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Examining Healthcare Financing in Nigeria: Implications for Attaining Universal Health Coverage

1. SUCCESS ADEYANJU ADEBAYO MSc, MBA, ACCA, ACFP
Solina Centre for International Development and Research (SCIDaR)
8 Libreville Cres, Wuse, Abuja 904101 success.adeyanju@solinagroup.com aatsuccess@yahoo.com

2. BUKOLA ADEYANJU DORCAS MSc
Institute of Human Virology, Abuja Nigeria badeyanju@ihvnigeria.org
bukoladeyanju@gmail.com

A critical factor in achieving universal health coverage (UHC) is the structure of a country's healthcare system. This is true since it establishes whether or not those needing health care can afford it. Nigeria finances the health sector via a variety of methods and sources. The degree to which a health sector like this will succeed in establishing a healthcare finance system depends on how different the proportionate contributions from these declared sources are. Finding the right combination of these sources in Nigeria takes time and effort. An overview of the situation of healthcare financing in Nigeria, including measures to improve it, is given in this review, which draws on relevant research. The following search phrases in searches of the WHO Library Database, Popline, The Cochrane Library, Science Direct, PubMed, and Medline was employed. Nevertheless, we were open to discussing how to finance public health, health care, and policy in Nigeria. References listed in pertinent articles and reports led to the discovery of further publications. We limited our review to English-language publications. There were no date limitations on the searches. It states that there are several ways that Nigerians pay for their health care, including tax money, donor funds, out-of-pocket expenses (OOPs), and health insurance (both social and community). It is crucial to review the health financing system and ensure that resources are used more efficiently while removing financial barriers to access by refocusing attention from out-of-pocket expenses to other hidden resources to achieve universal coverage with health financing as the basis for action. Implementing a successful healthcare financing system remains a challenge in Nigeria. Additionally, the national health bill must get presidential approval before it can be swiftly put into effect after it is passed into law.

Keywords: *Healthcare, financing, out-of-pocket payment, universal access to healthcare*

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I. Introduction

For the purpose of meeting population needs, the healthcare financing system purchases goods and services from both public and private sources. like salary, budgeting, capitation, and fee-for-service (Cuadrado et al., 2022). Revenue comes from main and secondary sources. Such as donor funding, co-payments, required and voluntary prepayments, out-of-pocket payments (OOPs), indirect and direct taxes, and fund pools that are built up to distribute risk among sizable demographic groups. (Junaidu, 2022) Ultimately, households—whether through taxes, health insurance, or out-of-pocket expenses—provide the majority of the money for the healthcare system. (Khan and Aregbeshola, 2021). Transferring funds from patients to healthcare professionals in exchange for their services is, thus, the most straightforward description of healthcare finance (Onwujekwe et al., 2020). The way a health system is funded indicates whether or not patients receive the care they require and whether or not their expenses go up while they are receiving it (Asmri et al., 2020, 2020). A healthcare financing strategy must be able to mobilize resources for healthcare, achieve equity and efficiency in the use of spending, ensure high-quality, affordable healthcare, ensure that essential healthcare goods and services are adequately provided for, and, most recently, ensure that the money is spent wisely in order to meet the MDGs (millennium development objectives).

In order to keep any household from going bankrupt because they have to use healthcare services, a funding framework for healthcare needs to provide sufficient money security. One way to offer this protection is to include a risk-sharing plan in the healthcare funding system. This way, the risk of accumulating unanticipated medical bills is spread across families and individuals. (Cattel et al., 2020) One of the main goals of universal health coverage (UHC) is to ensure that everyone has adequate access to healthcare without having to pay a large amount of money out of pocket for care (Taverne et. al., 2021).

One way to do this is by risk pooling through social health insurance (SHI) or tax-funded programs. The National Health Insurance Scheme (NHIS) was introduced. Increasing universal coverage can be achieved by governments through the implementation of SHI programs. Implementing SHI programs is one way that countries can increase universal coverage. In order to guarantee that Nigerians could get healthcare, the NHIS was established in 2005 (Adebiyi and Adeniji, 2021), and since its inception, only federal government employees (less than 5% of Nigeria's working population) have been enrolled in the NHIS. The plan was for state governments to expand the insurance plan's coverage by implementing the program for their workers. Nine years after the program's inception, only two states have embraced the program (Chen et. al., 2020).

Consequently, there are plans to broaden the coverage to include people employed in other states, in the informal sector, and in another formal industry outside from the federal formal sector. If this is done, the NHIS's primary objective (universal coverage) can be fulfilled. Several approaches have been put out to improve universal coverage in areas with a low proportion of employees in the formal sector. Households inside a community can contribute to insurance plans through "contributory schemes" like community-based health insurance (CBHI); an additional option is a tax-funded health scheme (Kolesar et al., 2020), which uses taxes to pay for healthcare for individuals outside the community.

A neighboring country has proposed enacting a "one-time NHIS premium payment (OTPP) policy" to shield people who do not work in the formal sector financially from danger. (Sannigrahi et al., 2020). A country's healthcare system's funding structure is crucial to achieving universal health coverage (UHC). This is accurate since they prove that health care services are available, affordable, and readily available to those who need them. This can be achieved by carefully combining all available healthcare financing options, including tax-based financing, donor funds, out-of-pocket expenses, deferrals, and subsidies, as well as health insurance exemptions. Stabilizing workers in the formal sector while raising enough money from various sources to cover health care costs is the main objective.

Formal sector workers in Nigeria, who encompasses 47% of the working population, are the group whose contributions are their agreed-upon deduction or tax, which can be easily retrieved from the source. (Eke, 2021) When the informal sector—roughly 53% of the working population is considered, the situation changes because of a deficient tax collection system, an inefficient method for calculating the amount that must be collected, and a lack of confidence in the individuals entrusted with collecting the money.

The majority of Nigeria's health sector funding comes from both pooled and unpooled sources of income. (Adebisi et al., 2020). The budgetary allotment, direct and indirect taxes, and donor money are the combined sources. According to Bagun (2020), fees (formal or informal direct payments made to healthcare providers at the time of service) account for approximately 90% of total health expenditures (THE), while commodities (medical products, such as bed nets or condoms) account for 10% of costs. Over 70% of THE originate from unpooled sources. (Gyamfi and Tsamenyi, 2002) Even with the availability of several financing options, there are still differences in healthcare spending between areas and an uneven allocation of resources within the health system in Nigeria. Thus, it is still difficult to establish a viable healthcare finance system in Nigeria. This review provides an overview of Nigeria's public healthcare financing status by drawing on pertinent and currently available literature.

II. Methodology

The researcher’s experiences and a survey of pertinent literature were used to compile the data for this publication. Grey papers, policy statements, and a thorough literature assessment were assessed. The reviewed records included information on healthcare finance, particularly in Nigeria. We used the following search engines in our searches: WHO Library Database: Popline, The Cochrane Library, Science Direct, PubMed, and Medline. However, we were open to discussing how to finance public health, health care, or policy in Nigeria. References listed in pertinent articles and reports led to the discovery of further publications. Only articles published in English were used. There were no date limitations on the searches. Additional data was acquired from the writers' personal experiences. These included insights from working with primary, secondary, and tertiary healthcare systems, interacting with private health sector workers, and participating in workshops and conferences; an overview of Nigeria's healthcare financing and the authors' diverse experiences with UHC were covered in one focus group discussion that was arranged. Their input was used in the different theme sections.

III. Results and Discussion

The analysis revealed that the Nigerian government has put in place a number of strategies and policies related to healthcare (Alawode and Adewole 2021). The research findings focused on ways to advance universal health coverage (UHC), such as where and how to raise the necessary funds for healthcare, how to get rid of the financial obstacles that keep many low-income individuals from receiving care, and how to provide an equitable and efficient range of health services. Among these programs and policies are the Health Financing Policy, the

National Health Bill, the National Health Policy, and the National Strategic Health Development Plan (2010–2015).

Table 1: Total federal allocation (2009-2014) to health; Recurrent versus capital

Year	% recurrent	Total NGN billion	Capital NGN billion	% capital	Recurrent NGN billion
2009	67	154.6	50.8	33	103.8
2010	68	164.9	53.0	32	111.9
2011	76	266.7	63.4	24	203.3
2012	77	282.8	65.0	23	217.8
2013	77	279.2	64.2	23	215.0
2014	82	262.7	46.3	18	216.8

Source: Budget Office of the Federation, Federal Ministry of Finance

Table 2: Federal allocation to health concerning the total budget and GDP.

Year	Total allocation (NGN billion)	Allocation to health (NGN billion)	as the percentage of the total budget	GDP (NGN billion)	As the percentage of the GDP
2009	3557.7	154.6	4.3	25,102.44	0.6
2010	4427.2	164.9	3.7	30,980.84	0.5
2011	4971.9	266.7	5.4	36,123.11	0.7
2012	4877.2	282.8	5.8	42,132.16	0.7
2013	4920.0	279.2	5.7	63,504.00	0.4

Source: Budget Office of the Federation, Federal Ministry of Finance. GDP=Gross domestic product

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Source: Budget Office of the Federation, Federal Ministry of Finance. GDP=Gross domestic product

Table 3: Federal Capital Health release and utilisation 2009–2011

Year	Allocation (NGN billion)	Total released	% released (NGN billion)	Amount cash-backed	% cash-backed (NGN billion)	Amount utilised	% performance.
2009	54.5	48.6	89.2	48.7	100	24.5	50.4
2010	57.1	33.6	58.8	33.6	100	32.8	97.6
2011	63.4	38.8	61.2	38.8	100	26.0	67.1

Source: Budget Office of the Federation, Federal Ministry of Finance

Table 1. Recurrent Allocation Trends. There is a noticeable increase in recurrent allocations from 2009 to 2011, with a significant jump between 2009 and 2010 (#103.8 to #111.9 billion). After 2011, recurrent allocations remain relatively stable, with slight fluctuations but no significant increases. Capital Allocation shows

that capital allocations have also shown an increasing trend over the years, with fluctuations. However, there was a notable decrease in 2014 compared to previous years. Total Allocation Trends: Total allocations have generally increased over the years, except for a slight dip in 2014. The total allocation peaked in 2012 at 287.8 billion ₦. Percentage of Recurrent Expenditure: The percentage of recurrent expenditure over the total allocation has increased steadily over the years, indicating [32] a higher proportion of funds allocated to recurrent expenses than capital investments. This percentage increased from 67% in 2009 to 82% in 2014, reflecting a growing emphasis on recurrent expenditures.

Table 2. The percentage of the total budget allocated to the health sector varies over the years. It increased from 4.3% 33 in 2009 to 5.8% in 2012 before slightly decreasing to 5.7% in 2013. This shows varying levels of prioritisation of the health sector within the overall budget. The allocation to the health sector as a percentage of GDP shows a consistent trend of being relatively low, ranging from 0.5% to 0.7%. This suggests that while the absolute amount allocated to health may increase, it remains a small fraction of the country's GDP. Comparing the allocation to health with GDP can provide insights into the government's commitment to healthcare relative to the size of the economy. Despite fluctuations in the allocation, it consistently represents a small fraction of the GDP, indicating potential limitations in healthcare funding relative to economic capacity. The data suggests that while there have been increases in the absolute amount allocated to the health sector over the years, the proportion of the budget and GDP allocated to health remains relatively low. This could have implications for healthcare provision, including access to quality healthcare services, infrastructure 53 development, and healthcare outcomes

Table 3. In 2009, the total released amount was 89.2% of the allocated budget, while in 2010, it decreased to 58.8%. This indicates a significant gap between the allocated funds and the release, especially in 2010. In 2011, the data showed that 61.2% of the allocated budget was released, maintaining a trend of partial release of allocated funds. Cash-backed Allocation. Both in 2009 and 2010, the amount cash-backed matched the total released amount, indicating that cash allocations fully supported the released funds. This reflects financial prudence and accountability in fund management. Utilisation Performance. The utilisation performance 2009 was relatively low at 50.4%, indicating that only about half of the released funds were utilised effectively. However, in 2010, the performance improved to 97.6%, indicating efficient utilisation of the released funds—analysis of 2011 Data. The data for 2011 needs more information on the amount utilised and the corresponding performance percentage. This suggests that either the utilisation data was unavailable or the funds needed to be utilised effectively or reported. Implications: The fluctuation in the release and utilisation of funds over the years highlights challenges in budget implementation and financial management within the health sector. The significant improvement in utilisation performance from 2009 to 2010 suggests potential enhancements in financial management practices or operational efficiencies.

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IV. Conclusion

The report thoroughly summarizes the patterns and consequences of government funding to Nigeria's health sector over time. Here are the key conclusions drawn from the data presented: There was a noticeable increase in recurrent allocations from 2009 to 2011, followed by relative stability with slight fluctuations in subsequent years. This indicates a consistent emphasis on funding ongoing operational costs in the health sector. Capital allocations demonstrated an increasing trend over the years, with fluctuations, but there was a notable decrease in 2014 compared to previous years. Despite fluctuations, there is a commitment to investing in infrastructure and development within the health sector. Total allocations generally increased, peaking in 2012, but there was a slight dip in 2014. This suggests varying levels of prioritisation and resource allocation to the health sector. The percentage of recurrent expenditure over the total allocation increased steadily over the years, indicating a growing emphasis on recurrent expenses compared to capital investments. This reflects a shift towards funding ongoing operational costs rather than capital-intensive projects.

Significant gaps existed between allocated funds and actual releases, especially in 2010. The data underscores challenges in budget implementation and financial management within the health sector. Utilisation performance improved significantly from 2009 to 2010, indicating potential enhancements in financial management practices or operational efficiencies—however, the lack of information for 2011 highlights the need for better data reporting and monitoring mechanisms. The fluctuation in fund releases and utilisation underscores challenges in budget implementation and financial management. For health programs and projects to be implemented effectively, it is imperative to keep an eye on the release and use of money provided. Overall, the data highlights the importance of monitoring the absolute amount and the relative allocation of resources to the health sector to assess the government's commitment to healthcare provision and its impact on public health outcomes in Nigeria.

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