Health financing reforms:
the Nigerian experience

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Introduction

Since Nigeria became independent in 1960, conscientious efforts at development have led to the formulation of various national development plans (the second for 1970–1974, third 1975–1980, fourth 1981–1985 and fifth for 1987–1991). The adoption of the structural adjustment programme in 1986 was followed by a three-year rolling plan (1990–1992). In 1998, the *Vision 2010* document was developed, and in 2003, the National Economic Empowerment and Development Strategy 2003–2007 was put in place.

The common objective of the development plans was how to achieve a free and democratic society; a just and egalitarian society; a united, strong and self-reliant nation; a great and dynamic economy; and a land of bright and full opportunities for all citizens. The health of the population is seen as a cornerstone of economic growth and social development. In furtherance of that principle, a national health policy was formulated in 1988 and revised in 1996 based on a philosophy of social justice and equity. The policy foundation adopted primary health care as the health system.

This article discusses health system financing in Nigeria with a view to examining how financing matches the general principles on which the health system is based.

Organization of the health system

The formal health system in Nigeria is organized along the three-tier system of government in the country: federal, state and local government. The federal level has responsibility for policy formulation, implementation and evaluation as well as provision of tertiary and specialized care. The state level has responsibility for technical backstopping for the lower level of care in terms of implementation, and the provision of secondary level of care through general hospitals. Primary health care is the responsibility of local government authorities. All levels of government provide legislation and funding for the health system in the country.

In terms of funding the health system, the National Health Policy articulates funding from budgetary sources, encouraging all levels of government to make adequate budgetary provision for the sector and, in particular, review their financial allocation to health in relation to the requirements of other sectors of the economy. Also recognized are additional avenues of revenue such as health insurance schemes and direct financing by employers of labour. Individuals are encouraged to establish and finance private health care while communities are encouraged to finance health care directly or find local community solutions to health problems through contribution of labour and materials.

The public heath sector is financed with allocation from the Federation Account's general revenue allocated to the various levels of government based on an agreed revenue allocation formula. The general mechanism for mobilization of revenue includes royalties and fees from the oil sector (the largest source of revenue for government); general tax revenue, including a value added tax; social health insurance; cost recovery, including user fees in some public health facilities; and external aid in terms of loans, donations and grants. The percentage of allocation to health has always been about 2-3% of the national budget, although this has increased marginally in recent times.

Funding for the sector comes largely from government, more specifically the Federal Government. According to the World Bank, the public spending per capita for health in Nigeria is less than US$ 5 and can be as low as US$ 2 in some parts of the country.

The Federal Government health recurrent budget showed an upward trend from 1996 to 1998, a decline in 1999, and a rise in 2000. The bulk of health recurrent expenditure went to personnel and construction of high technology hospitals that were at various stages of completion.

Beyond budgetary allocations, another concern in funding the health sector in Nigeria is the gap between budgeted figures and the actual funds released from the Treasury for health activities. In some specific cases, statistics show that the actual amount released from the budget as low as 30–40% in a year. This has further heightened the need to support the development and refinement of a national health account so as to track the sources and flow of funds to and within the health sector.

The mechanism for paying for services in the private health sector is through a fee for service. In very rare cases, some organizations and government departments engage in retainership, a practice whereby employees can benefit from health services up to a prescribed

monthly limit through a contracted private provider. The provider is reimbursed at agreed intervals. The major drawback of this scheme is that payment is made retrospectively. This implies that the provider must have the cash flow required for regular service delivery.

User fees in public facilities

A user fee was introduced in the health sector in 1986. User fees, which are charged at all levels of health care (national and sub-national levels), have been extended to such components as surgical packs, drugs and dressings, and, in some instances, delivery packs. Experience has shown that these schemes seem to run better at higher-level facilities like teaching hospitals but are very weak at general hospitals and health posts. This may be due to weak financial management capacity at these levels and the absence of clear retainer and use policy for fees collected.

Social Health Insurance

The National Health Insurance Scheme (NHIS) was first broached in 1962 as a compulsory scheme for public service workers. Since 1999, the scheme has been modified to cover more people. This scheme of mandatory and payroll deductions, introduced by the NHIS Act 35 of 1999, allows each insured person to decide which health centre to register with. A monthly contribution is paid to the health centre. Health maintenance organizations are expected to play a major role in coordination of the health centres while the overall regulation of the scheme rests with the National Health Insurance Scheme Council.

The basic objectives of the scheme are to ensure that every Nigerian has access to adequate health-care services; protect families from financial hardship due to huge medical bills; limit the rise in the cost of health-care services; ensure efficiency in services; and ensure the availability of funds to the health sector for improved services, amongst others.

Some stakeholders harbour fears regarding the implementation of the scheme. For example, organized labour, under the umbrella of the Nigerian Labour Congress, is weary of deductions from workers' salaries as previous deductions for the National Provident Fund and the National Housing Fund did not benefit workers.

While the NHIS is designed for the formal sector, the current effort at financing reform focuses on community-based financing schemes with the hope that the various existing schemes can be subsequently pulled together for the benefit of the populace.

Current efforts in the general reform process

The appointment of a new minister of health in July 2003 has rekindled the debate for reform in the health sector in general, and the financing of that sector in particular.

In a recent public statement, the Health Minister called for the location of health sector reform within the overall goal of economic growth, development and stability, with reforms embracing cross-sectoral issues, including public-private cooperation, management of public expenditure, financial accountability and civil service reform. The Minister's statement indicated specifically that the finance and budget management system would need significant improvement and enforcement. It is also important to note the effort at coordination with development partners through the Interagency Coordinating Committee. Although currently there is no common basket funding as such, the momentum generated at coordination meetings may lead eventually to that.

Conclusion

The current health financing reform in Nigeria is laudable, given the fact that private expenditures, estimated at over 70% of total health expenditure, are mostly out-of-pocket payments in spite of the endemic nature of poverty in the country. Donors and other development partners are poorly coordinated; this has resulted in duplication of efforts, over-resourced programmes and some areas of the health system patently neglected.

With the reform of the NHIS and better coordination of donors and partners within an institutionalized national health account framework, funding of health services will improve, leading to greater access to better quality of care for the Nigerian people.

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