Setting the Social Minimum through a Tax for Service Programme

An analysis of the perceptions of informal sector workers to pay taxes in exchange for free minimum basic healthcare in Nigeria.

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Email: info@ngf.org.ng
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About NGF

The Nigeria Governors' Forum (NGF) was established in 1999 as a non-profit, non-partisan association of the 36 democratically elected governors of Nigeria. Its vision is to actively and effectively promote inclusiveness, democratic values, good governance and sustainable development at the sub-national level. By virtue of its mandate, the Forum has evolved to become a veritable platform to leverage the potentials inherent in Nigerian States to address critical sub-national and national challenges.

Activities of the Forum are driven by an administrative and technical arm – the NGF Secretariat – a policy hub which gives direction and meaning to the Forum by effectively engaging with partners and stakeholders. The Secretariat is also the Forum's resource centre, as it provides reliable and current information in relevant areas of public policy.

Since its establishment, NGF has continued to enhance collaboration on governance and development amongst all State governors in Nigeria, and with other arms of government, the development community and the larger political system. By remaining non-partisan, it represents the collective interest of the 36 State governments of the federation.

Director General: Asishana Okauru, Esq

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This report is the outcome of a year-long research which took place between March 2020 and March 2021. The project was created as a long-term strategy to drive a stronger integration between the economic and health workstreams of the Nigeria Governors' Forum Secretariat.

The work was prepared by an NGF team led by David Nabena (Senior Economist). The team included Ahmad Abdulwahab (Senior Health Adviser), Olanrewaju Ajogbasile, (Senior Programme Manager, HelpDesk), Zubaida Abiola (Senior Programme Associate, HelpDesk), Abdulazeez Olorunshola (Economist), Chinekwu Oreh (Health Specialist), Olubunmi Akanbi (Senior Researcher) and Marvellous Olatunji (Researcher).

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All errors and omissions are the responsibility of the authors.

For questions about this report please email dnabena@ngf.org.ng

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Content

List of Figures

List of Tables

List of Boxes

Abbreviations and Acronyms

BOI	Bank of Industry Limited
COVID-19	Coronavirus Disease 2019
CBHI	Community-Based Health Insurance
DMAs	Drug Management Agencies
EA	Enumeration Areas
GDP	Gross Domestic Product
GPS	Global Positioning System
HFs	Health Facilities
HMBs	Health Management Boards
IDIs	In-Depth Interviews
IRS	Internal Revenue Service
NESG	Nigeria Economic Summit Group
NHIS	National Health Insurance Scheme
NGF	Nigeria Governors' Forum
OOPs	Out-of-Pocket Payments
PPMV	Patent and Proprietary Medicine Vendors
SDMA	State Drug Management Agency
SHIA	State Health Insurance Agency
SHMB	State Hospital Management Board
SIRS	State Internal Revenue Service
SMoF	State Ministry of Finance
SMoH	State Ministry of Health
SPHCDA	State Primary Healthcare Development Agency
TfS	Tax for Service
UHC	Universal Health Coverage
VAT	Value Added Tax

Introduction

The Nigerian economy has continued to record what is termed fiscal disequilibrium,[1] much of it attributable to five (5) key headwinds: oil boom and busts, a price inelastic tax system, poor public enterprise performance, increased expenditure created by political exigencies or administrative weaknesses, and worsening terms of trade. The country's public financial management system and to a large extent, the general financial system has been unable to cope with fluctuations in oil revenues.[2,3]

Since 2015, governments at both the federal and State level have continued to stir fiscal restructuring to shore up public finances and find alternative sources of revenue, amidst economic indications that many of them did not do enough to reduce their dependence on oil. During the time, the cost of crude had fallen to levels not seen for 14 years. The impact was devastating and became the third largest over the previous 30 years, when oil began trading in the futures exchange.

Five years later, in 2020, the COVID-19 pandemic also gave way for greater concerns about the government's capacity to cope with another fiscal crisis. For the majority of Nigerians, the health risks brought by the pandemic ranked behind multiple, complex, and larger structural concerns such as economic uncertainty, absence of social safety nets and the lack of an enforceable social contract between the government and citizens. In May 2020, majority of Nigerians reported that although they were concerned about the health threat to their households, they were more worried about the secondary-level effects including the impact on their financial future.[4] The pandemic had disrupted employment, income-generating activities, access to food, healthcare, and education - and with wider impact on the country's ailing human development indices.

Across the world, oil-exporting and tourist destination countries felt the highest economic impact of the COVID-19 pandemic,[5] but it was more prominent in countries that lacked well-designed and targeted social safety nets.[6] In fact,

decades of debate about the feasibility and effectiveness of unconditional (non-contribution based) cash transfers were brought to a temporary standstill as a global concession was forced by the unprecedented financial hardship brought on by the pandemic.

The pandemic has shone greater light on the vulnerabilities of citizens and the lack of protection and safety nets for many Nigerians. By the end of 2020, the number of unemployed persons in the country reached 33.3%[7] up from a pre-pandemic level of 23%. Inflation also hit a 4-year high of 18.12% in April 2021.[8] The World Bank estimates that the crisis pushed 7 million more Nigerians into poverty in 2020 from 2 million estimated pre-pandemic, placing the national poverty estimate at 42.5% of the population.[9]

The country took a swift response[a] after it recorded its first case of the virus in February 2020, but the rapidly changing environment will require greater collective action to secure the long-term resilience of the health sector side by side an effective drive for revenue mobilisation and fiscal sustainability.

While the impact of the pandemic is severe on many fronts, it provides an opportunity to build back better by creating political economy conditions within which sound leadership can push for a better and more tangible government-citizen relationship. The roll-out of a well-designed Tax-for-Service programme, could be at the heart of a new recovery that satisfies both social demands and political needs. No doubt, this requires building government legitimacy and trust.

The ailing fiscal social contract between governments and citizens remains a key concern. Independent surveys conducted by the Nigeria Economic Summit Group (NESG)[10] in 2018 and the Nigeria Governors' Forum (NGF) Secretariat in 2019 demonstrate that the majority of Nigerians are dissatisfied with the provision of essential social services, and this has strongly contributed to a low tax morale in the country. Low public trust and dissatisfaction with government services are the biggest risks to taxation in the country.[11] The 2018 NESG tax perception survey which covered 10,000 households and over 5,000 small enterprises in Nigeria showed that a fifth of taxpayers believe it is not wrong not to pay taxes, while more than half believe it is wrong but justified not to pay taxes.

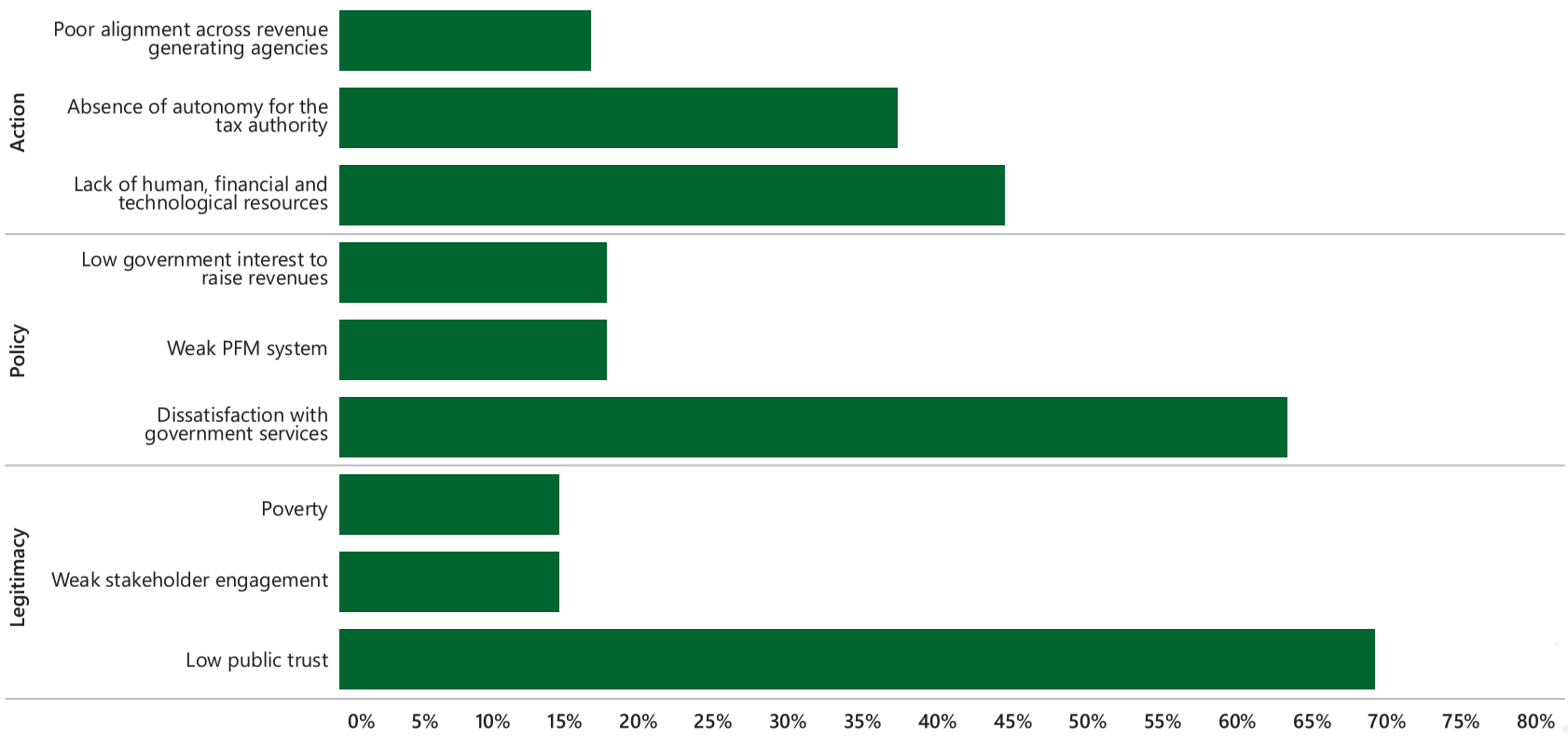
[a] When the number of cases in Nigeria rose to eight on 18 March, authorities banned people arriving from countries with more than 1,000 cases, including China, Italy and the United States. On 30th March, a two-week lockdown was declared in three major states - Lagos, Abuja and Ogun, domestic travel was largely banned, and most businesses were closed.

Most are however willing to be compliant or pay more when quality services are guaranteed by the government, especially social services including education, health, water supply, and new and improved streets.

Results from the NGF survey carried out with the participation of over 50 high-level State officials, including Commissioners of Finance and Executive Chairmen of the Internal Revenue Service (IRS) of States showed that public dissatisfaction with government services outweigh other challenges such as lack of human, financial and technological resources for tax authorities (figure 1.1). These risks continue to weaken governments' legitimacy and capacity to collect taxes.

The COVID-19 pandemic has reinforced the need to radically improve redistributive measures such as taxes and transfers, as well as what is termed "predistributive" measures that will bring about additional funding for health and measures to improve the efficiency of health services.

Figure 1.1: Risks of Taxation



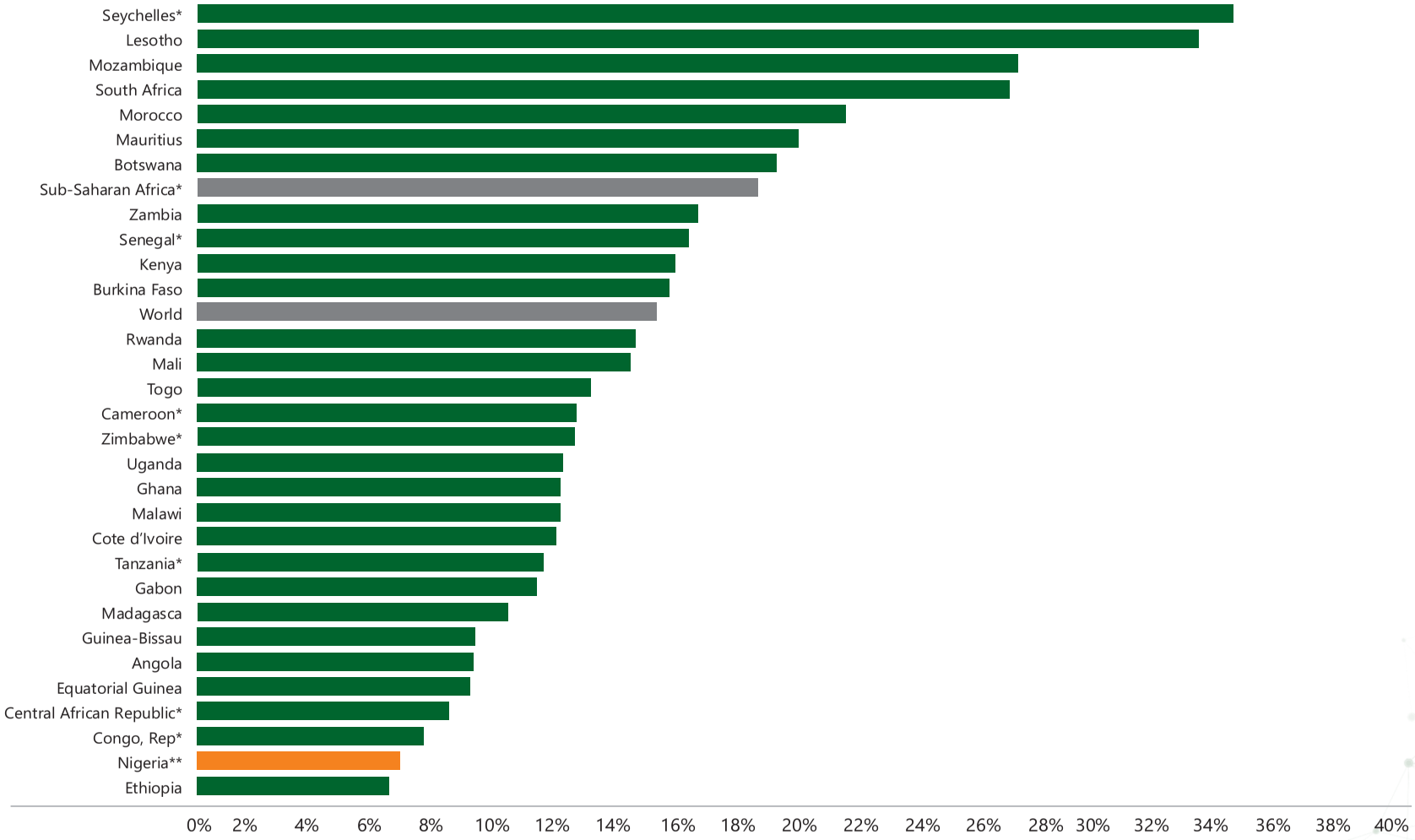
Source: Nigeria Governors' Forum, 2019

Over time, the vicious cycle of poor government services and the public's willingness to evade taxes has depressed tax revenues and in turn limited governments' capacity to provide quality services. Taxes levied as compulsory transfers to the central, state and local governments for public purposes are less than 7%[b] of the country's GDP compared to 18.6% in the sub-Saharan Africa[12] (figure 1.2).

At the State level, the size of domestic revenue growth recorded in recent times provides compelling evidence of the gap between the tax effort and potential of States, and the expansive room for revenue mobilisation. Raising the tax to GDP ratio of States from an average of less than 2% currently to at least 5% will lead to additional revenues for each State government, ranging between N50 billion – N240 billion (including value added taxes) annually .

[b] Certain compulsory transfers such as fines, penalties, and most social security contributions are excluded.

Figure 1.2 : Tax revenue (% of GDP), African Countries



Source: World Bank (2021), latest data as at 2019, *2018, **government estimate

1.1 Report Structure

This report is structured into four (4) sections:

I. Section 1 provides the context and case for the TfS, a short systematic review and defines the scope and methodological approach

II. Section 2 presents a meta-analysis from the survey conducted successfully with 1,000 respondents from the 12 representatives States (i.e., 12,000 across the 12 states), covering the 6 geopolitical zones of Nigeria. The objective is to present a country report using cross-data analysis.

III. Section 3 presents the results from the in-depth interviews (IDIs) and discusses the preparedness of the implementing institutions to take up the programme.

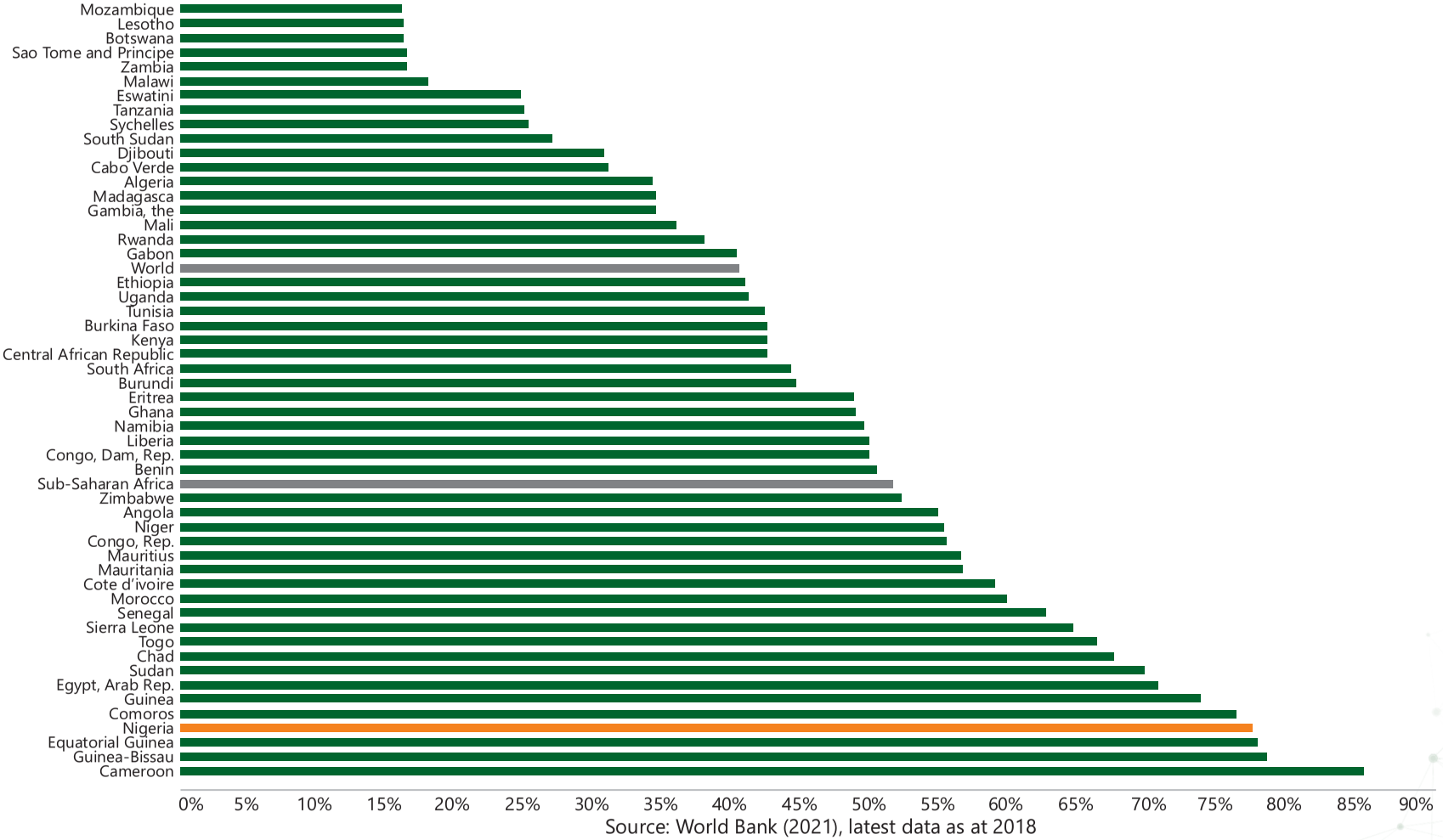
IV. Section 4 concludes by outlining key findings of the report to help State governments and other stakeholders implement the programme.

1.2 Case for the Tax for Service Model

In a developmental context, the revenue generation policy and universal health coverage (UHC) are both critical concerns and priorities for Nigeria. With less than 5% of the population covered by any form of prepayment mechanism for healthcare, moving towards a predominant reliance on public funding for health services is a priority for the government to achieve UHC.

Out of pocket household spending as well as funds from companies and non-profit organisations are daunting, either prepaid to voluntary health insurance or paid directly to healthcare providers. Domestic private health spending (% of current health expenditure) was 77.3% compared to an average of 51.4% in the Sub-Saharan Africa region and the global average of 40.3% (figure 1.3). High out-of-pocket payments (OOPs) for health have been proved to be highly regressive and a major barrier to seeking treatment for many.[13,14,15] In fact, many households ultimately forgo care or face serious financial difficulties when countries rely predominantly on private sources. Out-of-pocket health payments exceeding 40% of a household's non-subsistence spending have been termed catastrophic expenditure.[16] Where OOPs represented less than 15-20% of total national expenditure, the catastrophic health expenditure and impoverishment are low.

Figure 1.3 : Domestic private health expenditure (% of current health expenditure), African countries

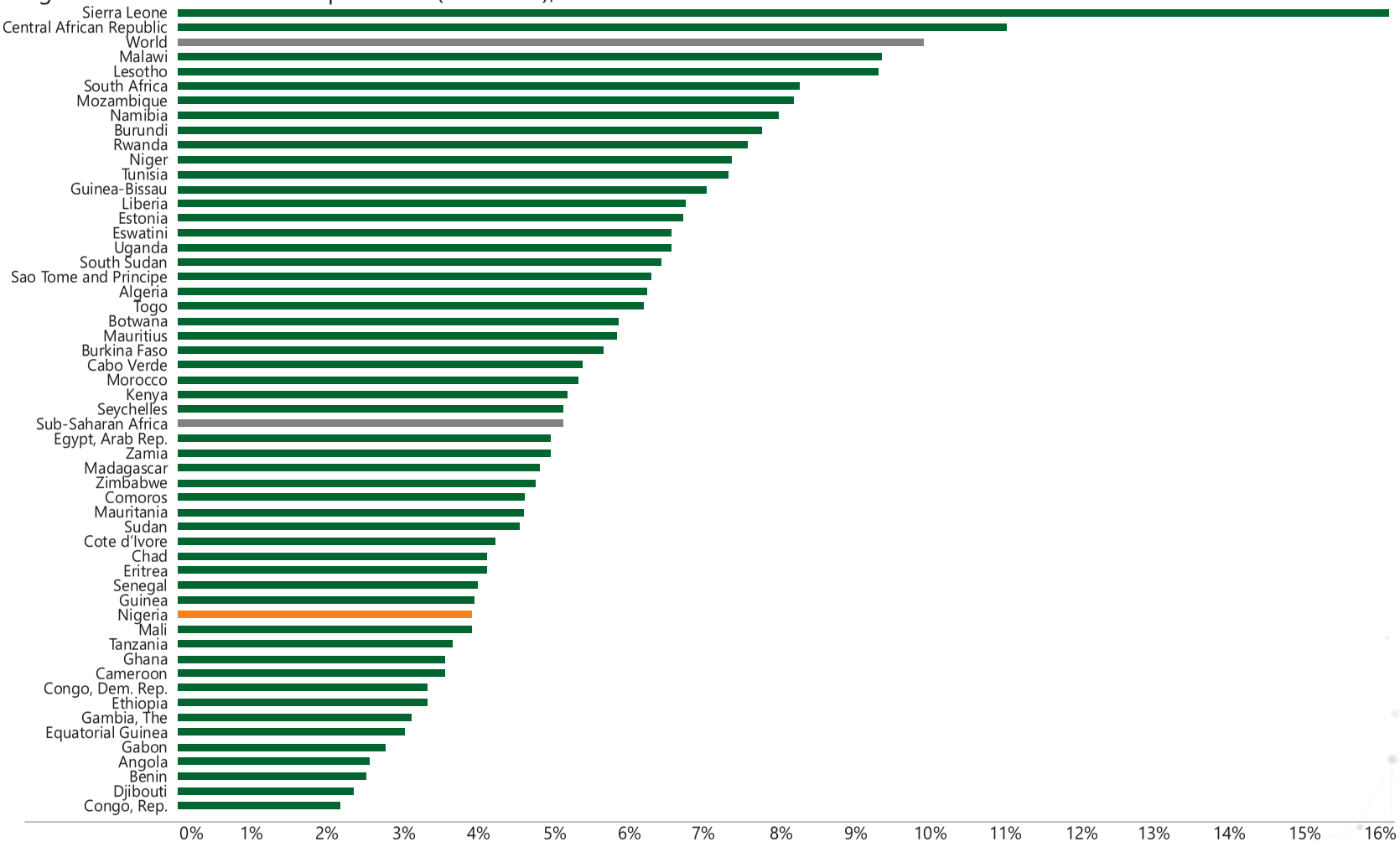


Source: World Bank (2021), latest data as at 2018

The other key funding source - government general expenditure on health - is also low. Nigeria's current health expenditure (% of GDP) is 3.9% compared to the sub-Saharan Africa average of 5.1% and the global average of 9.9% (figure 1.4). Although there is no set formula, empirical data estimate at least 5-6% of GDP and at least 15% of total government expenditure as the threshold where fewer households face financial difficulties in paying for health services.[17,18] These findings maintain a complementary message that high OOPs and low government health spending increases households' financial risk, levels of impoverishment and the extent of poverty.

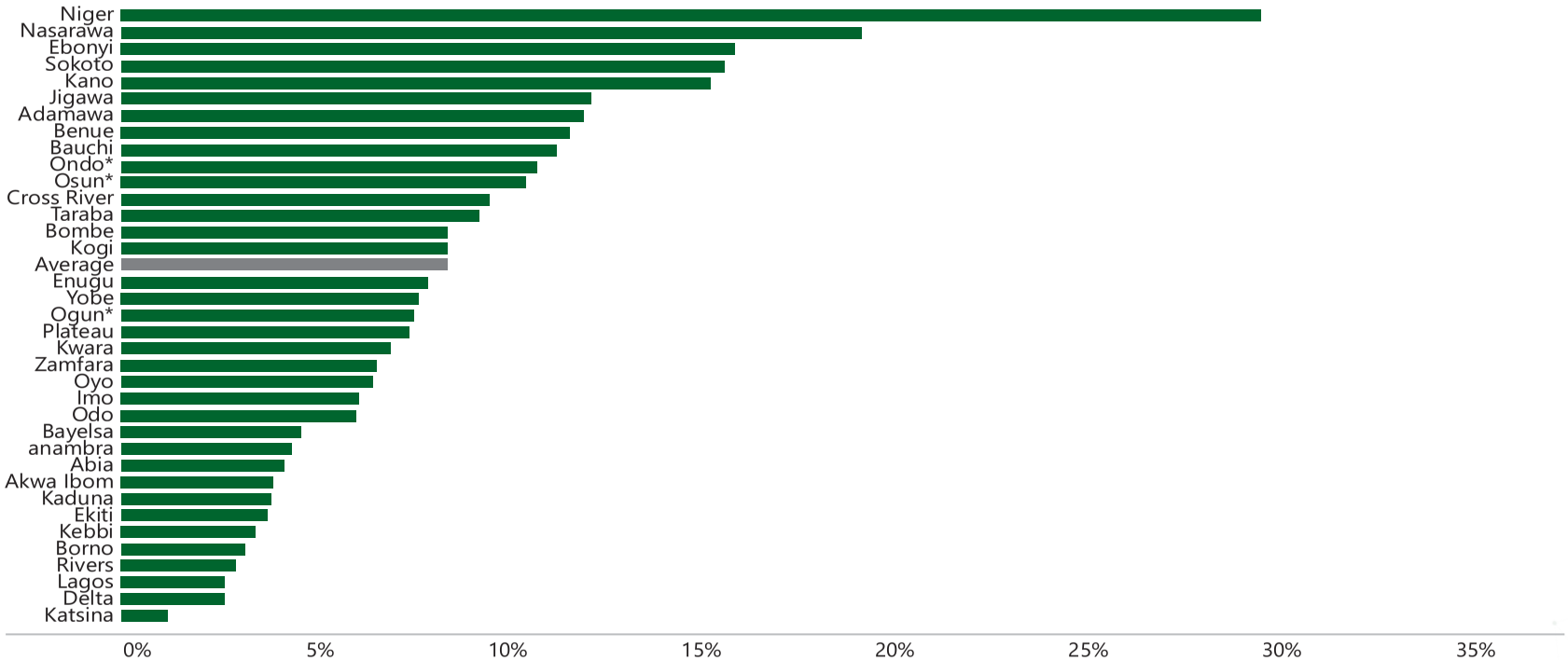
At the state-level, the level of financial mobilization for healthcare varies widely and depends on the roles governments play in health care provision, including the provision of critical health infrastructure, human resources for health, and other financing initiatives such as conditional cash transfers, free health care for vulnerable groups, health insurance for the formal sector, and community-based health insurance (CBHI) schemes for the informal sector. In 2020, government health spending (% of total expenditure) varied from as high as 29.5% in Niger State to an average of 8.5% for the 36 States of the federation (figure 1.5).

Figure 1.4 : Current health expenditure (% of GDP), African countries



Source: World Bank (2021), latest data as at 2018

Figure 1.5: Health expenditure (% of total expenditure)



Source: NGF estimates from the 2020 audited financial statements of States. Data as at 2020, *2019.

Note: Actual spending by the State ministries of health

A recent study[19] on the effects of five pandemics between 2003 and 2016 finds that on average, income inequality in affected countries increases steadily over the five years following each event, with the effect being higher when the crisis led to a contraction in economic activity, as is the case with COVID-19. The study suggests that the COVID-19 pandemic could have similar distributional consequences unless government policies are more responsive.

At the basis of a post-oil and post-COVID social contract lies the provision of tangible government services to citizens in exchange for the payment of their income tax. The Tax for Service (TfS) model is designed to reward compliant taxpayers in the informal sector with a minimum health package.[c] The initiative will lead to improved healthcare delivery and quality of life for more Nigerians; and will help fund the pre-existing state of health care and health inequalities especially among the poor, by providing greater access to those who have been disproportionately left out and in locations where health services are not guaranteed.

The Nigeria Governors Forum Secretariat has a mandate to strengthen the capacity of state governments to sustainably raise tax revenues and social financing.

The Nigeria Governors' Forum (NGF) Secretariat is playing an active role in mainstreaming the programme by advocating for the implementation of the TfS programme across States and securing the commitment of governors to mobilise resources to support different components of the model.

This report presents the key findings from an informal sector household survey. This baseline survey assesses tax compliance and health care needs of informal sector workers and analyses the willingness of these citizens to pay taxes in exchange for services related to primary healthcare. It also investigated perceptions about trust in government and their preferences in the design and implementation of the programme.

1.3 Systematic Review

The literature describes the provision of health care or health insurance, to some significant degree, at the public's expense, through taxes or regulations, as a

[c]The government may choose to provide other basic services in addition to or in place of a free minimum health care service, such as affordable and reliable financial services, agricultural services, or other benefit schemes to build the security and prosperity of families and communities.

social insurance programme.[20,21] Indeed, many countries that have moved closer to the attainment of universal health coverage started with small and scalable voluntary health insurance schemes that gradually grew into compulsory social insurance and higher levels of financial risk protection for a large pool of people[21]. The Students' Health Home insurance scheme started as early as 1952 in West Bengal while other schemes emerged in several western African countries, including Benin, Guinea, Mali, Senegal since the 1980s.[22,23,24,25]

Following the push for universal health coverage since the start of the 21st century, policy makers slowly rejected the fragmented array of these voluntary schemes, recognizing that a large proportion of the people who remain uncovered were in informal employment and many were too poor to contribute insurance payments;[26] although in many health financing systems, hybridization still exists, with the collection, pooling and expenditure of resources relying on a mix of mechanisms.[21] These insurance schemes are generally characterized by independent or quasi-independent funds, a reliance on mandatory earmarked payroll contributions, and a clear link between the contributions and a defined benefits package.[27] In practice, governments are more capable of managing compulsory insurance in the formal sector, with limited avenues to cross-subsidise the non-formal sector.[28] This is a bigger challenge in developing countries where most employment is informal.

One of the most comprehensive systematic reviews on the impact of such health insurance programmes for the informal sector and the poor in low- and middle-income countries was conducted by Acharya, Arnab, et al. (2012).[28] Their findings show mixed results for enrollment, utilization and outcome – for example, high enrolment is not always correlated with better outcomes, although there was evidence that health insurance prevents high levels of expenditure, especially in low-income countries.[29] The study provided evidence from 34 studies undertaken to measure the impact of nationally or sub-nationally implemented health insurance schemes for the poor or informal workers. All the insurance schemes reviewed had a capitation and a well-defined benefits package, except in Vietnam where it was completely free.

Positively, countries such as Senegal,[30] Tanzania[31] and Mali,[32] which offer forms of community-based insurance schemes recorded higher utilization of care and better financial protection among those insured compared with the non-insured. In Ghana, the National Insurance Scheme was seen to have verifiable positive outcomes, including that woman who are enrolled are more likely to receive

higher levels of prenatal care and preventive check-ups, with recorded decrease in infant deaths and fewer birth complications.[33]

There was also emphasis on the impact of non-financial barriers to accessing healthcare, including awareness, level of education, distance to health facilities and the attitude of doctors which impact healthcare access and utilisation.[34,35,36] Patterns showed that more educated households are consistently more likely to join, particularly if household members have secondary education and higher as the cases showed in Senegal, Vietnam and Ghana. There were also other studies that revealed a negative relationship between the level education and enrolment – including in Nicaragua,[37] Tanzania[31] and Mexico.[38] Enrolment rates varied by location and programmes, and these determinants have lessons for future insurance policies.[39]

No doubt, these results raise questions of internal and external validity,[40] did it work there? will it work here? Even as important for policy makers in Nigeria, is the question, how can it work here? In this sense, the 'mechanism' or "theory of change" of the policy and the 'context' do matter.[41]

Box 1.1: Findings from a systematic review of the impact of insurance programmes on the poor and informal sector in low- and middle-income countries

Enrolment

1. Gender of the head of the household seems not to matter, although there are some cases in which female-headed households are more likely to join.
2. There is no clear pattern in other demographic variables, although families with young children and families headed by the elderly seem to be more likely to join.
3. More educated households are consistently more likely to join, particularly if household member(s) have secondary or higher education degrees.
4. Participation in an insurance programme is consistently correlated with per capita expenditure: richer households are more likely to join.
5. Initial conditions, such as chronic illnesses, seem not to influence the decision to join.
6. Residence in rural areas and distance from health facilities do not seem to deter households from joining insurance programmes.

Utilisation

1. Evidence on utilisation is mixed. Two countries studies on Georgia and Nicaragua report no higher utilisation among the insured. In China and Vietnam, evidence is mixed for the same state-sponsored large insurance programme when different studies are examined. Two studies report different results for Mexico. Some studies that report higher outpatient care for the insured reported no difference in the use of inpatient care.
2. Overall, CBHI studies report a positive effect of insurance on utilisation more than for extended SHIs; the CBHI studies did not take selection into account more than the SHI studies. The problem of intentional programme placement may be more acute among the CBHIs than for SHIs.

Impact on OOP

1. It is not always the case that insurance is able to reduce OOP expenditure for the insured. The results are highly mixed even for the same insurance scheme. Two large studies in China and Mexico showed a decline in OOP expenditure while others showed mixed results.
2. The result for the poor is more modest when overall OOP expenditure is lower for the insured.
3. When only studies that take selection into account are considered, SHIs report more modest results than CBHIs. This difference persists with CBHIs that do not take selection into account.

Health Outcome

1. Findings were mixed on the impact of health insurance on the health status of the insured.

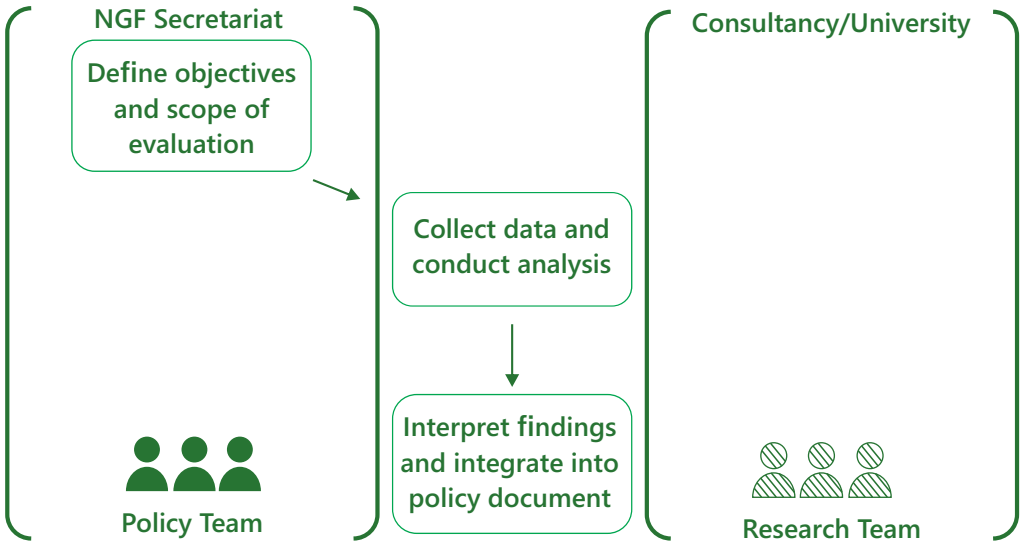
Source: Adapted from Acharya, Arnab, et al. (2012)

1.4 Our methodological approach

This study employed a mixed method approach through the combination of empirical surveys and interviews to collect qualitative data that will adequately contextualise the case for the programme at the State and country level. The mixed method approach capitalizes on the strengths of quantitative and qualitative data to provide compelling evidence on how the policy problem and questions can be addressed.[42,43]

The organisational model for structuring the evaluation followed a partnership model,[44] with the NGF Secretariat team defining the policy research relevance, scope and objectives; the research team conducting the evaluation; and both parties interpreting the key findings.

Figure 1.6 : Research Model



Data collection took place from December 2020 to January 2021. This Tax-for-Service baseline survey included a representative informal household survey as well as in-depth interviews with key stakeholders in the following twelve (12) states:

Table 1.1 : Representative States of the survey

S/N	Geopolitical Zone	Selected States
1	South South	Edo and Delta
2	South East	Anambra and Enugu
3	South West	Ogun and Ekiti
4	North Central	Kwara and Plateau
5	North East	Yobe and Borno
6	North West	Kaduna and Kano

The household survey was conducted successfully with 1000 respondents in each state (i.e., 12,000 in all 12 states). The survey utilized a 40/60 rural/urban split to sufficiently capture the urban population who may have more exposure to both taxation and access to health facilities. This split was later adjusted with weights to make sure that the weight of each household reflected its actual probability of selection in the survey. The survey also employed a 50/50 gender split to ensure equal representation of men and women. References to 'Nigeria' in the analysis are based on data from the representative 12 states randomly selected from the six (6) geopolitical zones in the country.

The methodology was designed to exclusively sample adult citizens (age 18 and above) that are employed informally. The survey team did this by making sure that employed persons within households were not officially registered or did not maintain a complete set of accounts, which could also include workers who held jobs lacking basic social or legal protection and employment benefits. It excluded workers who paid income tax, who were employed by the government or any other formal employer who had an officially registered business or company. The selection of the sample population relied on the definition of informal sector workers by the Bank of Industry Limited (BOI). The informal sector comprises any economic activity or source of income that is not fully regulated by the government and other public authorities; this includes enterprises that are not officially registered and do not maintain a complete set of accounts; and workers who hold jobs lacking basic social or legal protection and employment benefits. [45]

The survey used a multi-stage random selection process. First, there was the random selection of dwelling structure using enumeration areas (EA) that were randomly selected by the National Population Commission of Nigeria, followed by randomly generated GPS coordinates within each EA. Secondly, there was the random selection of households in which the electronic device randomly selected

one household after the enumerator entered all households living in the dwelling structure. And thirdly, there was the random selection of a respondent within that household. Finally, there was a stringent procedure for quality control in which every two enumerators received a dedicated supervisor, and independent 'back-checkers' implemented post-hoc controls.

Besides the household survey, the baseline survey also included in-depth interviews (IDIs) with key stakeholders in each state who consist of policy-makers who are in decision-making positions about the design of the policy or programme, and programme implementers who will be responsible for implementing the programme. These interviews were used to understand their respective positions and measure their institutional readiness for the TfS programme. Interviews were conducted in each state with representatives of the State Ministry of Finance (SMoF), the State Internal Revenue Service (SIRS), the State Ministry of Health (SMoH), the State Health Insurance Agency (SHIA), the State Primary Healthcare Development Agency (SPHCDA), the State Drug Management Agency (SDMA), the State Hospital Management Board (SHMB), and health facilities (HFs).

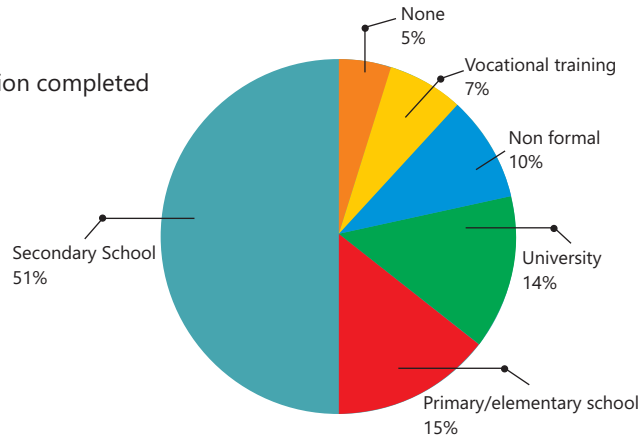
Country Summary

The meta-data analysis was based on respondents' feedback which reached a maximum of 12,088 informal sector workers, including those who refused to answer and those who do not read. To guarantee the delivery of a full and representative dataset, local government areas (LGAs) included a set of additional interviews for quality assurance. Although the number of interviews reached sufficient statistical power, they were still kept in the dataset. Weights were then added to reflect the probability of selection to ensure that no LGA was over-represented.

2.1 State Informal Household Characteristics

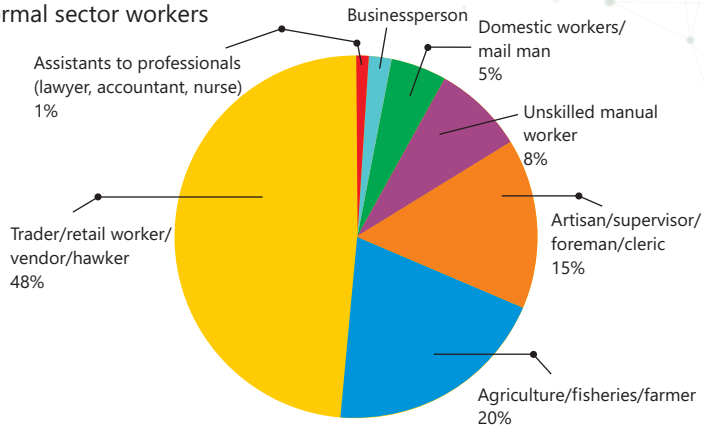
53% of informal sector workers in Nigeria live in households of up to 4 persons, including themselves. 44% of these workers are also heads of their household, indicating how important the informal economic activity is for the livelihood of not just these workers but their households. Informal sector workers in the country are also relatively well-educated (figure 2.1). 51% finished secondary school and an additional 21% received vocational training or a university degree.

Figure 2.1 : Highest level of education completed



48% are employed in the services industry as traders, retail workers or vendors; 20% work in the primary sector as farmers or fishermen; while 16% work as artisans, supervisors, foremen or clerics (figure 2.2).

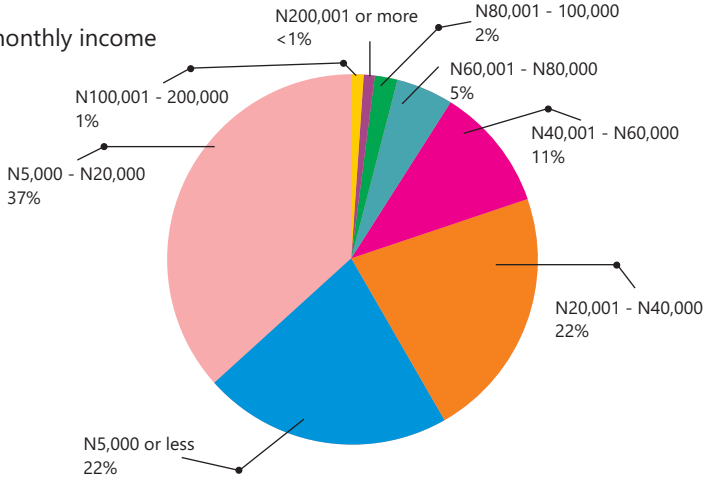
Figure 2.2: Occupation of informal sector workers



Note: Agriculture also includes fishermen; traders also include hawkers, barbers, and tailors; Artisan/skilled labour also include supervisors, foremen, clerical workers and small-scale manufacturers; Assistants to professional includes persons who assist legal aids, accountants, nurses, engineers and teachers.

In terms of their personal incomes, over 50% earn below 20,000 Naira while less than 2% earn above 100,000 Naira (figure 2.3). It should be noted that there may have been some level of underreporting in income levels amongst the respondents. The level of financialization among informal workers is also low, with just 57% of them owning or operating a bank account.

Figure 2.3: Average personal monthly income



Informal sector workers have a relatively modest outlook of their relative living conditions, with about 41% of them who believe they are better off than other people living in the state, and another 25% who believe their living conditions are about the same. These are not surprising results, and it shows that personal feelings of resentment do not appear to be widespread. Importantly, there is a lot of optimism around improving their own living conditions with 83% believing that their living conditions will be better or much better a year after.

Informal workers who work as or assist legal aids, accountants, nurses, engineers and teachers earn on average more than other informal workers. Artisans too, are less frequently earning lower than 5000 Naira per month. Traders and primary sector workers on the other hand have a roughly equal income distribution but earn less than artisans. The lowest earners are domestic workers and unskilled labourers (table 2.1). Somewhat surprisingly though, urban and rural income differences among informal workers are not so significant. While rural informal workers earning below N5,000 per month are a somewhat larger group (24% versus 20%), the urban-rural distribution in other income brackets are roughly the same.

Table 2.1 : Personal income across occupational groups

	< N5,000	N5,001 - N20,000	N20,001 - N40,000	N40,001 - N60,000	N60,001 - N80,000	N80,001 - N100,000	N100,001 - N200,000	> N200,001	**Total**
Do not know	15%	71%	14%	0%	0%	0%	0%	0%	100%
Refuse to answer	0%	0%	53%	0%	23%	23%	0%	0%	100%
Other	9%	23%	16%	9%	22%	22%	0%	0%	100%
Agriculture	23%	34%	21%	12%	5%	2%	2%	1%	100%
Trader/vendor/retail	23%	39%	21%	10%	4%	2%	1%	0%	100%
Domestic worker	29%	47%	16%	5%	2%	0%	0%	1%	100%
Artisan/skilled labour	14%	33%	29%	14%	6%	3%	1%	0%	100%
Unskilled labour	32%	32%	21%	9%	4%	2%	0%	0%	100%
Businessperson	11%	25%	29%	12%	15%	6%	1%	2%	100%
Assistants to Professional	1%	14%	30%	20%	12%	7%	13%	4%	100%
Total	22%	37%	22%	11%	5%	2%	1%	0%	100%

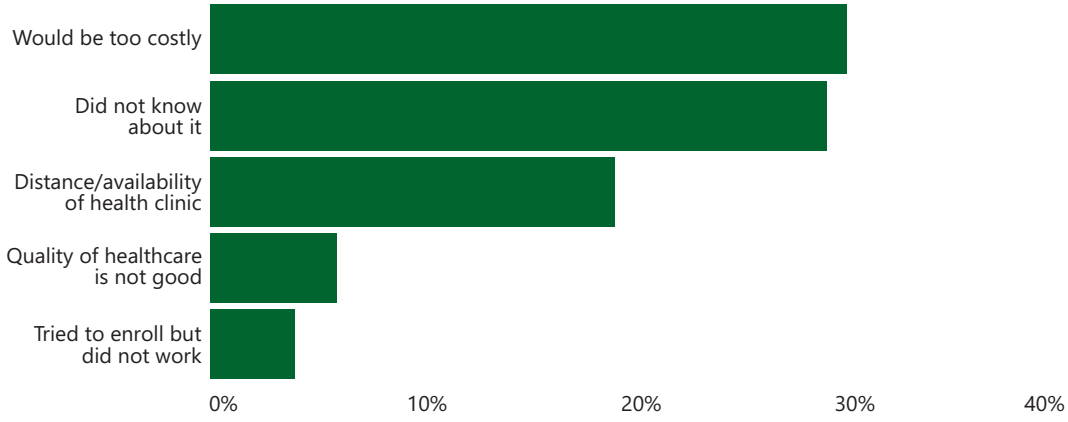
Note: Agriculture also includes fishermen; traders also include hawkers, barbers, and tailors; Artisan/skilled labour also include supervisors, foremen, clerical workers and small-scale manufacturers; Professional includes persons who assist legal aids, accountants, nurses, engineers and teachers.

2.2 Healthcare Needs

Two thirds of informal sector workers in Nigeria have never heard about health insurance, indicating a severe lack of knowledge about the concept of health insurance in the first place. Workers that earn less have heard less about health insurance. While the type of job does not appear to make a big difference, education does. 61% of informal workers that have attained a university degree have heard about health insurance, versus 32% that completed secondary school, 21% that completed primary school and 18% that had no education.

When explained that health insurance is a system in which an individual pays a monthly fee to a health insurance provider who then uses the money to pay for health care in case of illness, only 8% of these workers indicate that they are currently enrolled in such a programme. Respondents indicated three primary reasons for not enrolling in a health insurance programme: that it is too costly (30%), that they did not know about health insurance (29%), and that there is no health facility located close to their area of residence (19%) (figure 2.4). The few informal workers (8% of total respondents) that are enrolled in an insurance programme are either registered with the State Health Insurance Scheme (37%), a private provider (32%) or the National Health Insurance Scheme (28%).

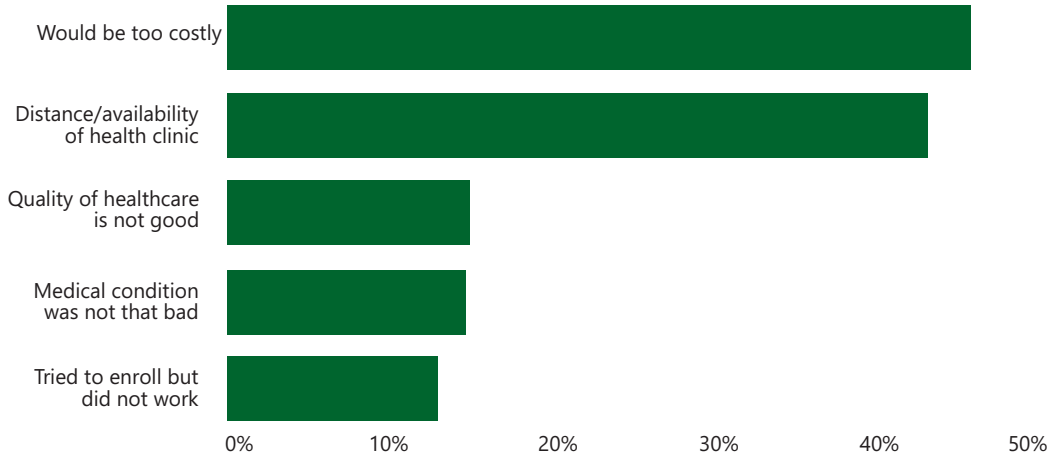
Figure 2.4 : Primary reasons for not enrolling in a health insurance programme



Note: Respondents were allowed to give multiple reasons that they wanted for not enrolling in a health insurance programme. Answer options were not read out and so the numbers here reflect how many respondents mentioned an argument spontaneously. These were the top 5 reasons.

Over the past year, 18% of informal sector workers needed medical care for themselves or somebody in their household whom they paid medical bills for. For 60% of those people with healthcare needs, more than one of their dependents (including themselves) needed healthcare. About 59% of health care needs were linked to malaria. Of all informal sector workers (or their dependents) that needed medical attention, 18% could not access medical care. The reason why they did not access healthcare when needed is mainly related to cost, with 46% highlighting that it was too costly, and 43% reporting that health clinics where either unavailable or located too far (figure 2.5). There was no significant difference between rural and urban informal workers in highlighting the problem of the distance of health clinics.

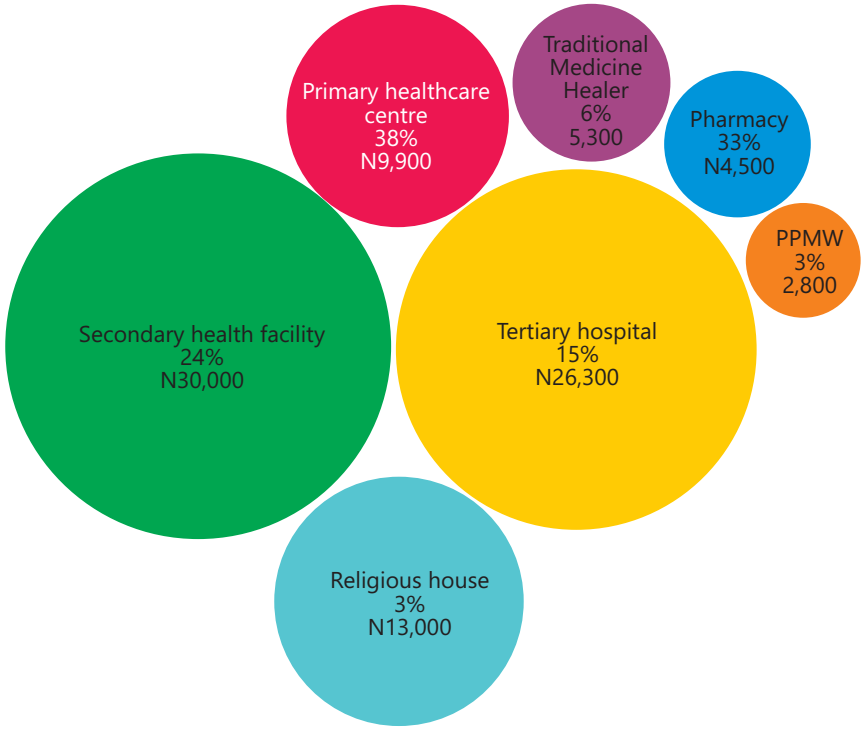
Figure 2.5: Main reasons for not accessing healthcare



Note: Respondents were allowed to give multiple reasons that they wanted for not accessing healthcare. Answer options were not read out and so the numbers here reflect how many respondents mentioned an argument spontaneously. These were the top 5 reasons.

The experience of people who have access to healthcare services is crucial to learn and improve health services. Of the informal sector workers that seek medical care for themselves or their dependents, 38% consulted a primary healthcare centre, 33% a pharmacy, 24% a secondary health facility, and 15% a tertiary hospital (figure 2.6). The average spending on care was 9,900 Naira in primary healthcare centres, 26,300 Naira in tertiary hospitals, 4,500 Naira in pharmacies, and 30,600 Naira in secondary health facilities. To pay for health services, 65% of these workers paid the full amount right away, whereas 19% paid in instalments and 12% had to borrow money from family or friends to cover the expenses.

Figure 2.6: Use of health facilities & average spending by those that accessed healthcare

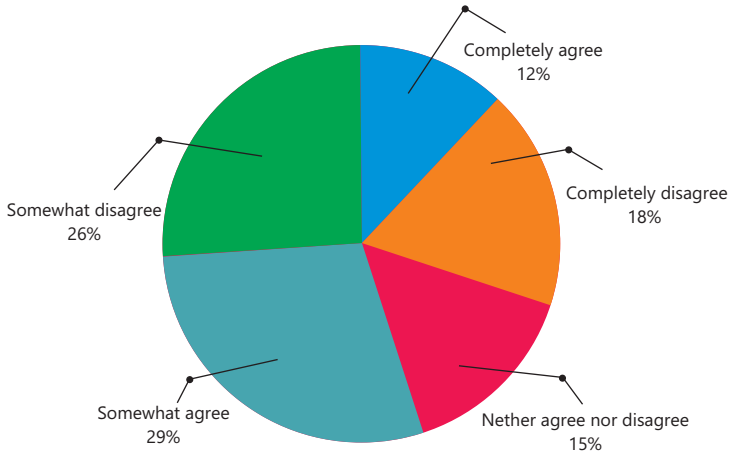


Note: These statistics only pertain to informal workers that access healthcare. The ones that did not access healthcare are not included. Average spending is self-reported average spending. Religious house, traditional medicine healer and PPMV had few observations, and so these average spending statistics are prone to error.

Importantly, after receiving healthcare, about 13% had to borrow money to cover living expenses, while another 10% had to reach into their savings to cover living expenses. This shows how disruptive unexpected healthcare costs can be to the lives and livelihoods of informal workers, and how healthcare coverage could help resolve this. Unsurprisingly, people that had to borrow money for healthcare expenses and those that had to subsequently use savings or borrow money to cover living expenses were mainly lower income workers.

Healthcare affordability remains a critical challenge for informal sector workers. In the baseline survey, 44% of all respondents (i.e., those who accessed healthcare and those who did not) indicated that health services are not affordable to them, with another 15% on the fence (figure 2.7). Only 41% considered it somewhat or entirely affordable. Affordability is linked to income, but it is subsequently also linked to the worker's occupation. Mostly domestic workers (55%) indicated that health services are not affordable to them, followed by unskilled labourers (49%), agricultural workers (46%) and artisans and skilled labourers (46%).

Figure 2.7 : Health services are affordable to me

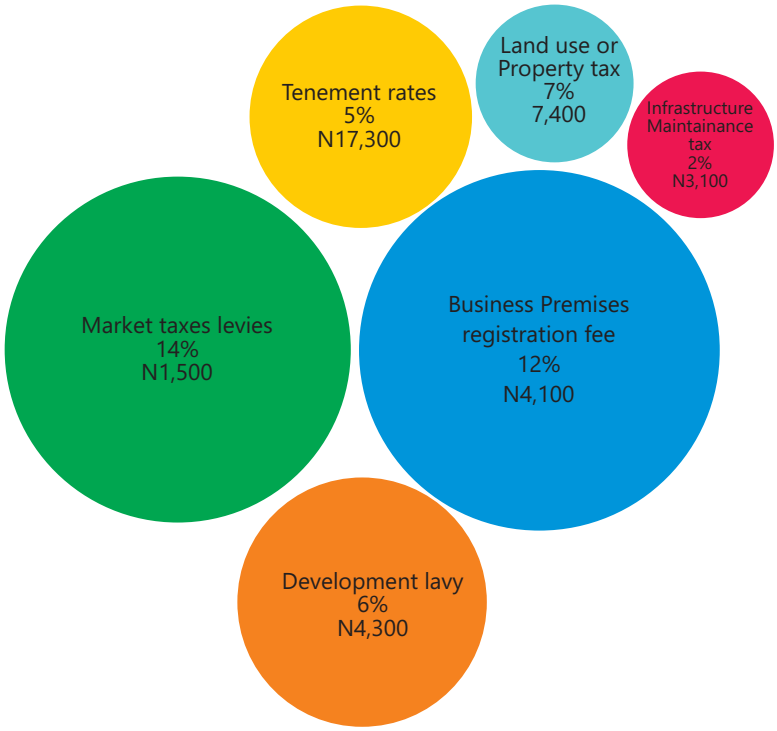


This lack of affordability and the unavailability of health clinics translates into a reduction of healthcare access in times of need. Almost one third of people (32%) indicated that they had postponed or skipped seeking healthcare or medication when they needed it in the last three months alone. 40% of the poorest income group indicated they had done this, versus about a quarter in higher income groups. Besides affordability, public confidence in health clinics could also still improve. While 58% are confident that the health clinic could help if they were to seek medical assistance, 27% lack such confidence and 16% are neutral.

2.3 Tax Payment and Perceptions

Tax payment among informal sector workers is relatively low. Only 2% of all informal sector workers have a Tax Identification Number based on the self-reported assessment. The study also notes that the taxes most paid by these workers are market taxes and levies and business registration fees, paid by 14% and 12% of informal sector workers respectively (figure 2.8). However, the taxes with the highest marginal rates are tenement rates and land use/property taxes. While market taxes and levies, and business premises registration fees are paid by more workers, tenement rates generate higher marginal revenues per worker.

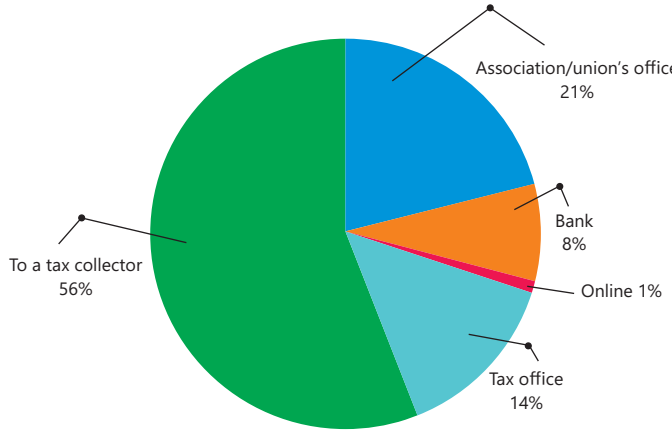
Figure 2.8: Share of workers who paid selected taxes and the average rates paid



Because tax payment is low, there are no clear distinctions over which informal occupations pay the most land use taxes, tenement rates, development levies or infrastructure maintenance taxes. It is however clear that traders and artisans more often pay business premises registration fees and market taxes and levies. The data also shows that higher income occupation groups working as businesspersons and professional service deliverers pay business premises registration fees and market taxes more frequently, but as the income distribution indicates, they are also more able to afford it. In reverse, the poorer informal workers such as domestic workers, unskilled labourers and farmers tend to pay taxes less often.

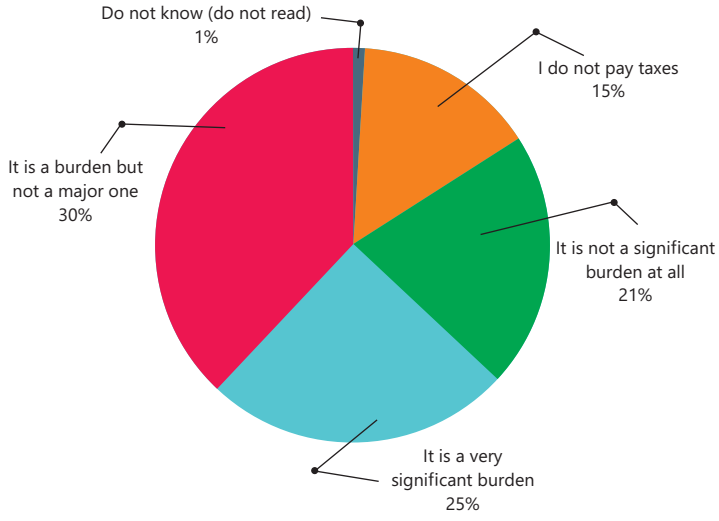
Respondents indicated that most of the taxes are paid to the local government or SIRS. More than half of the respondents generally pay their taxes to a tax collector (56%), followed by 21% that pay to their association or union and 14% that pay at a tax office (figure 2.9). Only 8% of informal sector workers pay taxes in a bank. Positively, the majority (78%) reported that they receive a receipt of payment when paying taxes.

Figure 2.9 : Location where informal sector workers generally pay taxes



When asked about their opinion on how much taxes they are required to pay, 25% indicated that it is a very significant burden, 39% that it is a burden but not a major one, and 21% responded that it is not a significant burden (figure 2.10). 15% admit to not paying taxes at all. Groups that more often indicate that taxes represent a major burden include traders and unskilled labourers (31%), whereas farmers and businesspersons most often indicate it is not a significant burden at all (29% and 28%, respectively). Interestingly, persons who work as businesspersons or with professional service providers are also the most likely not to pay taxes at all (26% and 36%, respectively).

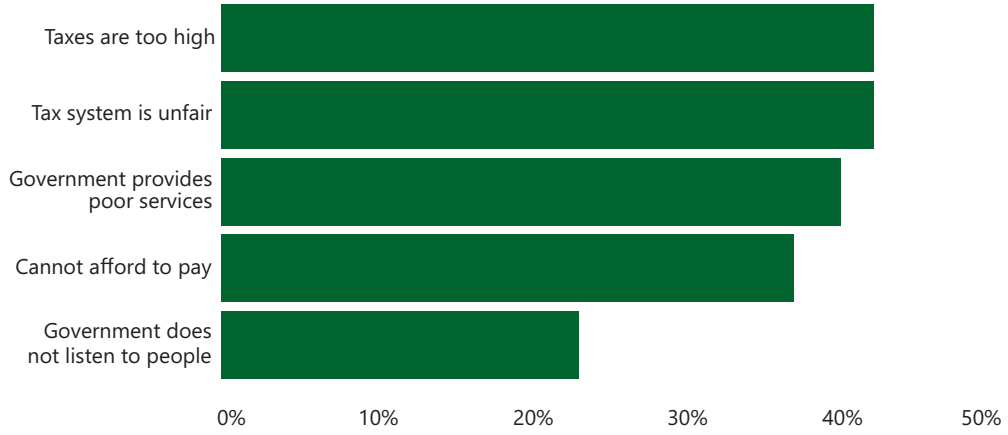
Figure 2.10: Opinion on tax burden



43% of informal sector workers believe others sometimes avoid paying taxes, with another 34% who believe they evade taxes often or always (figure 2.11). This indicates a high level of tax non-compliance in the country, which according to

informal workers is as a result of an unfair tax system, high taxes, and poor government services. It should be noted that some occupation groups make a distinction between taxes that are too high and affordability. For example, 51% of businesspersons will argue that taxes are already too high, but only 32% noted that people cannot afford to pay them.

Figure 2.11 : Main reasons for not paying taxes

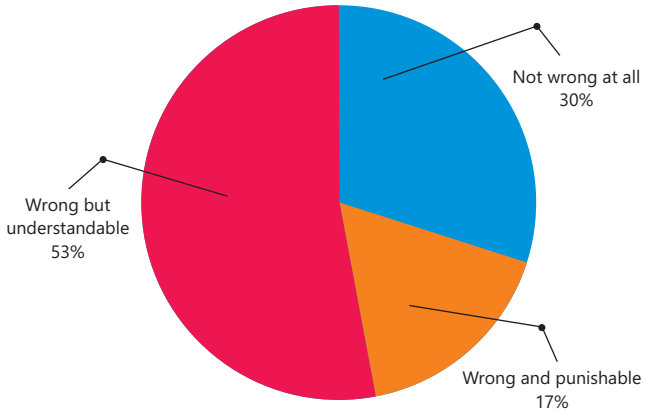


Note: Respondents were allowed to give multiple reasons that they wanted for not paying taxes. Answer options were not read out and so the numbers here reflect how many respondents mentioned an argument spontaneously.

In terms of workers' tax morale, there are two clear trends. On the one hand, tax morale is very low. Only 17% believe that evading taxes is wrong and punishable, versus 30% that think it is not wrong at all and 53% that believe it is wrong but understandable (figure 2.12). On the other hand, 61% of informal workers say they would be willing to pay taxes if the main reasons mentioned above are addressed.

Unsurprisingly, the real factor determining tax morale is income, with lower income informal workers much more likely to say it is not wrong at all and less likely to consider tax evasion as wrong and punishable than high income earners. In the same vein, we noticed that businesspersons are more likely to consider tax evasion as wrong and punishable (34%) than other groups, while domestic workers are most likely to say it is not wrong at all (43%). Instructively, there are no clear distinctions between rural and urban workers, or between male and female workers.

Figure 2.12 : Perception about not paying taxes



Many informal sector workers question the notion that tax authorities have the right to make people pay taxes. This is a core principle and the number of people who hold this notion can teach us something about social contract fundamentals. Unfortunately, less than half of the informal workers in Nigeria agree that tax authorities always have the right to make people pay taxes, and almost 30% explicitly disagree that tax authorities always have the right to make people pay taxes. Again, we notice no difference between urban and rural, or male and female urban workers. We do notice that agreeing to tax privilege of the government is something more prevalent among lower-income informal workers such as unskilled labourers and domestic workers.

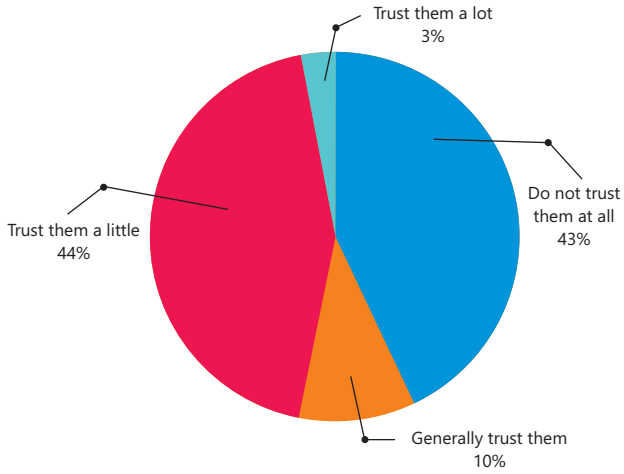
In addition to a poor tax morale, low compliance is related to how easy informal sector workers consider tax evasion to be. 52% of respondents believe it is easy or very easy to avoid paying taxes, while only 34% and 11% think it is difficult or very difficult, respectively. Most informal households also believe there is no penalty (35%) or only a small penalty (25%) associated with tax evasion, compared to 24% and 14% that believe there is a medium and high penalty, respectively. This perceived ease of non-compliance appears to have a significant impact on actual non-compliance. More than half of informal sector workers (56%) believe that most people will cheat to some extent if they think they can get away with it, while 53% admit they will not pay taxes themselves if they know they will not get caught.

2.4 Trust in Government

Besides monitoring and enforcement, tax non-compliance appears to be linked to low tax morale, which itself is correlated with low trust in the tax collection process, tax authorities, and the government. A striking 44% of all informal sector workers do not trust tax officials to collect taxes fairly at all, with an additional 42% that only trust them a little and less than 13% that trust them (figure 2.13). 36% of

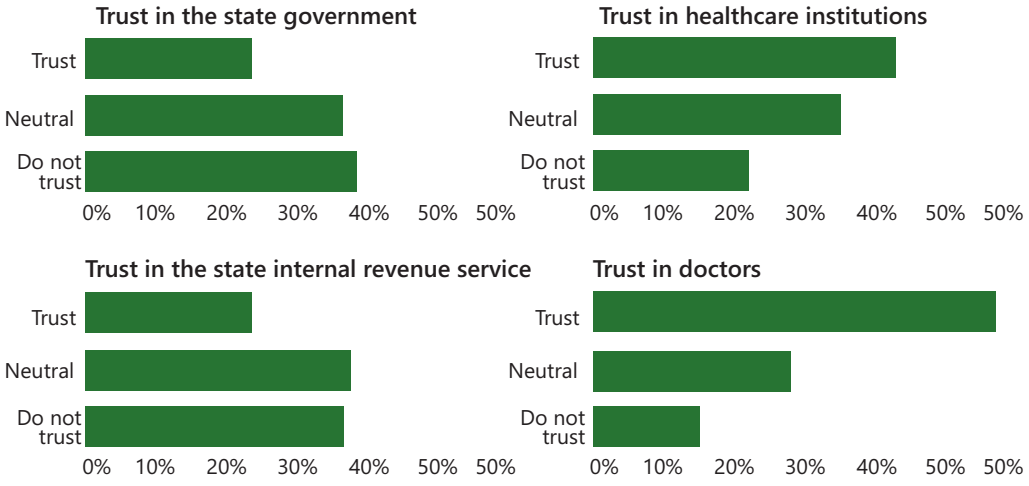
informal workers also believe tax officials sometimes ask for bribes, with an additional 31% who believe this happens often or always.

Figure 2.13 : Trust in state tax officials to collect taxes fairly



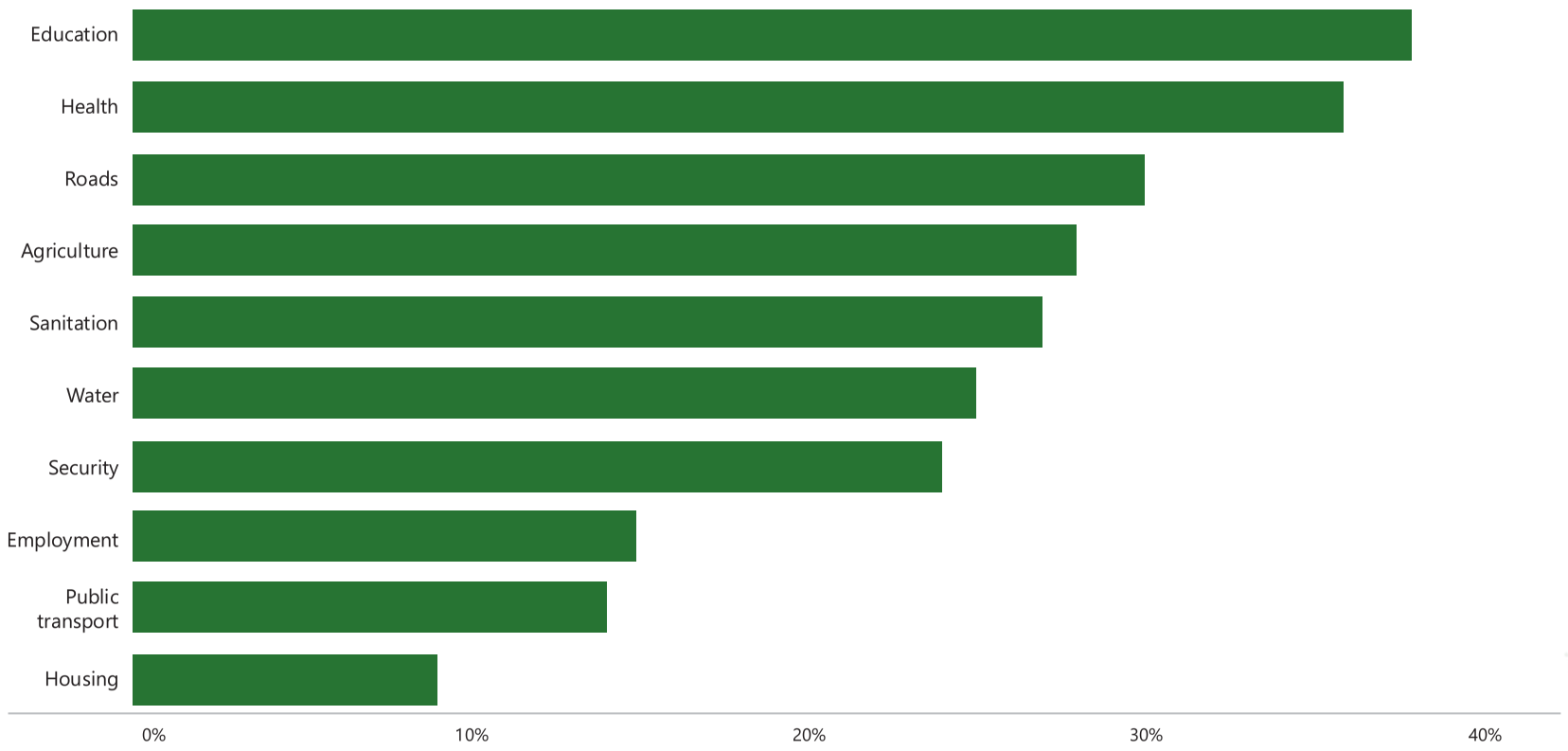
Besides tax collection, informal workers in Nigeria also do not trust tax authorities and the government in general. 37% do not trust the State Internal Revenue Service and most consider it somewhat likely (41%) or very likely (43%) that the state government misuses tax revenue (figure 2.14). Similarly, 39% do not generally trust the State Government either, with 64% of all informal workers believing that the State Government acts more in its own interests than for the good of the people. Contrary to core governmental bodies, there is less distrust in health institutions and doctors, where people who distrust them represent only 22% and 15% of all informal workers, respectively.

Figure 2.14: Trust in government and institutions



When asked what the top three (3) areas where informal sector workers believe the government provides good services in, the education, health and roads sectors were ranked the highest, while public transport and housing ranked the lowest (figure 2.15).

Figure 2.15: Believes the government provides good services in the following areas



Note: Each service reflects 100%, with the number reported as the percentage of informal sector workers that are satisfied with services in the sector.

2.5 Tax-for-Service Programme Preferences

There is limited experience with informal workers receiving social benefits in Nigeria, but those who have received benefits are generally very satisfied with the service. This can yield positive stories for improving benefit delivery to a wider range of informal workers. Figure 2.16 shows that for each social benefit, less than 20% of informal workers have been able to access it. Of those who have had access to social benefits, the overwhelming majority were satisfied. When asked what services the government should invest more money in, the top two choices were education and health, followed by security and agriculture (figure 2.17). This demonstrates great potential for the Tax-for-Service programme.

Figure 2.16: Share of workers who have received social benefit and their level of satisfaction

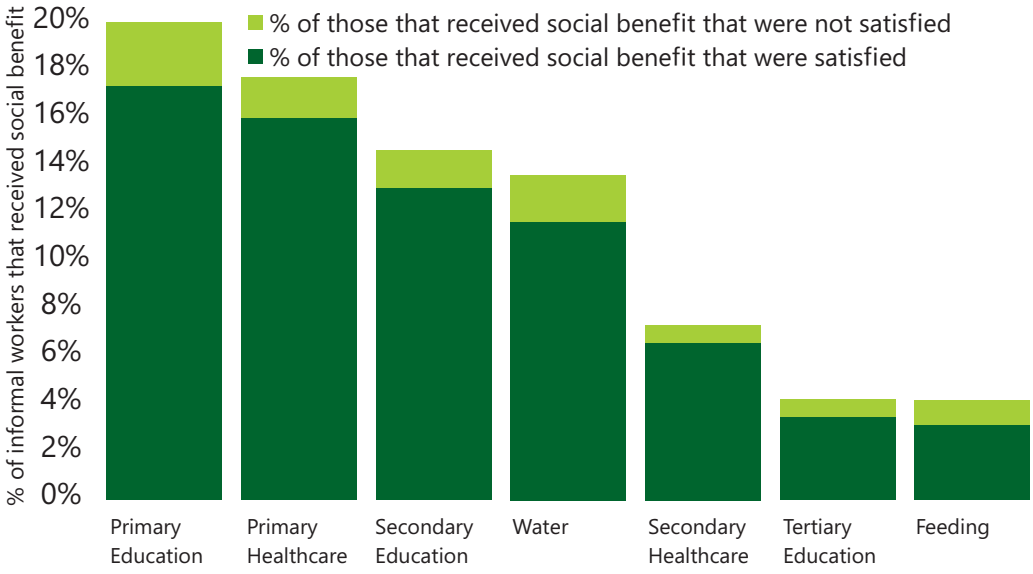
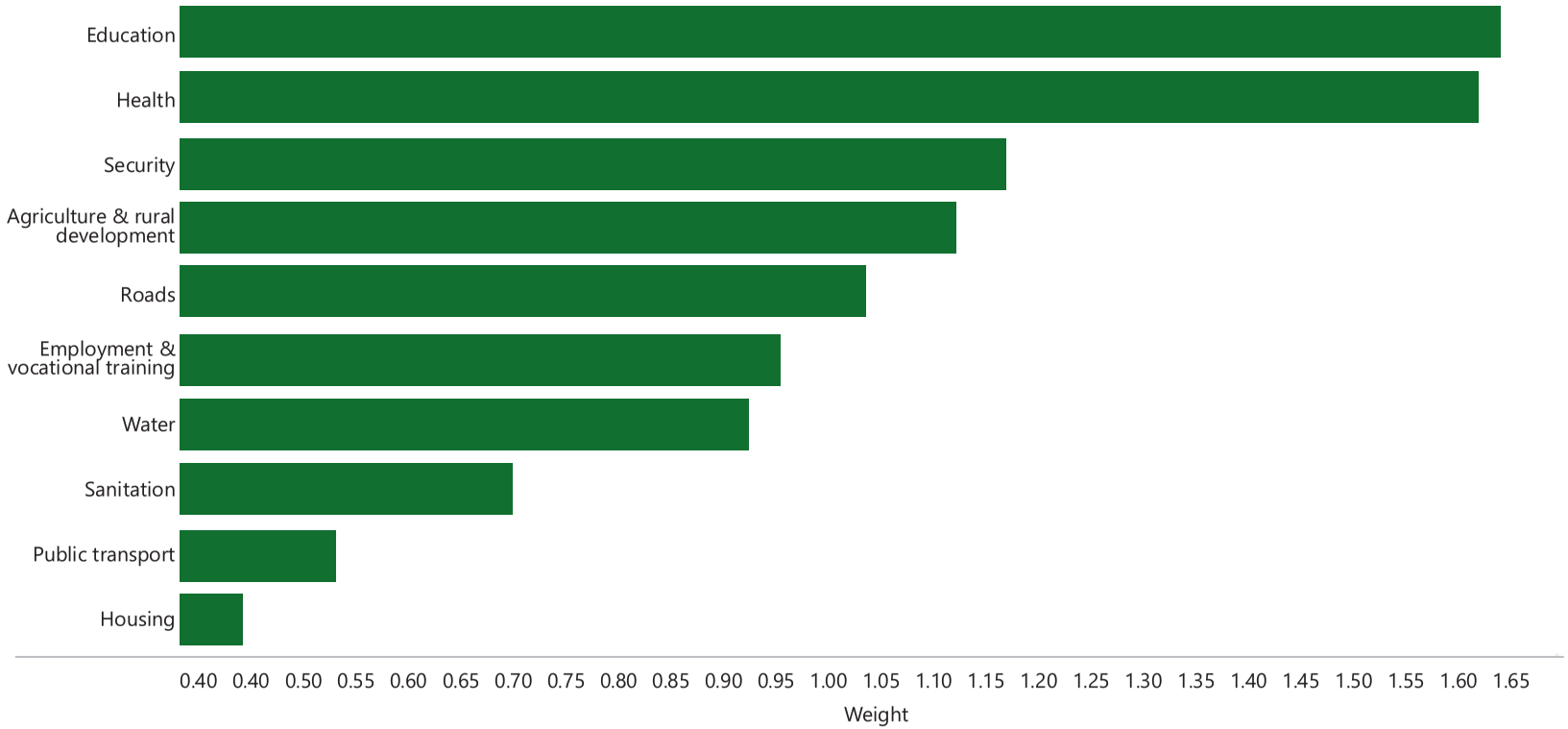


Figure 2.17 : Priorities of informal workers for government's use of tax revenue



Note: Each respondent was given 10 marbles and told those 10 marbles represented extra money the government could invest. They were then asked to distribute the 10 marbles across sectors they thought were important. They were told that not every sector had to be covered in case they thought the government should not spend more money in this sector.

Before explaining the Tax-for-Service programme, 47% of informal workers in Nigeria were optimistic about paying taxes on income if they can access free services for medical needs. The main reasons why they would be interested is because it would be affordable to them (34%), they find the quality of healthcare good (32%) or there is healthcare nearby (13%). People who are not interested argue that paying taxes would be too costly (41%), that the quality of healthcare is not good enough (12%) or that there are no health facilities around (11%).

The survey team then inquired about the three most important health conditions that informal sector workers would welcome free-of-charge care for. Malaria came out strongest (66%), followed by child delivery (8%) and basic medical checks (5%).[d] If their top three services were covered, then informal sector workers were, on average, willing to pay monthly income taxes of at least 1,600 Naira and at most 2,200 Naira. It should be noted that informal workers with higher incomes are willing to spend more than lower earners, indicating again that affordability is a key constraint.

Table 2.2: Self-reported amount to pay as income taxes per month

Self-reported willingness to pay per month	Median	Average	25th-75th percentile
Minimum amount	500	1600	500-1000
Maximum amount	1000	2200	500-2000

In total, 60% were willing to pay 1500 Naira in income tax if they would receive health services for their top three priorities free of charge. The ability is clearly related to their monthly income, with 50% of those earning N5,000 or lower willing to pay this amount, versus 75% for those earning between N80,000 and N100,000. Again, it is the domestic workers and unskilled labourers that appear to struggle the most.

After explaining what the Tax-for-Service programme proposes, 93% of informal workers were positive about the programme. The 7% who do not believe in the programme do so because they do not trust the government to implement the

[d]The list of choices included malaria, diarrhea, respiratory infections, first aid and wound dressing, child delivery, basic medical checks (e.g., high blood pressure, blood sugar testing, weight), basic medication for high blood pressure or diabetes, family planning or child spacing services, road and traffic accidents, fractures and sprains, heart disease, sickle cell related problems, eye problems, dental problems, ear problems, and skin problems. Respondents were also able to identify another service outside of this list, but less than 1% chose to do so.

programme well (44%) or because they do not want to pay tax (24%). People who feel positive about the programme do so because it would respond to their need for healthcare (39%) and they do not mind paying taxes for it (25%) (figure 2.18). This is despite 82% who feel that they are in good health, which shows a general awareness of the usefulness of healthcare services. It should be noted that of the people who feel positive about the programme, 58% did not feel positive about paying taxes prior to receiving low-cost health care. When asked what authority they would be most comfortable paying taxes to, 41% of informal workers answered the local government authority, followed by 25% that chose the SIRS (figure 2.19).

Figure 2.18 : Main reason to feel positive about the Tax-for-Service programme

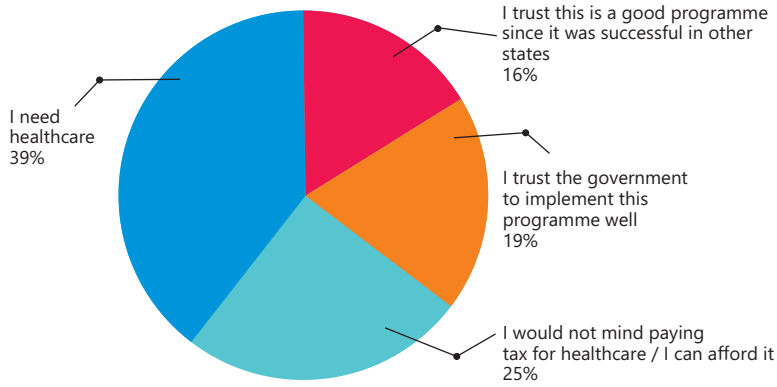
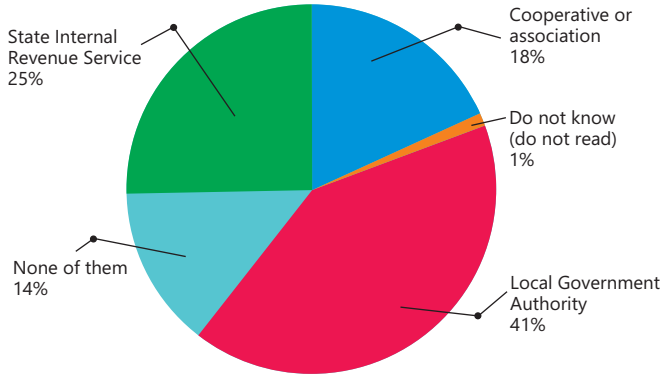


Figure 2.19 : Authority informal sector workers are most comfortable paying taxes to



Institutional Readiness and Perceptions

Implementing the TfS programme requires readiness from various governmental and health institutions. This project also included in-depth interviews with representatives of key institutions who are positioned to be responsible for the policy design and programme management function. This group referred to as the 'Policy Team' includes policymakers who are in the decision-making positions of the policy design, and implementers responsible for implementing the policy. These consultations were confidential in nature. This section summarizes the key observations without attribution.

3.1 State Ministries of Finance (SMoF)

The ministries of finance identified short-term priorities and key development objectives that are relevant to potential TfS programmes. Short-term priorities include paying salaries and pensions, which is not surprising since the interviews were conducted amid the COVID-19 crisis. Most states, however, noted that development objectives include health, alongside education, with the government planning to spend more tax revenue in these areas. Tax policy priorities include, besides making tax administration and collection more efficient, the broadening of the tax net and improvement in internal revenue collection. These objectives point to the potential strength of implementing a TfS programme.

3.2 State Internal Revenue Service (SIRS)

Interviews with the State Internal Revenue Service in the twelve (12) states indicated that most SIRS have an informal sector unit, and most also operate a presumptive tax regime. Many presumptive tax regimes started operation in recent years, with some states indicating that the regime is not always well known and often adjusted to cater for local needs and contexts. Most SIRS also register taxpayers electronically or through a combination of manual and electronic means. In many states, upon registration, taxpayers receive a TIN number, and, in some states, they receive an identification card. The performance in terms of

communicating with taxpayers and receiving feedback is mixed, with some states in need of more capacity to reach out to taxpayers.

3.3 State Ministries of Health (SMoH)

The Ministries of Health showed good understanding of the number and distribution of health facilities in their states. While primary healthcare facilities are numerous and geographically spread out across most states, secondary and tertiary health facilities are less available and sparsely distributed.

3.4 State Primary Healthcare Development Agencies (SPHCDA)

Primary Healthcare Development Agencies guarantee the standards of primary healthcare centres by implementing periodic quality assessments, although the frequency varies. The agencies highlight challenges in the implementation of health insurance schemes. These include institutional challenges, such as the ownership and management of primary healthcare centres by local governments and the need to map and bring them under one regulatory roof. But mostly, the challenges point to the need for more funding to support the recruitment of additional local skilled practitioners, better infrastructure and state-of-the-art equipment, and essential medication. These improvements will help raise the reputation of public primary healthcare facilities, given that most people choose private hospitals over public healthcare centres. Some agencies noted explicitly, the difficulty of covering and reaching informal sector workers and vulnerable persons.

3.5 State Health Insurance Agencies (SHIAs)

Health Insurance Agencies have a mixed record when it comes to the enrolment of informal workers. A few states have some experience, while others are starting or planning to kickstart the enrolment of informal sector workers into their health insurance programmes. In general, the coverage of informal workers is low, and states plan to upscale their efforts in this area. In terms of insurance premiums, most states have similar amounts for the formal and informal sector. In the formal sectors, states have the premium set as a percentage of the worker's gross salary, often between 3% and 5%, or as a nominal amount, somewhere between 7,000 and 14,000 Naira. For informal workers, the amount is usually set as a nominal amount, and include similar amounts, which are explicitly stratified according to income.

3.6 Health Facilities (HFs)

Health facilities that are State Social Health Insurance Scheme providers reported that they have enrolled thousands of persons, depending on the state. The implementation of insurance is new to many health facilities and some are still in the preparatory phase. For those that have adopted the payment of capitation and service fees, payments are usually on a monthly basis. These facilities noted a few challenges with the implementation of insurance schemes, such as poor engagement with other institutions, payment delays, lack of qualified staff, infrastructural deficiencies (e.g. network availability) and the exploitation of access to medication by enrollees..

3.7 State Hospital Management Boards (HMBs)

The Hospital Management Boards confirmed similar challenges, with several still working on the implementation and upscaling of the SSHIS, which requires greater funding, time and the availability of qualified personnel. Most facilities and HMBs are positive about the SSHIS, although they pointed to the expected challenges of setting up a new scheme.

3.8 State Drug Management Agencies (DMAs)

Most states have a functioning drug management system. These DMAs run lists of tracer drugs to monitor the availability of essential medicines. DMAs also use standardized drug price lists across all the health facilities. These agencies point to several challenges that impact on the availability of essential medicines and medical consumables, including lack of funding to scale up services to a larger number of facilities. Many of them also experience stock shortages.

Greater investment is required to hire and train additional personnel; pay salaries that are competitive with private institutions and that will be capable of attracting more qualified pharmacists; and upgrade logistics, including electronic equipment to manage inventories. Some states still manage their inventories manually, which is rather slow and inefficient. In addition to distribution-related challenges, storage and transport services also need additional upgrade. Some DMAs specifically pointed to the difficulty of regulating the quality of drugs, which fall under federal regulations.

Conclusions

A Tax-for-Service programme in which informal sector workers pay taxes in exchange for free minimum healthcare could be a policy innovation that strengthens the social contract between citizens and the government. Its innovation rides on its capacity to raise internal revenue generation from informal sector workers that can be ring-fenced in a core domain of human development. Survey results reveal a dire need for better healthcare for informal workers in a system where two thirds of informal workers have never heard about health insurance. The programme could potentially improve the generally low tax morale and tax compliance in the country.

But there are challenges to overcome to ensure that the programme is rolled out successfully. On the one hand, informal sector workers struggle with trusting tax authorities and the government. This is in part due to their limited exposure to social benefits and in part due to the perceived self-interested priorities of the government. On the other hand, not all informal sector workers are equal. Some are able to spend higher amounts on health insurance than others, with a significant share highlighting that the cost of healthcare is a primary reason not to enroll or not to look favourably to tax payment.

These challenges necessitate additional attention to the programme's design elements, such as the timing of tax payment and the start of health insurance. A strong communication campaign is required to explain the benefits of health insurance and increase its legitimacy, including that of the agency implementing it. In the survey, before explaining the TfS programme, 47% of informal workers in Nigeria felt motivated to pay taxes on income if they can access free services for medical needs. After explaining the programme, however, this number increased to 93%.

Workers have shown a strong desire for progressive taxes, their experience and policy views show that they are willing to pay more in exchange for services that will benefit them directly such as healthcare and education. But fundamentally, this shift in attitude for progressive policies in general existed even before the

COVID-19 pandemic.

The implementation of such a contractual publicly mandated social programme that addresses the inequality in health access will also be capable of ameliorating the multifaceted and cyclical nature of poverty traps and living standards. This pseudo public health insurance programme will be vital among informal workers who are self-employed workers and not registered for income tax or value-added tax, including women who are side-lined and constrained by the lack of protection. There has been demonstrated interest for TfS in States, but the results call for political consensus and collective action.

Given the unpredictability of other equally, if not more destabilising crises in future – including but not limited to health, environmental, political or economic crises – the lessons learned about the importance of income support (health cover) during this pandemic can improve long-term resilience for households regardless of their socioeconomic standing.

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