IGR to the proposed target of N10 billion will support expansion of coverage of the vulnerable population groups and sustain other government initiatives. It further has positive fiscal implication for KBSCHS by providing health coverage for additional 10,000 vulnerable individuals.
- Kebbi state needs to focus on expanding the tax base to include nonpayers such as Lake Rice Investments, farmers (Rice, Onions, Guinea corn, etc) and import duties from fabric as well as increasing the very low contribution rates from existing corporations.
- KBSG 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.
- The State's Internal Revenue Service needs to embark on aggressive posture in mobilizing revenue in the state.
- All sources of revenue leakage should be eliminated by employing technology in tax collection, generation of receipts, etc
- Taxpayers should be given adequate Enlightenment and education. Kebbi State IRS requested the Governor to lead the awareness creation.
- Investors in Kebbi State should be supported as this will increase the internally Generated revenue of the state as well as ensuring compliance to tax payment including the existing Lake Rice Investment.
- Up to date report should be generated showing revenue distribution by revenue types and revenue agency.

7.2 Reprioritization of Health

- The state needs to place the health sector and its funding as top priorities in its finance and planning activities in addition to pursuing efficiency gains.
- Ministry of Health and its MDAs need to sensitize and educate program officers to explore and utilize approved budget allocations. Low budget performance is one of the metrics by Ministry of Budget and Economic Planning for reducing budget allocations in the state including health sector. There were instances where health sector budget was reduced as a result of low performance.
- KBSG should consider 15% budget allocation and at least 15% expenditure share to health out of total government expenditure which will increase the fiscal room of the health sector.
- Budgeting for health should be sensitive to population growth as it will help to alleviate the widening

of existing gaps.

7.3 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.*
- Create a budget line for the provisions of Government contribution to KBSCHS on behalf of the public-sector employees.
- Consider LGAs creating an equity fund equivalent to at least 1% of LG CRF
- Consider a percentage of funds for disabled and other vulnerables, assuming 20%, that accrue to Kebbi State Social Security Welfare Fund and Zakat Committee.

7.4 External Funding

- KBSG should creatively coordinate donor funds by proactive engagement of bilateral and multilateral donors for assistance
- KBSG needs to strengthening Development Partners Forum under the chairmanship of Deputy Governor as well as revive and strengthening the Steering Committee on Counterpart Fund under the chairmanship of Commissioner of Finance. Recommend a specific proportion of Donor funds to be applied toward the health insurance fund.

7.5 Efficiency Gains

- Demonstrating commitment towards ensuring increased budget performance for capital expenditure relative to recurrent expenditures
- Reducing excessive expenditures on wages and salaries to free up resources for other health activities.
- Addressing health worker absenteeism
- Ensuring that most Kebbi State health sector financing is allocated to highest causes of deaths
- Delivering more services at the lower levels of care and implementing a sound referral system.



BOLD THINKERS DRIVING
REAL-WORLD IMPACT