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REVIEW ARTICLE

ECONOMIC EVALUATION OF HEALTH CARE SYSTEM IN NIGERIA: ITS CHALLENGES AND PROSPECTS

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ABSTRACT

Universal health coverage is a situation where everyone can access the health services they need without suffering financial hardship paying for them. This implies that there is some sort of risk pooling mechanism (e.g. insurance) and that the poorest are supported with their health expenses. 60% of all health spending is financed directly by households without insurance. This is way above the 15% threshold beyond which household risk being pushed into poverty by health care expenses. This paper thus reviewed the economic aspect of health care system: Its challenges and prospects in Nigeria. The results of this review showed that health care financing is worse hit especially in the poor continent where health care faces serious problem of acceptability with out-of-pocket expenditure accounting for over 70% of total private health expenditure is enough to dent the little progress of the health system made. It is therefore important that the government is responsible for the largest share of spending on health, rather than individuals, otherwise the poor may be denied access to healthcare and others may be pushed into poverty through expenditure on health.

INTRODUCTION

Financing health systems is a major challenge in both developed and developing countries but Nigeria has yet to show the ability to face this challenge so that the health system can benefit all the citizens of the country. There is a need to incorporate other financing models for the health system if we must reduce the level of out-of-pocket expenditure for the poor. The out-of-pocket expenditure as percentage of private expenditure on health of 22.6 per cent in the USA shows that userfees are still needed in financing health care. At the just concluded 2014 WHO's World Health Assembly (WHA) in Geneva, Switzerland, issues of health care financing, health-related Millennium Development Goals (MDGs) resurfaced as Nigeria navigates through means of finding solutions to some of the challenges. In modern health care service delivery, many nations have tinkered with the idea of government being the sole provider of funds to the sector (WHO, 2014). Most countries have had to look at the private sector as a reliable partner in financing health care service delivery. According to the World Health Organisation (WHO), healthcare financing is very critical for reaching universal health coverage.

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Health financing assist in no small measure in bringing closer universal health coverage to the masses and even the vulnerable (WHO, 2014). At home, experts believed that Nigeria cannot treat her way out of the current health crisis if government continues to be the single contributor to the nation's health funds (WHO, 2014). The nature of healthcare financing defines the structure, the behaviour of different stakeholders and quality of health outcomes. The pattern of health financing is therefore closely and indivisibly linked to the provisioning of services and helps define the outer boundaries of the system's capability to achieve the overall goal of enhancing nation's economic development (Rao *et al*., 2005). Health care financing therefore does not only involve how to raise sufficient resources to finance health care needs of countries, but also on how to ensure affordability and accessibility of healthcare services, equity in access to medical services as well as guarantee financial risk protection. Carrin *et al*. (2007) documented that how health systems are financed largely determines whether people can obtain needed health care and whether they suffer financial hardship at the instance of obtaining care.

The Nigerian Health System

The Nigerian health system is based on the three tier structure of the government (Federal, State and LGA) with autonomy and considerable authority in the allocation and utilization of

resources at each level. The National Health Policy and recently, the National Health Bill ascribe roles and responsibilities to each level. Federal responsibilities include: policy formulation, setting standards, guidelines, coordination, regulating practices for the healthcare system and delivery services at tertiary care level. The States have responsibilities for secondary level care while the local governments are charged with primary level care which is the foundation of the National Health Systems. Each level of health care includes a wide range of providers namely: the public and a large and growing private sector.

Nigeria has also adopted the Ward Heath System (WHS) and the Reaching Every Ward (REW) strategy, an adaptation of the WHO-AFRO Reaching Every District (RED) approach to further bring healthcare nearer to the people. The performance of the Nigeria's health system has been rated poorly. Following the assessment of the functional states of national health systems, Nigeria was ranked in the order of 187th position among the 191 member states by the World Health Organization in its 2000 report (HSR Programme, World Health Report, 2000). The poor performance of the Nigeria's health system is manifested in the wide spread dilapidation of PHC infrastructure, near total breakdown of the system, declining morale and commitment of PHC workers and loss of confidence in the health services by the communities. This situation compounded by gross shortage of appropriate and skilled health workers in the rural areas resulted in most facilities being grossly underutilized for PHC services, including routine immunization. The Federal Government of Nigeria, embarked on its comprehensive health sector reform programme in order to strengthen its health system and improve the health status of Nigerians. The health policy has also been revised towards making the health system more responsive to the needs of Nigerians.

Healthcare Challenges in Nigeria

The poor health status of a large percentage of people in sub-Sahara Africa is widely known for years. Over the past decade, however, Africa's health care crisis has received renewed attention because of the greater awareness of the militating factors and a greater understanding of the link between health and economic development (Lowel *et al* (2010). The major factors that affect the overall contribution of the health system to economic growth and development in Nigeria include inter alia; lack of consumer awareness and participation, inadequate laboratory facilities, lack of basic infrastructure and equipment, poor human resource management, poor remuneration and motivation, lack of fair and sustainable health care financing, Unequal and unjust economic and political relations between Nigeria and advanced countries, the neo-liberal economic policies of the Nigerian State, Pervasive Corruption, Very low government spending on health, High out-of-pocket expenditure on health, Absence of integrated system for disease prevention, surveillance and treatment.

Very low governments spending on health: According to Central Bank of Nigeria reports, federal government health spending increased from the equivalent of US$141 million in 1998 to the equivalent of US$228 million in 2003. Health spending as a proportion of total federal spending decline between 1998 and 2000, but increased in subsequent years, reaching 3.2% in 2003. Most federal health spending goes to teaching and specialized hospitals and federal medical centres. State spending on health is currently around 6.3% of total spending, estimated for 2003 at about US$420 million or US$3.50 per capita. Like federal spending, state health spending is concentrated on the main area of state responsibility, secondary hospitals, and is also most likely on personnel. For 2003, the data available showed that spending on health was equivalent to US$300 million or US$2.45 per capita. Like other levels of government, most health spending by local governments is on personnel (World Bank CRS, Nigeria, 2005).

High out-of-pocket expenditure on health: This has further exacerbated the pauperization of the adverse economic condition of the poor. The 2004 Nigeria Living Standard Survey (NLSS) collected data on household health expenditures from a representative sample of 19,159 households. The estimate from these data of average annual per capita out-of-pocket spending on health is Naira 2,999, equivalent to around US$22.50.

The survey data indicate that this out-of-pocket spending on health services accounts for 8.7% of total household expenditures. This health spending includes expenditure on outpatient care, transportation to health care facilities and medication. This is one of the largest share of health expenditure out of total household expenditure in developing countries. Over the years, government resources dedicated to health are extremely low in Nigeria. According to World health Organization (WHO, 2004), private health spending represents the largest proportion of total health expenditures in Nigeria. In 2004, private out-of-pocket health expenditure was equal to nearly 70% of total health expenditure in Nigeria. Prepaid plan represent around 5% of total health spending. Government health expenditures represent 30.4% of total health expenditure for the period.

Pattern of Health care Financing

There are two broad ways of financing healthcare, the public finance in which government is responsible for health care of its citizen and the free market driven type, in which health care is the responsibility of individuals and employers. Nations adopt either of the two with modifications to ensure quality health for all citizens (Qudus, 2012). Nigeria mainly practises a free market financing with pockets of public funding in some states in the form of 'free health'. Free Market driven health financing aims at providing best quality health service through market competition and innovations.

Health services are provided at a cost determined by forces of demand and supply, with economic gains by the providers influencing pricing. To ensure individuals (children, elderly, unemployed, low income earners e.t.c) to the left of the demand curve who cannot afford the equilibrium price are not priced out of health care, government provide safety nets. The free market health financing as practised in Nigeria is devoid of safety nets as it is in Singapore (3M programs) and the USA (Medicare) where this system is practised.

Thus many Nigerian households have reached their catastrophic threshold (the percentage of a household's income above which a given health expenditure is considered to be inimical to the survival of the household.), forcing them to the street and social media to beg to save their health (Qudus, 2012). Payment for services in market based financing could be directly from personal income in form of Out-of-pocket or through employers, in which employers of labour are responsible for the health of their staff, (an indirect form of out of pocket, as the cost of health care provision is considered in formulating staff salary).

It could also be a joint venture, in which the employer and employee have an agreement on sharing cost of employee health care. In public funding, governments make budgetary provisions to ensure free access to health by all citizens at no cost. To ensure sustainability and avoid overuse, some governments opt for revolving scheme in which health is provided at a much subsidised cost. The setbacks for this are that it limits choice and it doesn't encourage health innovation. The out of stock syndrome (o/s) is also a common feature of this system in Nigeria. Many governments advertise free health in the media yet most prescriptions are marked o/s or N/A (not available). It is unfortunate that the host nation for 'Health for All' conference, in which African countries resolved to spend at least 15% of its budget on health, still spend a paltry 3.5% a decade after. This maybe attributed to the life expectancy which remained unacceptably low at 47 yrs. With a vicious circle of ignorance, poverty and disease, it is obvious that public funding and market based funding (without safety nets) cannot ensure health for all Nigerians (Qudus, 2012).

Nigerian Health Care Financial System

Nigeria's health expenditure is relatively low, even when compared with other African countries. Nigeria's Government signed the Abuja Declaration in 2001, which commits them to spending 15% of the total government budget on health (Abuja Declaration, 2001). The total health expenditure (THE) as percentage of the gross domestic product (GDP) from 1998 to 2000 was less than 5%, falling behind THE/GDP ratio in other developing countries such as Kenya (5.3%), Zambia (6.2%), Tanzania (6.8%), Malawi (7.2%), and South Africa (7.5%) (Soyinbo, 2005). In 2013, the Nigerian Government allocated 5.6% of the total government budget on health at the federal level (Federal Ministry of Finance, 2013).

The following ECOWAS states all spent more than Nigeria as a proportion of their GDP in 2011: Sierra Leone, Mali, Niger, Burkina Faso, Senegal, Benin, Togo, Liberia, Ghana, Cape Verde, and the Gambia. The WHO recommends that total health spending, including both government and private spending, should amount to a minimum of $54 per person (this is expressed in 2005 dollars) (WHO, 2010). In 2013, the Government of Nigeria allocated $10.90 per person in Nigeria, which is the equivalent of NGN 1,709 per person for health (Federal Ministry of Finance, 2013), down from $11.50 or NGN 1,782 in 2012 (Federal Ministry of Finance, 2013). Health care in Nigeria is financed by a combination of tax revenue, out-of-pocket payments, donor funding, and health insurance (social and community) (WHO, 2009). Achieving a successful health care financing system continues to be a challenge in Nigeria. Limited institutional capacity, corruption, unstable economic, and political context have been identified as factors why some mechanisms of financing health care have not worked effectively (Adinma and Adinma, 2010).

Tax Revenue: The total government health expenditure as a proportion of THE was estimated as 18.69% in 2003, 26.40% in 2004, and 26.02% in 2005 (Soyibo *et al*., 2009). Remarkably, the federal budgetary component of health expenditure has increased over the years. It increased from 1.7% in 1991 to 7.2% in 2007 (Soyinbo, 2005). Nevertheless, the budgetary allocation for health is still below the 15% signed by the Nigerian government in the Abuja declaration (WHO, 2009). Given this level of government spending, it will be very difficult to provide the essential health care services, and with the vagaries of the oil prices in the world market, a low tax base, and other preponderant issues, health care will always be at the peril of underfunding by the Nigerian government.

Out-of-Pocket Payments: The issue of user fee in Nigeria has attracted scholars; however, there is dearth of information on the effect of user fee on revenue generation, health care seeking behaviour, access to care, efficiency, and utilization of services in Nigeria. The ability to pay might require poor household sacrificing their longer term economic well-being. This is referred to as catastrophic health expenditure and this has been shown to be high in Nigeria (Onoka *et al*., 2010). The use of waivers and/or exemptions in Nigeria has also been suggested, but the implementation of waiver and exemption is fraught with challenges that have made it ineffective in many settings (Gilson *et al*, 1995; Russell and Gilson, 1997). Such difficulties include identification of eligible poor, limited administrative capacity, willingness of the health workers in enforcement of the guidelines, and inconsistencies in granting of exemptions (Kivumbi and Kintu, 2002). James *et al*. concluded that abolishing user fees may not be appropriate in all contexts, nonetheless, in settings where it has been shown to have had limited benefits, removal should undoubtedly be a favorable policy options (James *et al*., 2006). User fees have been removed by the federal government and some states for the treatment of malaria in the under-5s and pregnant women (Onwujekwe, *et al*., 2010).

Social Health Insurance: The NHIS is organized into the following social health insurance programmes (SHIPs): Formal Sector; Urban Self-employed; Rural Community; Children Under-Five; Permanently Disabled Persons; Prison Inmates; Tertiary Institutions and Voluntary Participants; and Armed Forces, Police and other Uniformed Services. It is only the formal sector SHIP that is currently operational. Membership with the formal sector SHIP is mandatory for federal government employees and about 90% coverage has been achieved. The formal sector SHIP is presently extending to include all state and local government employees with Bauchi and Cross River having achieved full coverage (Kannegiesser, 2011). There has been a lag in the expansion of NHIS to achieve a considerable coverage since it became operational.

A World Bank survey in 2008 reported that about 0.8% of the population was covered by NHIS. This has attracted a lot of censure since many people are left out and not benefiting from it. The act that set up the NHIS makes it optional, and this has been pointed out to be one of the reasons many Nigerians are not benefiting from it. The NHIS is focused on making the scheme mandatory for every Nigerian and aims to get every Nigerian enlisted by December 2015. Other factors such as poor medical facilities, shortage of medical personal, lack of awareness, and poor funding have been identified as challenges that affect the efficacy of NHIS in Nigeria (Agba *et al*., 2011). Various stakeholders have also raised issues about the potential mismanagement and bureaucracy that may affect the scheme.

Community-Based Health Insurance: The Nigerian government intends to use CBHI to cover people employed in the informal sector and in the rural area. CBHI was piloted and introduced in Anambra State in 2003. However, since the change in government in 2005, the scheme has been dormant owing to the diminished support and interest by the new government (Uzochukwu *et al*, 2010; Adinma *et al*., 2010). A study that evaluated the impact of the Anambra community health care financing scheme in one of the communities on maternal health services reported that the scheme was highly accepted and it provided adequate funds for maternal health services for a great proportion of the rural communities. CBHI has also been introduced in Lagos and Kwara state (Jimoh, 2009).

Donor Funding: This refers to financial assistance given to developing countries to support socioeconomic and health development. Financial assistance to Nigeria has not been tremendous. *De facto*, it witnessed a declining trend before the return of the democratic governance in 1999. The annual average official development assistance inflow from 1999 to 2007 was estimated at US$ 2.335 and US$4.674 per capita, respectively (United Nations Development Programme, 2011). These figures are way below the Sub-Saharan African average of US$28 per capita (7,57). The contribution of development aid to health care financing in Nigeria was estimated as N27.87 billion (4% of THE) in 2003. This increased by 29% to N36.04 billion (4.6% of THE) in 2004 and by just 1% to N36.30 billion (4% of THE) in 2005 (Soyibo *et al*., 2009).

The Way Forward

The roadmap to a better healthcare system must see private investment as a strategic ally. This must be driven by private financing as well, experts argued. In 2010, WHO postulated that the way to ensure better healthcare for the poor was to key into private healthcare financing. The importance of healthcare financing can be attained through "raising funds for health; reducing financial barriers to access through prepayment and subsequent pooling of funds in preference to direct out-of-pocket payments; and allocating or using funds in a way that promotes efficiency and equity. Developments in these key health financing areas will determine whether health services exist and are available for everyone and whether people can afford to use health services when they need them.

Therefore, effective healthcare financing will not only resolve health crises but will also address issues of poverty. And with the growing concern on the increasing level of poverty, scaling up health care financing and reaching the target goals for health-related Millennium Development Goals (MDGs) can go a long way in tackling abject poverty in developing countries.

Conclusion

Government should massively increase investment and public spending on health. The health system currently rely on mixture of government budget, health insurance, external funding and private sources including non-governmental arrangements and out of pocket payments. Despite the variety of financing sources, the level of health spending is relatively low. Nigeria spends less than 5% of her gross domestic product (GDP) on health and per capita health spending is slightly lower than US$35 per person per year. The ridiculously low per capita health spending in Nigeria indicates a negligent lack of commitment by Federal, State and Local Government to health, and the leadership continues to pay lip service to healthcare services. At a minimum, per capita health spending must increase to $60 in order to provide a minimum range of services.

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