Review Article

HEALTH CARE EXPENDITURE IN NIGERIA AND NATIONAL PRODUCTIVITY

Abstract

National productivity of any country is a function of the health of such nation which is usually an offshoot of how much such nation invests into the health care system. This paper assesses the health care expenditure of Nigeria and resultant effects on the national productivity.

An overview of literature shows that health care expenditure in Nigeria is very poor and low has compared to other developing nation even in Africa. The little money that is made available is invested majorly in the curative aspect of health care as against preventive health care that brings about national productivity.

This paper suggest that to achieve the much needed improvement in national productivity, special attention must be paid to increasing national investment in health sector especially in primary prevention.

Key Words: Health Care, Expenditure, National Productivity

1.1 HEALTH CARE FINANCING IN AFRICA

The improvement and extension of healthcare delivery in Africa has been constrained by gaps in financing. Sub-Saharan Africa makes up 11% of the world's population but accounts for 24% of the global disease burden, according to the International Finance Corporation (The Business of Health in Africa, n.d.). More worrisome still, the region commands less than 1% of global health expenditure. Public-sector funding for healthcare remains uneven across the continent. Despite the fact that 53 African countries signed the Abuja Declaration pledging to devote 15% of their national budgets to health, most remain far from that target and, according to some estimates, some countries have actually cut their spending on health over the past decade (Health Situation Analysis in the African Region, nd). More than half of healthcare costs on the continent are

currently met by out-of- pocket spending, a ratio that rises to as much as 90% in some countries. With many of the poorest unable to afford treatment, costs are kept down artificially by people's inability to pay, further exacerbating the problem.

Nigeria, with its population of over 170 million and a population growth rate of 2.5 percent, is the most populous country in Africa and the 8th most populous country in world (The World Bank, 2011). The country's tumultuous history is reflected in its abundance of states—beginning with only three states at the time of Nigeria's independence from the British government in 1960 and now with 36 states and the Federal Capital Territory (FCT), where the capital Abuja is located. This highlights the potential challenges of managing such a heterogeneous country. Nigeria is ranked as one of the fastest growing economies in the world with a growth rate of 6.4 percent in 2007 and 7.4 percent in 2011 (The World Databank, 2013). Nigeria's GDP per capita in PPP adjusted dollars is $1,500 according to World Bank estimates from 2011.

The constraints to achieving universal health care in Nigeria are numerous and complex. Factors limiting Nigeria's health outcomes are both demand and supply-side including inadequate financing, weak governance and enforcement, inadequate infrastructure and poor service quality, , household poverty and insufficient risk pooling (Gustafsson-wright & Schellekens, 2013). Health care financing has in recent times received extensive research and policy attention in both developed and developing countries. One of the foremost issues is how to raise sufficient resources to finance health care needs for all citizens (WHO, 2000). Health care provision in Nigeria is a concurrent responsibility of the three tiers of government namely Local, State and Federal governments. Nigeria operates a mixed economy therefore private providers of health care have role to play in health care service delivery. The federal government role is mostly limited to coordinating the affairs of the University Teaching Hospitals (Tertiary health care

system) and federal medical centers, the state governments manage the various general hospitals (secondary health care system) while the local government focuses on dispensaries and health centers (Primary health care system) which are regulated by the federal government (Rais, 1991). Quality rural health services in rural communities are needed to attract business and industry. (Chirilos & Nostel, 1985; Lyne, 1988; and Scott, Smith, & Rungeling, 1997).

1.2 NIGERIA'S HEALTH SYSTEM FINANCING

Nigeria operates a pluralistic health care delivery system with the orthodox and traditional health care delivery systems operating alongside each other, albeit with little or no collaboration. Both the private and public sectors provide orthodox health care services in the country. In 2005, Federal Ministry of Health (FMoH) estimated a total of 23,640 health facilities in Nigeria of which 85.8% are primary health care facilities, 14% secondary and 0.2% tertiary. However, 38% of these facilities are owned by the private sector, which provides 60% of health care in the country (Federal Ministry of Health, 2005). Also, 60% of the public primary health care facilities are located in the northern zones of the country, they are mainly health posts and dispensaries that provide only basic curative services. The Private Out-Of-Pocket- Expenditure (OOPE) in Nigeria accounts for over 70% of the estimated $10 per capita expenditure on health (Federal Ministry of Health, 2004), limiting equitable access to quality health care.

The public health service is organized into primary, secondary and tertiary levels. While the Constitution is silent on the roles of each levels of government in health services provision, the National Health Policy ascribes responsibilities for primary health care to local governments, secondary care to states and tertiary care to the federal level. At the same time, a number of parastatals, based at the federal level, for example, the National Primary Health Care

Development Agency (NPHCDA) are currently engaged in primary health care services development and provision; the latter is evidently part of its mandate. Although national policies, formulated by the Federal Ministry of Health provide some level of standardization, each level is largely autonomous in the financing and management of services under its jurisdiction. The health system is in a deplorable state with an overall health system performance ranking 187th out of 191 member States by the World Health Organization (WHO) (WHO, 2000).

Primary Health Care (PHC), which forms the bedrock of the national health system, is in a prostrate state because of poor political will, gross under funding, and lack of capacity at the LGA level, which is the main implementing body. The health system remains overstretched by a burgeoning population; physical facilities are decaying, equipments are obsolete and there is scarcity of skilled health professionals. In addition, the roles of stakeholders are misaligned and coordination systems are weak. These are further compounded by the dearth of data which renders evidence based planning, policy formulation and health systems management weak. The very weak health system contributes to the limited coverage with proven cost-effective interventions. For example, immunization coverage is 23% (National Population Commission (2008); only 12% of under-fives sleep under Insecticide Treated Nets, 20% of children in urban areas and 14% resident in rural areas with fever are appropriately treated with antimalarials at home, contraceptive prevalence rate is 15% and only 39% of women deliver under the supervision of skilled attendants (National Population Commission, 2008).

In attempt to resolve the anomaly in health care financing, Nigeria government established National Health Insurance Scheme (NHIS), designed to facilitate fair financing of health care costs through risk pooling and cost-sharing arrangements for individuals. The scheme is federally funded with little or no input from the states, local governments and people in the

informal sector of the economy. Since its launch in 2005 the scheme claims to have issued 5 million identity cards, covering about 3 percent of the population. (National Health Insurance Scheme (NHIS), nd). The majority of the enrollees, however, are individuals working in the formal sector and the community scheme still leaves large gaps among the poor and informally employed. Several proposals are currently in the works to expand the reach of NHIS. One of such proposals is to make registration mandatory for federal government employees (Dutta & Hongoro, 2013). Earlier, the creation of a "health fund" collecting an earmarked "health tax" of 2 percent on the value of luxury goods was proposed. This fund would be used for the health insurance of specified groups of Nigerian citizens, including: children under-five, physically challenged or disabled individuals, senior citizens above 65years, prison inmates, pregnant women requiring maternity care, and indigent persons. At a broader level, the National Health Bill which was first proposed in 2006 to improve its poor health sector by allocating at least 2 percent of the federal government's revenue to the health sector is still not signed into law due to some gray areas of the bill that is yet to be reconciled by the stakeholders.

Healthcare expenditure, which is the sum of public and private health expenditure covers the provision of health services (preventive and curative), family planning activities, nutrition activities, and emergency aid designated for health but does not include provision of water and sanitation.) (% of GDP) in Nigeria was 5.07 as of 2010 with its highest value over the past 15 years being 7.55% in 2003 while its lowest value was 3.91 in 2002.

1.3 HEALTH STATUS INDICATOR

The health status indicators for Nigeria are among the worst in the world. The life expectancy at birth is 49 years while the disability adjusted life expectancy at birth is 38.3years; vaccine-

preventable diseases and infectious and parasitic diseases continue to exact their toll on health and survival of Nigerians, remaining the leading causes of morbidity and mortality. In the face of these, non-communicable diseases are increasingly becoming public health problems, especially among the affluent urban population.

Even though only 2% of the global population is in Nigeria, the country, with an estimated infant mortality rate of 75 per 1000 live births, child mortality rate of 88 per 1,000 live births, under 5 mortality rate of 157 per 1,000 live births (National Population Commission, 2008) and a maternal mortality ratio of 800 per 100,000 live births, contributes a disproportionate 10 % to the global burden of maternal and also infant mortality (Federal Ministry of Health, 2008). Wide regional variations exist in infant and maternal mortality across the zones. Infant and child mortality in the North West and North East zones of the country are in general twice the rate in the southern zones while the maternal mortality in the North West and North East is 6 times and 9 times respectively the rate of 165/100, 000 recorded in the South West Zone (FMoH, 2004).

1.4 THE STATE OF HEALTH IN NIGERIA

Nigeria has very poor population health as measured by several health indicators. In the last decade, maternal mortality rate is estimated to be 800 per 100,000 live births and this was one of the highest in the world. Infant and under-five mortality rates were estimated to be 100 and 201 per 1,000 live births respectively (Demographic and Health Survey 2003). There was observed vast regional inequalities in health outcomes across the country. Infant Mortality Rate (IMR) ranges from 121 and 125 per 1,000 live births in the Northeast and Northwest respectively to 66 and 69 in the Southeast and Southwest respectively and in general the prospects of achieving the Millennium Development Goals (MDGs) are slim but more promising in some than other states.

Nigeria Demographic and Health Survey (NDHS) 2003 shows that Under 5 mortality for illiterate mothers is 269 while it is 113 for mother with secondary education and just 80 for mothers with more than secondary education.

The health status of Nigerians has always been ranked low. In 1999, Nigeria ranked 74th out of 115 countries, based on the performance of some selected health indicators (World Bank, 1999). Nigerian overall health system performance was also ranked 187th among the 191 Member States by the WHO in 2000 (National Health Policy, 2004).

In the recent time Nigeria's health indicators have either stagnated or worsened despite the federal government's acclaimed efforts to improve healthcare delivery. Life expectancy at 52 years is below the African average, while the numbers of child mortality are astounding —partly because of the country's size. Annually, one million Nigerian children die before the age of five, this is mostly due to neonatal causes followed by malaria and pneumonia. Maternal mortality is 630 per 100,000 live births which is comparable to low-income countries such as Lesotho and Cameroon. (The World Databank, 2010). An estimated 3.3 million Nigerians are infected with HIV and access to prevention, care and treatment is minimal. (The World Databank: Health Nutrition and Population Statistics, 2010). Even the little prevention, care and treatment services provided has been mostly financed from donor fund from developed nations of the world. Nigeria also continues to combat the double burden of both communicable and non-communicable diseases (NCD). It therefore becomes imperative to ask if governance has an impact on the effectiveness of health expenditure in Nigeria.

1.5 CONSTRAINTS TO ACHIEVING UNIVERSAL HEALTH CARE IN NIGERIA

The constraints to achieving universal health care in Nigeria are numerous and complex. Factors limiting Nigeria's health outcomes are both demand and supply-side including inadequate financing, weak governance and enforcement, inadequate infrastructure and poor service quality, , household poverty and insufficient risk pooling.

1.5.1 Inadequate government financing for health

There are four main sources of public funding for the public (nonfederal) health sector: state governments, local governments, direct allocations from the federal government, private individuals and organizations, including non-governmental organizations and international donors in some states. The federal government and some state governments have increased funding to public health care (PHC) over the past decade, with a dramatic increase between 2005 and 2007 where the percent increase in health sector allocations jumped from 31.4 percent to 86.2 percent. (The World Health Organization, 2009). Nonetheless, Nigeria spends a mere 5.3 percent of its GDP,) or $139 (PPP) per capita on health care. This is extremely low, in particular when compared to other African countries such as Burkina Faso (6.7 percent) and the Democratic Republic of Congo (7.9 percent), which have considerably lower GDP per capita. It is also not certain the actual percentage that is spent directly on health has good percentage of monetary allocation and acclaimed spending in Nigeria are usually lost to leakages and corruption in the system.

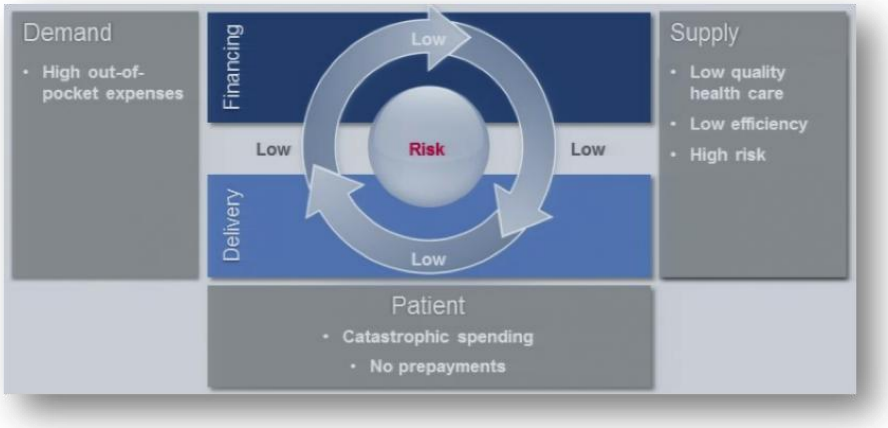
In order to achieve effective access and financial protection, the government must begin by making a more serious commitment to spend on health. The absence of institutionalized National Health Accounts (NHA), however, contributes to the challenge of reassessing health spending in the country. Also, low levels of external health financing reflect an unwillingness to invest in the

187 country. Just 9.2 percent of spending is donor funded, which is very low compared to, for
188 example, Ghana with 16.9 percent, which has a comparable GDP per capita. (WHO, 2011).

189 **1.5.2 Poverty constraints, insufficient risk pooling and burden on private individuals**

190 Nearly two-thirds of Nigerian's live below the poverty line; eighty percent work in the informal
191 sector. Even not all those that work in the formal setting are able to access the scheme. Most
192 states of the country up till now have not enrolled their workers on the scheme. As the national
193 health system mostly covers the formally employed only 3 percent of the population is covered
194 by the NHIS. Private prepaid schemes are unreachable for the poor as premiums are
195 unaffordable. With the overburdened public system unable to deliver, people have no option but
196 to pay for health care out-of-pocket. By default, the private health sector has grown rapidly over
197 the past decades and now provides over 65 percent of health care services (FMoH, 2009). The
198 health financing system is therefore mainly based on out-of-pocket user-fees; payments are made
199 at the point of service. Beyond the inability to pay for existing expensive health insurance
200 schemes, it is common in poverty stricken environments, that decision-making take place in a
201 much shorter time horizon, with people refraining from saving, investing and buying health
202 insurance. The willingness to prepay for health care is low in an environment of low trust in
203 which people are unsure of benefits from a product or service in the future against a payment
204 today. In Nigeria, prepaid spending or risk-pooling only encompasses 3.1 percent of all private
205 health spending. The remaining private spending consists of out-of-pocket payments. This makes
206 the development of risk pools difficult and creates an environment that is not conducive to
207 private investment. The high share of out-of-pocket expenses is the most expensive, least
208 efficient and least inclusive financing channel. It weighs heavily on households budgets and
209 forces many into poverty due to unpredictable catastrophic health expenditure. In short, the poor

are stuck in a vicious cycle for health care as the figure below shows. Prepayment is low because people do not trust the system and because the quality of the services is low, while a lack of steady revenue stream discourages providers from investing.



Source: PharmAccess Foundation, 2012

Figure

Poverty incidence has varied but remained high over the past decade. In 2004, the poverty rate was 54.4 percent, it rose to 62.6 percent in 2010 and dropped back down to 54.4 percent in 2011. (The World Bank PovCalNet, 2011). There are great regional disparities, reflected in a contrast between rural areas with a poverty rate of 69.0 percent and 51.2 percent in the urban sector (The World Databank: Poverty and Inequality Database, 2010). The poorest zones of the country are those in the North while the South East zone has the lowest incidence of poverty. Inequalities, as measured by the Gini coefficient, rose steadily since 1985, save for a slight decline in 1992. As of 2011, the total population inequality is back at the only slightly better 1992-levels with a Gini coefficient of 0.397. (The World Databank: Poverty and Inequality Database, 2011). Human

development indicators are staggeringly low considering the country's GDP per capita. Nigeria ranks 156th out of 173 countries with data on the Human Development Index (HDI) (UNDP, 2011).

1.6 HEALTH CARE EXPENDITURE AND ECONOMIC GROWTH

Better health care is a primary human need. According to the World Health Organization (WHO, 2005), fifty percent of economic growth differentials between developed and developing nation is attributable to ill-health and low life expectancy. Developed countries spend a high proportion of their Gross Domestic Product (GDP) on Health Care because they believe that their resident health can serve as a major driver for economic activities and development. This is however, not the case in many developing nations especially Nigeria and is therefore not strange that much impact has not been made in the area of reduction of infant, under five and maternal mortalities since 1970. For instance, the Nigeria's rate of infant mortality (91 per 1000 live births) is among the highest in the world, and the immunization coverage has dropped below thirty percent while the mortality rate for children under age five is 192 deaths per one thousand. By year 2007, it was reported that more than one hundred and thirty four thousand women died from pregnancy complications. In addition, the life expectancy ratio on the average has been on the decline over the study period.

It should however be noted that despite the increase in government expenditure in health care in Nigeria, the contribution of this to health is still marginally low whereas the extent and magnitude of its impact on economic growth is undetermined. In the actual sense there has been increase in the amount of money allocated and spent on health services but per capita

expenditure on health has not witness much increase over the year. Per capita determine the effect of monetary allocation to a common man on the street.

Bakare & Olubokun (2011) in their quest to establish the relationship between health care expenditure and economic growths in Nigeria submitted that gross capital formation has positive coefficients and it is significant at the 3% level. They found out a direct relationship between capital formation and gross domestic output in Nigeria. This indicates that a unit increase in the gross capital formation will increase the GDP by about 84 percent. There result suggests a direct relationship between health expenditure and gross domestic output in Nigeria. It implies that the increase in health expenditure over the years has boosted national income which is a good measure of national productivity. They also showed that 1 percent increase in the health expenditure leads to about 69 percent increase in the real Gross Domestic product.

It is therefore not a sweet saying that increase in per capita expenditure will result in better health indices and resultant healthy nation and increase national productivity.

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