HEALTH CARE FINANCING REFORM IN NIGERIA: CURRENT TREND

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Abstract

The issue of healthcare financing has become a very sensitive one not only in developed countries but also in less developed and third world countries where it has become necessary to address certain health problems. The health budgets have been very insignificant for the enormous challenges posed by these health problems in most of these countries. A critical assessment is given in this paper to the situation of health financing in Nigeria, various sources of health financing in Nigeria and reforms that have taken place are given consideration. Majority of the literature and materials used are obtained from secondary sources and data. The paper therefore is largely descriptive and historical. Finally, findings in the paper have shown, that the government alone can not handle healthcare financing and there is need to encourage increased participation of private sector, including the international Organizations such as U.N.D.P., WHO, U.N.I.C.E.F., etc. There are various useful suggestions and recommendations that are also proffered in the policy options and conclusion.

Introduction

For the last two decades, government of most countries in the sub-Saharan African region have been facing great difficulties in providing quality health care facilities to the total population most especially the underserved and vulnerable groups. This is as a result of the recurrent cost problems in health in most of these countries, leading to inadequate supply of drugs, chemical, medical equipment and other essential consumables.

The per capita health expenditure of United States $9 a person is much lower than what is obtained in other African countries for instance in Ghana (US $16) (Canagarajah.,1997). The reason for this lower per capita health expenditure of United States may be as a result of high success achieved in controlling and eradicating some of the dreadful and common killer diseases. In 1990, health income cost at least 8% of world income. On the average 60% of this is public spending, which is in high income countries, in contrast to what happens in poorer countries where the State finances small share in health cost. (Murray, Govinderaj and Musgrove, 1996). Improvements in Nigeria's health care have been very slow because primary health care services are compromised by limited resources spent on factors that are supposed to maintain and improve this quality.

According to Canagrajah (1997), healthcare spending as a percentage of Gross Domestic Product in 1990 was 2.7% in Nigeria 3.5% in Ghana and 4.3% in Kenya. Gorgen (1994) in comparing the government's commitment to health financing in Anglophone countries with Francophone countries explained that in most of the English speaking countries, health services were until recently free of

charge and comparatively a high commitment was given to the health sector. Only gradually the situation started to deteriorate when there was introduction of fees which make the utilization to drop sharply, but afterwards people accepted it only where the quality of performance was alright. On the other hand, in French speaking countries the state of health services was much worse.

Nigeria Budget in 1996 neglected human resource development, particularly basic education and health. There was a modest increase of 7% in education budget while the budget for health was reduced by 6% (World Bank Reports, 1996).

The primary objective of this paper is to consider the various sources of finance available to provide qualitative health care services in Nigeria, the degree of

utilization of these sources and suggest ways through which the available resources will be used to accomplish efficient delivery of health care services at the primary level. The paper is structured according to the following sections: Introduction, Health Care System and Health Care Expenditure, Government's Role in Health, Sources of Financing Health Care, the Current Trend of Health Care Financing in Nigeria, Policy Options and Recommendations.

Health Care System and Health Care Expenditure

Four Health Care settings are identified by the Department of Health, Education and Welfare. These are; ambulatory, in-patient short term, in-patient long term and home. Within each setting, health resources are identified. Resources are those general categories of facilities in which care might be given. The taxonomy does not offer a perspective on how these services are interrelated, how they are funded and who provides them (Numerof, 1982).

Kelman (1975) offers a schema that tries to show how various parts of the system are intertwined. This schema identifies essentially 4 parts in health care: primary providers, secondary providers, financing mechanisms and consumers. Health care expenditure are those household, government and private institutions income that are spent on health services (FMH, 1988). According to Dunlop and Martins (1995) "The level of health expenditures is affected by a nation's health status via several path ways". First the poorer a nation's health status, the heavier the burden of disease (BOD). Also, if a country's health status is low and it has a high burden of diseases, the average labour productivity of the population will be lower and via the relationship between Gross Domestic Product and health spending, health expenditure will be concomitantly less.

Government Role In Health

It is very important we consider the role of government in health matters, since large share of health expenditure is financed by public spending. Most of what will be discussed in this section will be based on the work of Musgrove (1996). According to him there are five distinct instruments of public intervention. These include: information, mandate, finance and provision or delivery of services when it is infeasible to finance private providers equitably.

The government need to do better, particularly in poor countries where much private medical practice may be of low quality. The government should use regulation, mandates, training and other interventions to make the private sector function better.

Sources Financing Health Care

The following major sources of financing health care will be briefly considered: User fees/ charges, prepayment schemes, revolving fund, direct government/private financing, health insurance, community self help projects, aids, grants and others.

User Fees or Charges: These fees are paid in different ways; often as a minimum fee for registration per episode of illness or only once per annum, as a lump sum for certain services or prescribed drugs. User charges have been seen as one of the means of financing health care that can bring about improve health services in most sub-Saharan African countries. Most patients are able to raise money for the hospital fees by selling their cereals, stocks or other products, loan from friends, neighbor/community or family. In Ghana the percentage of the budget collected by Ministry of Health through user charges ranges from zero to 15%, Kenya it is only 5% (Vogel, 1989).

Prepayment Schemes: This form of financing is being tested by more and more countries in recent time. The prepayment scheme was introduced in Zaire in 1986 as a result of difficulties in paying for hospital care as well as the increasing financial gap for the hospital management that showed a need for charge (Freddy, 1994). The prepayment scheme is in form of small co-payment in cash followed with premium per household member collected once or twice annually, by Health Centre Staff and Village Committee. The scheme is different from insurance option because the premium from prepayment can be related to revenue from selling crops and is based on the existence of notion of risk sharing in the community.

Lotteries and Betting: It is not recognized as a major source of health care financing in developing countries. It also provides a ready source of money to government in financing health care.

Revolving Fund: The revolving fund allows certain amount to be committed or allocated for drugs supplies or procurement. The National Policy ^n Health State that users shall pay for curative services while preventive services shall be subsidized. Teaching and Special Hospitals are therefore encouraged to make essential drug fully available by supplementing routine budget allocations with the establishment of drug revolving fund or other cost recovery mechanism.

Direct Government/Private Financing: This is done by both private and public sector employers. The public sector employers in most cases use government hospitals or provide their own clinics for their staff while most private employers enter into either full time or part-time retainership with private hospitals or have their own hospitals. In Nigeria, only very few private employers are not making this provision for their staff and effort is on by the Federal Government to mandate all employers to provide health care services for their workers in terms of social insurance or health insurance. The government is setting the pace by its National Health Insurance Scheme Public Enlightenment Campaign currently on air both in the Radio and Television Stations in Nigeria.

Community Self-Help Projects: In this type of financing, the community enters into either voluntary or compulsory contribution to provide for their health facilities. They sell their stocks, land live stock and other products and use the proceed as their contributions. It can also take the form of labour or fund raising./ Most communities in Nigeria through self help projects have constructed bridges, hospitals, dispensaries, schools, police stations and so on.

Health Insurance: This is one of the alternatives for financing health care (Deferranti, 1985; World Bank, 1987). It may be in form of private health insurance or social insurance. Social Insurance is the mandated insurance policy for workers, in which certain percentage of their wages are contributed to the scheme, while at the same time their employers are also mandated to contribute somewhat higher payroll tax to the scheme and in some cases the government can be the third contributor. Social insurance is often referred to as social security. The private health insurance on the other hand is distinct from social insurance in two ways. It covers only health care alone and does not include pensions for invalidity and old age, and it is financed through premium, which is based on the nature of the illness of the individual covered by the policy. Private health insurance can be either profit or a non-profit, bought by the either groups or individuals. In Nigeria there is no formal private or public health insurance at present time (World Bank Report, 1996; Roger, 1994). Most developing countries especially in Africa have tried the social insurance option, this include: Kenya, Zimbabwe, Burundi, Uganda, Zaire, Tanzania and Ethiopia.

Aids and Grants: These Aid and Grants can be either local or foreign. The local one can be in form of donations in kind or cash from local charitable organizations or philanthropic individuals or organization like Rotary Club, Lions Club, Island Club, Community Development Association, Guinness Nigeria PIC and others. Other major sources of charitable organizations include wealthy individuals, business enterprises and religious groups.

On the other hand, the foreign aids and grants are usually from foreign donors like the World Health Organization, World Bank, UNICEF, Multinational Companies like Mobil or Shell Petroleum Development Company, Chevron,

United Trading Company (UTC) and others. They help in financing health care services in these developing countries in order to bring about improvement in the delivery system and also alleviate poverty. Although it is generally expressed that these charitable organizations have some selfish intent motive that may not coincide with the most pressing health needs of the population, they serve as a major source of financing health care in most developing countries. They have been able to make remarkable contributions to the development of health care services in developing countries.

Other sources of health care financing include sales tax revenue, the general tax revenue and deficit financing. This sales tax revenue are obtained from the tax imposed by State and Local Governments in developing countries on some commodities while general tax revenues are in form of duties on imports and exports in low income countries. Deficit financing involves borrowing from either local or international creditors.

The Current Trend Of Health Care Financing In Nigeria

Nigeria's National Policy on Health emphasizes the reallocation of health resources in favour of preventive services and primary health care as the most effective and least expensive for the under - served communities (Denton and Kail, 1995; World Bank Reports, 1996).

It has been very difficult to reallocate resources from the hospital based curative services which have been receiving the lion's share of health budget to community based curative preventive and promotive services. The government is now trying to incorporate the strategy in the current budgetary allocations on health. But as result of the present economic situation, the Federal Government expenditure on health has not shown any significant improvement over the previous years, on the average the allocation to the health sector has been about 2% of the national budget.

In 1997 and 1998 the total budgetary allocation on health are N7,343 Billion and Nil.93 Billion respectively. This represented 3.2% and 4.9% of the Total budget for 1997 and 1998 respectively (Guardian 1998). The Capital and Recurrent Expenditure on Health for the 1999 fiscal year are N5,595,128,000 and N8,152.202,970 respectively, for year 2000 the capital and recurrent expenditure are N6,814,735,252 and N10,837,129,731: in year 2001 the sum of Nl 9,460,610,000 was allocated as capital expenditure on health while N5,600,000,000 was allocated for the National Programme on immunization and the sectoral allocation of proposed budget 2002 on health was N14.9 billion (Guardian, 1998,1999,2000 and 2001).

In further analyzing the Federal Government contribution to health care financing in Nigeria, terms of ownership of health establishments in Nigeria in 1991, 77.5% are government owned, 16.44% are privately owned which include community, Mission, Joint, Corporation and Industrial (Appendix: Table 1). This is also the trend at the state level. For example in Kwara State, the government i.e. the Federal, State and Local Governments owned 60.24% of the hospitals as

at December 1996, 33.88% are privately owned while others owned 5.88%. Others include Mission, Joint, corporation and industrial (Appendix: Table 2). hi Kwara State, the percentage of budget allocation to health between 1993 to 1998 reveals that the state had the highest allocation to health in 1995 with 21% during the six years period covered. The percentage allocation on health has been on decline since 1995 to lowest percentage figure of 8.29% in 1998 fiscal year (Appendix: Table 3) This has also revealed similar trends in other states and Nigeria as a country.

The United Nations Development Programme (UNDP) in technical cooperation with the Federal Government signed the Programme Support Documents (PSDs) for four National Programmes. The programme has a budget of US $ 12.3 million out of the total budget of $82.7 million embarked for the four Programmes covering the period 1997-2001 (U.N.D.P., 1999).

In its own contributions the United Nations Children Fund (UNICEF) between 1982 and 1988 embarked on Water and Sanitation, (WATSAN) programme in Imo State in 1981 and 5 more of the then 21 states of Nigeria: Gongola (1984), Kwara (1984), Cross River (1987), Niger (1988) and Anambra (1988). This approach encourages the Federal Government to adopt a National Plan for Rural Water and Sanitation (RUWATSAN) using a similar strategy and invested $50 million annually during the 1986-87 period. Although these financial inputs by the UNICEF are minimal in regard to sector requirement in Nigeria they do manifest a turn around and a significant contribution to development of improved health care delivery in Nigeria.

The World Bank since 1985, has supported investment of $270.4 million in five health projects in Nigeria (including the National Population Project). A large proportion of total government allocations for health, despite its small nature, are used for wages, leaving the remaining small balance for drugs, supplies and maintenance. The quality of Nigeria's Public Health Sector has become so poor now that only very few choose to use it while majority seek health care from private clinics/hospitals, traditional healers, chemists, religious homes and others in their preference for affordability or low cost, perceived quality, proximity and promptness of service (Centre for Health Policy, 1999; Denton and Kail, 1995).

As part of its effort to address the inadequate supply of drug in government hospitals, the Federal Government through the Petroleum Trust Fund supplies drugs to the hospitals. It is expected that the Petroleum Trust Fund project will be a resource for further investment in health and education but this has not been the case, hence its subsequent scrapping off by the civilian administration of President Obansanjo.

Policy Options And Conclusion

In considering the foregoing analysis it will be observed that despite the recent increase in the federal expenditure allocations, there is no feasible solution

to the problems militating against efficient delivery of health care services in Nigeria. In other to put right this situation the following policy options will be recommended:

There is need for the federal Government in conjunction with the Federal Ministry of Health and Social Services to focus more on expenditure priorities within the health sector and the best way to utilize the resources available. The goal of the Government health reform should be towards increased access and quality of health care services, with particular regard to preventive health care at the primary health care level.

Purchase of adequate supplies is necessary at many health facilities. Despite the recent improvement through programmes like the Essential Drugs Scheme, there are still supplies of non essential drugs or expired drugs in the pharmacy of most of

these hospitals.

Most health facilities are in poor state of physical condition, there is also poor communication and transport links between facilities. The Federal Government should refurbish existing buildings rather than build new ones in order to conserve resources. Government should also put priority on the primary health care that provides the greatest access to the population. There should also be emphasis, access to safe water, sanitation and electricity.

The Federal Government will need to increase private sector participation, generate more revenue collection for public services, encourage alternative payment systems such as insurance schemes and eliminates low priority expenditures. The government effort of implementing National Insurance Health Scheme is commended and it is hoped that more efforts will be employed to inform and educate people about this scheme in recent times. Other private sectors health services provider like traditional herbalist, religious homes and chemist should be integrated into formal health system because of their growing influence in the health sector.

Privatization of the commercially viable tertiary care services could also broaden the federal bids for private sector's participation in health care financing. Orthopaedic hospitals, psychiatric homes and some of National Medical Centres can be tried in this regard. To reduced operation and maintenance costs, the Federal Government can test on a pilot basis, by contracting out the management of some States and Federal hospitals.

Finally, it can be clearly stated that if the existing constraints to the efficient delivery of health care already mentioned are overcome and the Federal Government exploit the various alternative sources of finance to increase the allocation of health budget there will be better and efficient delivery of health to the people, including the underserved.

Appendix

Table 1: Ownership of Health Establishment in Nigeria: 1999 Number of Hospitals

Federal Government	205
State Government	3,355
Local Government	7,268
Community	140
Mission	610
Joint	10
Corporation	39
Industrial	42
Private	2,295
Total	13,964

Sources: Federal Ministry of Health, Lagos, Federal Office of Statistics, Abuja, *Annual Abstract of Statistics,* 1997 Edition.

Table 2: Health Establishment by Ownership in Kwara State as at December, 1996 Number of Hospitals

Federal Government	
State Government	1
Local Government	54
Private	283
Mission	190
Joint	8
Corporation	19
Industrial	-
Total	6
	561

Sources: *Health Statistical Bulletin,* Department of Planning, Research and Statistics, Ministry of Health, Ilorin.

Table 3: Kwara State Budget and Percentage Health Allocation (1993-1998)

Particulars	1993	1994	1995	1996	1997	1998
State budget	1,123,815,70	1,069,275,27	l,341,163,2S	2,303,536,072,	463,929.92	
3,179,497,757						
Health						
	69,879,964	73,888,119	63,813,912	95,484,920		143,848,034
	140,504,564	73,495,000	112,285,700	217,900,000	2!	119,760000
Budget:						
Recurrent						
Capital						
Total						
(Capital & recurrent)	143,374,964	186,173,819	**281,713,912**	308,434,920	321,930,564	263,608,034
Allocation to Health	12.5%	17.4%	21%	13.17%	13.07%	8.29%

Source: Kwara State Bureau of Budget and Planning: Approved Budget Estimates 1993-98.

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