Ibadan Journal of the Social Sciences

Contents

VOLUME 8 / NUMBER 2 / SEPTEMBER 2010

FACULTY OF THE SOCIAL SCIENCES, UNIVERSITY OF IBADAN
ISSN 1597 5207

Ibadan Journal *of the*
Social Sciences
Volume 8, Number 2 September 2010

Contents

©2010 Ibadan Journal of the Social Sciences
Volume 8, Number 2, Sept. 2010

National Health Accounts of Nigeria: Results from Second Round of Estimation

*Akanni O. Lawanson, Olanrewaju Olaniyan and Adedoyin Soyibo
Department of Economics, University of Ibadan, Ibadan, Nigeria

National Health Accounts (NHA) tracks the flows of health spending from financial sources to end users. This paper uses the framework to capture the general health expenditure and updates the earlier NHA for Nigeria by providing estimates for 2003 2005. The estimates were prepared in line with the WHO's guide to the NHA estimation. Our estimates reveal that households are the major source of health funds in Nigeria. Government funding accounts for a quarter of the health funds and but the main incidence still lies with households. These funds were spent about equally in private and public health facilities. Although resource pooling is not widespread, health insurance show promise as a significant potential option in health care financing. Given health as a public good, the implication is that there is need for government focus on the responsibility to lessening the burden of health expenditure on poor households if its stewardship role is not to be called to question.

Introduction

The importance of health to the development of any nation cannot be overemphasised. This is why out of the eight millennium development goals (MDGs) that Developing Countries are pursuing, three of them, address health issues. In order to further develop the country, Nigeria as one of the signatories is vigorously pursuing policies that would enhance the health sector of the country (Soyibo et al, 2009). Nigeria, a federal country has the highest population in Africa. With a population of 140 million in 2006 (NPC 2006), Nigeria's population is projected to grow to 160.9 million in 2015 with annual growth rate of the population at 2.7%. By 2005 about 48 percent of the citizens live in urban area (WHO, 2006). The remaining 52 percent of the population lives in rural areas, which lack modern social amenities. Divergence in health and economic indicators across the country especially rural urban divide and across geopolitical zones are still prevalent in the country (Olaniyan, 2007). Macroeconomic developments since the return to democratic rule in 1999 had been dominated by strong economic growth. Real GDP increased from 1.19 to 9.57 per cent in 2003 (Olaniyan, 2007). The growth rate since 2004 has also surpassed the projections as stated in National Economic and Empowerment Development Strategy (NEEDS). Although the growth rate declined to 5.63 in 2006, the rates for the two previous years were above 6 percent. The growth rates during these periods have been driven by strong growth in the non-oil sector.

Assessments of the health of Nigerians show that the health situation of the country is dismal and

[1] We acknowledge the financial support of the Federal ministry of health, Abuja, Nigeria for funding the "Estimation of the National Health Accounts of Nigeria, 2003-2005", which provides the data utilised for this paper. Also acknowledged is the support of the United Kingdom's department of International Development (DIFD) through the Partnership for Transforming Health System (OPATHS) for the various seminars and meetings that shaped the final NHA report. The authors are however responsible for all errors

efforts to change the situation over the years have been insignificant (Soyibo et al, 2009). Indeed, Nigeria lags behind many other African countries on various health indicators. For example, the Total Fertility Rate (TFR) by the 2008 NDHS is 5.7 births per woman. Life expectancy in Nigeria has been low, and there are indications suggesting that the life expectancy has been declining in recent times, partially due to the effect of HIV/AIDS. Life expectancy at birth, which was 53.2 years in 1991 (53.8 years for females and 52.6 years for males), has declined to 45 years for males and 46 years for males in recent times (WHO, 2006). Infant mortality rate in 2008 was 75 deaths per 1,000 live births while the overall under-five mortality rate for the same period is 157 deaths per 1,000 live births (NDHS, 2008). However, estimates from the 2008 NDHS reveal that there is a decrease in under-five mortality, from 201 in the 2003 NDHS to 157 deaths per 1,000 live births in the 2008 NDHS.

In order to address the poor health status, various stakeholders have made efforts to finance various aspects of the heath sector with a view to addressing the country's poor health status. It is therefore imperative to investigate the destination of these funds, the channels through which they are spent and the specific agents who provides the funds. This is because an understanding the structure of health expenditure in relation to the amount paid by the different stakeholders for the diverse health services consumed is an important input of health policy. With comprehensive information detail on who pays for health, to whom was it paid and the uses to which the funds are put, it is possible to identify the extent of the responsibilities of the different stakeholders in financing health services in the economy. Many studies have identified National Health Accounts as a framework that answer these questions.

NHA is defined as the approach used for describing the structure and flows of health expenditure between the different stakeholders in the health accounts space. The framework provides answers to such policy questions like (WHO, 2004):

- Who pays and how much is paid for health?
- Who are the important actors in health care financing and health care delivery and how significant are they in total expenditure?
- How are health funds distributed across the different services, interventions, and activities that the health system produces?
- Who benefits from health expenditure?

NHA traces for any given year all the resources that flow through the health system from sources to uses over time and across countries. While *sources* relates to the primary origin of the funds, the *uses* are the categories of providers or types of health services on which the fund is expended. Financing sources, which are broken down into public and private refer to entities through which resources enter initially into the health system for health goods and services. Financing agents are the institutions receiving and managing funds from financing sources to pay for or purchase health goods and services. The *uses* are the health activities or categories of persons receiving health care benefits, which are usually disaggregated by functions, providers, geographical location, and often by gender. NHA is designed to capture the full range of information contained in the resource flows and reflect the main functions of health care financing: resources mobilization and allocation, pooling and insurance, purchasing of care, and distribution of benefits (Soyibo, et al., 2007). As a

[2]The three health MDGs are MDGs 4-6 and they seek to reduce child mortality, improve maternal health and combat HIV/AIDS, malaria and tuberculosis, in that order

[3] NEEDS is the Nigerian version of Poverty Reduction Strategy Paper (NPC, 2004)

result of the usefulness of NHA to policy and actions in many countries there have been attempts at institutionalising NHA estimation in many countries.

The compilation of health accounts has been argued to lead to increased transparency among the financial flows within public sector. The construction and use of the NHA in Nigeria can therefore be seen to be of immense policy benefit to address interventions issues for promoting access to health care by the poor, and other disadvantaged groups. The estimation of the National Health Accounts (NHA) of Nigeria, 2003-2005 was a follow-up to that of 1998-2002. This paper presents an update of the results and analysis of the estimation of the NHA of Nigeria for the period 2003 to 2005. It seeks to provide a better understanding of health expenditure in Nigeria at both the national and sub-national levels.

The next section highlights the literature review and conceptual issues, while section 3 presents a description of the methodology of the paper. Estimation results and analysis is presented in Section4 before Section 5 concludes the paper.

2. Literature Review and Conceptual Framework

There is an increasing recognition of the importance of the NHA as a tool which can assist policymakers and managers to improve health performance in countries where NHAs have been estimated. There are presently many countries around the world estimating NHA. The main conceptual framework for the estimation of NHA is contained in WHO (2003). Many studies are also beginning to utilise the System of Health Accounts (SHA) framework which is an integrated system of comprehensive and internationally comparable accounts. SHA used health accounting statistical system with the system of International Classification for Health Accounts (ICHA). The new sets of accounts estimates using this approach are called the "SHA based health accounts" (Orosz and Morgan, 2004). Most of the initial estimation of NHA focused on broad country estimates (Tangsharoensathen, *et al*, 1999). One of the issues that have been controversial in the estimation of NHA is the definition of what constitute health boundaries as well as what constitutes health expenditure. The problem of defining what constitutes health services or the health sector is always difficult and controversial. The conceptual difficulty lies in the fact that many human activities can be regarded as contributing in some way to the improvement of health (Bernam, 1997). Most literature on NHA have however settled for WHO's (2003) definition of health expenditure as "any expenditure on all the activities whose primary purpose is to promote, restore or maintain health of individuals and the country". Most estimates of NHA try to track the transfer of finance from ultimate sources to financing agencies. The sources include government Ministries departments and agencies, households, private firms, development partners and firms. These sources channeled their funds through financing agents and financing agencies, after receiving funds from ultimate sources of finance, purchase services directly from public and private providers.

Nandakumar (2004) reviewed estimates from 26 countries that were founding members of three regional NHA networks in low and middle income countries and found that there were similar as well as peculiar problems of the various countries. For example, concerns about equity and resource mobilisation were shared by all the countries. However, while MENA and LAC countries were also concerned about a larger burden of the expenditure on households, ESA countries were concerned about excessive dependence on donor funds. In the same vein Ojermark (undated) reviewed NHA results in African countries and found disparities in the sources and destination of

health funds. Orosz and Morgan also document a comparative analysis of 13 OECD countries and their findings indicate that various countries have had to adapt their health statistics to changes in financing and provision of health services. WHO (2009) further found that while OECD health expenditure as percentage of OECD countries average 11.2 in 2006, the proportion was 4.1 on the average for African countries. The per capita health expenditure further illuminates the disparity with per capita health expenditure being $3,509 and $39 in OECD and African countries respectively. These studies thus show that NHA can be utilised to show the extent of disparities in health resources mobilisation and utilisation in different countries.

In addition to studies on inter country distribution of health resources using NHA estimates, recent studies of NHA in many countries that have completed the first round of estimates have included estimates on Satellite accounts of NHAs (Bannett et al, 2001; Garg, 2001). This has brought out more importance of NHA especially in providing basis for the arguments on whether respective countries have been able to progress towards attainment the health related MDGs especially MDGs 5 and 6. In this wise estimates from Bannett et al (2001) and Phiri and Tien (2004) provide estimates of Satellite accounts for HIV/AIDS in Rwanda and Zambia respectively. Some studies have also estimated health accounts for lower levels of government other than national government (Garg, 2001). Given the widespread estimation of NHA in many countries, findings from such surveys have been synthesized for policy into the usefulness of NHA (see Nandakumar et al, 2004 and Magnoli, 2001)

3. Methodology

The data requirements for estimating NHA are many and varied. This is because some of the data are at the government level while others are at the private sector. In order to be as comprehensive as possible, both primary and secondary data were collected for estimating expenditure within the NHA boundary.

In the case of the Nigerian public sector, the data on government expenditure was collected from secondary sources. Nigeria is a federal country with three tiers of government namely Federal, States and local governments. This means that government health expenditure has to be collected at all the levels. In order to get useful estimates, a data plan was developed by the NHA estimation team at the University of Ibadan. Since the study was done in conjunction with the Federal Ministry of Health, there is a focal person in charge of NHA in the Federal Ministry. The focal person collected all the secondary data from the files and records and departments within the Federal Ministry of Health. In addition, there are desk officers in all the State Ministries of Health in the country. This facilitated data from the government sources as they were useful in the collection of data from the various ministries of health, departments and agencies in the different states and local governments which they represent. While most of the data on government department agencies, and tertiary hospitals were collected by these focal persons, the information was triangulated with separate expenditure collected from individual tertiary hospitals, agencies and other sources by the research team.

The data for the private sector were for the expenditure of the household, private employers, insurance firms and development partners. In the case of the household health expenditure, we relied on the National Living Standard survey (NLSS, 2004). Since the data has health expenditure and

[3] The focal person is a staff of State Ministry of health that has attended the NHA training and chosen by the NHA technical committee in conjunction with state governments to assist in collecting NHA data from the respective states.

and utilisation variables, we computed the household information from the survey data. However, in the case of health insurance firms, HMOs, other firms, we conducted a survey. In the case of the survey of firms, we used stratified random sampling using size of enterprise for stratification. This is important, because the larger the company, the more likely it spends on the health of employees. The findings from these surveys was complemented by secondary data from the Annual Abstract of Statistics, 2007(NBS, 2007) and triangulated using results from the enterprise survey and NLSS survey. In the case of donor funding, we conducted a survey of donors working in the health sector in Nigeria. The response rate was low and so we utilised the data from the National Planning Commission as contained in NPC (2007).

For analysis of our data, the household and enterprise survey data were analysed using STATA software. The administrative data were analysed using Microsoft Excel. In the case of the survey data, the focus was computing appropriate per capita health expenditure from the sample after which the estimate is used to determine the appropriate NHA value using appropriate population figures. Allocation to the relevant NHA cells was done using purpose-built Excel Programmes. However it should be noted that we have constraints in collecting government administrative and data from donor agencies. Although, States NHA focal persons in all the States and the Federal Ministry of Health, government bureaucratic procedure makes the collection of data difficult. We have however restricted ourselves to using the data that we believe are available, reliable and consistent. At the end of the day, we were able to complete estimation of NHA tables for three years: 2003, 2004 and 2005.

The NHA estimation experience utilised a plethora of primary and secondary data in estimating the NHA for the three years. Public sector, the data on government expenditure data were collected at the federal, states and local government levels, with the assistance of FMoH focal person, and desk officers in all the SMOHs in the country. For the public sector health expenditure data, two situations emerged from this NHA estimation experience. The first situation occurred when there was total coverage of the appropriate agencies or entities, in which case, the total health expenditure was derived through addition. The second situation is when there was no total coverage. In this situation, the appropriate per capita health expenditure was determined from the available estimate. The desired NHA or SHNA estimate was then similarly estimated as before. The data at the federal level was triangulated with separate expenditure data collected from individual tertiary hospitals, agencies and other sources by the research team. For the collection of data from relevant Ministries, Departments and Agencies (MDAs) that spend significantly on health three different questionnaires were used, each for federal MDAs, state and local government MDAs, and for development partners. Household data were obtained from the household health expenditure data collected by the NBS in the NLSS exercise of 2004, by computing the per capita household health expenditure from the survey data together with an indication of where the expenditure took place. The household health expenditure was subsequently derived by multiplying the per capita value by the proportion of the population that reported being sick and spending on health. Health expenditure data from private sector enterprises were collected through enterprise survey, with different

[5]Surveys for firms were conducted in twelve states, two from each of the six geopolitical zones of the country. This is based on our experience and past studies which indicate that more than 95 percent of these organisations are in these five cities.

questionnaires for non-insurance private sector enterprises, and insurance companies including health insurance companies. The findings from these surveys was complemented by secondary data from the Annual Abstract of Statistics, 2007 (NBS, 2007) and triangulated using results from the enterprise survey and NLSS survey. The data from the development partners were collected at both national and regional levels depending on their coverage. The expenditure on health from the development partners are then summed up to derive the health expenditure attributable to donors.

4. Analysis of Findings

We found that the resource envelope available for health has been increasing over the years. Total Health Expenditure (THE) in Nigeria was estimated as N661.662 billion in 2003 and grew nominally by 18% and 24% to N788.72 billion in 2004 and N976.69 billion in 2005 respectively (Table 1).

Table 1: Characteristics and Trend Analysis of Health Expenditure in Nigeria; 2003- 2005

Health Expenditure in (Million Naira)	2003	2004	2005
Total Health Expenditure (THE)	661,662.16	788,723.91	976,687.60
General Government Expenditure	**123,681.78**	**208,207.86**	**254,174.42**
Federal	47,026.82	115,068.86	130,760.24
State	48,022.77	56,963.53	78,778.28
Local	28,632.19	36,175.47	44,635.90
Private Expenditure	**537,980.38**	**580,516.05**	**722,513.18**
Household	489,785.11	518,409.62	656,545.51
Firms	20,323.11	26,068.46	29,670.97
Development Partners	27,872.16	36,037.98	36,296.70
GDP (billions)	5,403.01	9,913.52	11,411.07
Population (thousands)	128,569	132,273	136,083
Ratios			
THE/GDP	12.246	7.96	8.56
Govt./THE	18.69	26.40	26.02
HHHE/THE	74.02	65.73	67.22
Per Capita THE	5,146.36	5,962.85	7,177.15
Per Capita HHHE	3,835.58	3,946.07	4,857.61
Per Capita THE in US $	39.76	44.67	54.61
Per Capita HHHE in US $	29.65	29.56	36.96

Notes: Dollar values were calculated using average effective exchange rate from CBN (2008)
THE = Total Health Expenditure; HHHE = Household health expenditure

Out of this total health expenditure, the Federal Government health expenditure was estimated as N47.02billion in 2003. This grew nominally by 145% to N115.07 billion 2004 and by 14% to N130.76billion in 2005. The leap in the growth between 2003 and 2004 was as a result of provision of special funds by the federal government for the upgrading of some selected university teaching hospitals in the country. The corresponding estimate of health expenditure in the states was N47.0 billion in 2003. This grew by 18.6% in 2004 and by 38% to N78.8billion in 2005.

These resources translates to a per capita expenditure of N5,146 in 2003 which further increased to N7, 177 in 2005. The private sector continued to account for a larger share of health expenditure in the country. Although, the proportion of household health expenditure out of total health expenditure declined from 74 percent in 2003 to 67 percent in 2004, the per capita household expenditure however increased from an average of $30 to $37 during the same period.

Composition of Health Financing Sources

There are three principal sources of fund for the health sector in Nigeria which are government sources, private sources and rest of the world including development partners and donors. As shown in Table 2, the Nigerian household is the major source of fund for the health system in Nigeria.

Between 2003 and 2005, household accounted for an average of 68.6 % of all sources. The government accounts for 24.2 percent of the total health expenditure. Within government, federal government spent the most out of the three tiers of government and local governments spending the least. Within the private sources, households accounted for more than 90 percent of private sources of funds for health. It was more critical in 2003 when about two thirds of all health funds are sourced from households. This means that households carry most of the health burden in the country. This calls for efforts to be further directed at strengthening the capacity of the various tiers of government to finance health services in the country.

Table 2: Sources of Funds for Health Expenditure (percent)

	2003	2004	2005	Average (2003-2005)
Federal Govt.	7.1	14 6	14.6	12.1
State Govts.	7.3	7.2	8.1	7.6
Local Govts	4.3	4.6	4.6	4.5
Households	74.0	65 7	67.2	68.6
Firms	3.1	3.3	3.0	3.1
Develop. Partners	4.2	4.6	3.7	4.1
Total	100.0	100.0	100.0	

Composition of Financing Agents

The NHA framework suggests that funds are channelled through special entities to their uses. These entities through which health funds are channelled from sources in paying for health services received from health care providers are called financing agents. From Table 3, it is seen that most of the health funds were channelled through out-of pocket (OOP) expenditure of households which accounts for the highest proportion at an average of 69 percent between 2003 and 2005. Total health expenditure channelled through household OOP in 2003 was N492.50 billion during the year. This is nearly N3billion more than amount generated from households as a financing source. In 2005, a total of N660.18 billion representing 68% of total health expenditure passed through this medium.

Table 3: Structure of Health Expenditure by financing agents (percent)

	2003	2004	2005	Average (2003-2005)
Public financing agents	22.6	30.7	29.4	28.0
Out of pocket expenses	74.4	66.1	67.6	69.0
Health insurance	2.4	2.4	2.2	2.3
Others (NGOs and health departments of firms)	0.6	0.9	0.8	0.8

Public sector financing agents accounted for 28 percent while NGOs and firms account for 0.8 percent. It should be noted that most of the difference in the health expenditure of government and NGOs between their funds and the amount they spent comes from the Development Partners. Although the absolute value of the expenditure through health insurance increased between 2003 and 2004, it represent an average of 2.3 percent of all financing agents and the proportion which was 2.4 percent in 2003 and 2004 actually reduced to 2.2 percent in 2005. Given the consistent high proportion of OOP, there is the need to address issues related to health equity as well as the burden of health care spending on the part of the households. While most of household funds are channelled through OOP, most of the government funding are channelled through government financing agents. In the case of donors and development partners in Nigeria, most of their funds are channelled through government and local NGOs and other aid groups. There is still limited usage of resource pooling as less than 2.5 percent of the health funds pass through health insurance.

Uses of Health Expenditure by Type of Provider

Health providers in the country are also classified as whether they are government owned or private owned. Private sector providers receive 48.6 percent of health funds. Out of these, private clinics and for profit health clinics accounts for 32.6 percent of the expenditure (Table 4). Our findings reveal that 51.4 percent of health expenditure were spent in government owned medical facilities with the bulk of it spent in State owned facilities. Private clinics and facilities still represent the single main provider group in the country with as much as 32.6 percent of the funds spent in these facilities. In 2003, a total of about N224.07billion or 34% of THE was expended in private health facilities in Nigeria. In contrast, a total of N175.88 billion (19% of THE) was expended in state health facilities while N 28.44 billion was expended in LGA health facilities. Health expenditure in services like health administration, training, research and consultancy amounted to over N68.14 billion (10% of THE) in 2003 with expenditures in Mission/NGO hospitals totalling N9.28billion. The health expenditure in both Federal facilities, and chemists and pharmacies/traditional care accounts 4.4% and 4.1% of THE, respectively.

Table 4: Health Expenditure by providers (percent)

Providers	2003	2004	2005	Average (2003-2005)
Federal government health facilities	4.4	10.7	10.3	9.1
State government health facilities.	26.6	24.6	18.1	23.2
Local government health facilities	19.4	18.2	18.2	19.1
Private (for-profit) health facilities	33.9	30.6	31.0	32.6
Mission /NGO and other not for	1.4	1.3	1.3	1.4

profit health facilities.				
Chemists and traditional health care	4.1	3.6	3.7	3.9
Others	10.3	10.9	10.0	10.7
TOTAL	100.0	100.0	100.0	100.0

Structure of Health Expenditure by Function (percent)

Most of the total health expenditure in Nigeria is spent on curative care followed by public health prevention Curative care accounts for about two thirds of all health expenditure during the period of analysis (Table 5). This is like the experience of many low income developing countries. Expenditure in rehabilitative health care was very minimal at about one percent average for the period 2003-2005. However, Administration accounts for 11.5 percent during the same period while training and research account is the least function to which health expenditure is directed.

Table 5: Health Expenditure by Function (percent)

Functions	2003	2004	2005	Average (2003-2005)
Pub Hlth Prev.	14.4	10.0	13.9	12.8
Curative Care	74.0	74.8	73.9	74.2
Rehab. Care	0.2	3.0	0.1	1.0
Training & Res.	0.3	0.5	0.4	0.4
Others (Administration etc.)	11.1	11.7	11.7	11.5
TOTAL	100.0	100.0	100.0	100.0

3.5 International Comparison

We further compare the performance in Nigeria with selected countries in Africa and found that total health expenditure as a percentage of GPD in Nigeria falls within the African range. In 2004, Nigeria spends 7.96 percent of GDP on health which translates to $44.67 per capita. Total health expenditure as percentage of GDP ranges between 4% and 11 % in other countries. The corresponding per capita expenditure is however a reflection of the strength of the economy. For example, while 7.2 per cent translates to US$33.3 in Malawi, and 7.96 translate to $44.67 in Nigeria, 7.5% translates to $709 in South Africa. However, given the performance of African countries on health expenditure South Africa is an outlier while Nigeria is within the range of other African countries.

The relative performance of Nigeria to other Oil producing countries in Africa is mixed. For instance, while Angola commit lesser percentage of her GDP (2.5%) in 2005 to health expenditure, her per capita expenditure on health turned out to be US$85, which is greater than what obtains in Nigeria. Also Cote d'Ivoire, another oil producing country, spent 6.7% of her GDP on health in 2008, which translate to US$96 per capita health expenditure, while Algeria spent 3.1% of GDP on health in 2005, which translate to US$96 per capital health expenditure.

Table 6: Per Capita Health Expenditure and Health Expenditure as Percentage of GDP in Selected African Countries

	per capita health expd. (US $)	of GDP
Angola (2005)	85.0	2.5
Ghana (2002)	13.6	4.24
Algeria (2005)	96.00	3.10
Kenya (1998)	74.99	5.30
Tanzania (2000)	18.50	6.80
Cote d'Ivoire (2008)	85.00	6.70
Nigeria (2004)	44.67	7.96
Egypt (2001/2002)	71.26	6.00
Rwanda (2006)	33.93	11.00

South Africa (1998)	709.22	7 50
Malawi (1998)	33.30	7.20
Mozambique (1998)	31.51	4.00
Zambia (1998)	43.00	6.2

Source: Nandakumar et al, (2004); Nigerian figure was got from our estimation.(See Soyibo et al, 2009)

4. Discussion

Our estimates for the three year period reveal some interesting results that calls for policy actions. First, households continue to be the major source of health financing in Nigeria. Over the period of this study, average HHHE was 68.45% of THE, up from 64.25% over the period 1998-2002. This compares poorly with Zambia, whose HHHE was 21.20% of THE in 2002, Kenya whose corresponding value was 51% in the same year (Ojermark, not dated) and Egypt whose HHHE/THE ratio was `60% in 2001/2002 (Foud,2005). World Bank (2005) reported that, despite recent economic growth, Nigeria remains poor. The 2004 NLSS survey shows that poverty is highly unequally distributed with large urban and regional differences. Poverty is highest in the northern Zones with North-Central Zone in between (NBS, 2012). This shows that the burden of health care expenditure, very high in the households, would be exacerbated for poor households.

In addition, government funding of health care is improving. Average GTHE over the period 2003-2005 was 24.10% of THE, slightly below a quarter of THE. This is up from an average of 20.65% of THE over the period 1998-2002. Thus the increase has not been fast enough, as it is less than 1% per year. Given the endemic poverty in the land, government at all levels need to increase its funding of health expenditure faster than it currently does. It is gratifying to note that all levels of government fund health expenditure through OOP expenditures, a kind of cash transfer approach to funding the health of its staff. Government should devise similar means of funding health care of the poor. In general, and not just its employees only.

Health Insurance continues to show promise as a significant potential option in health care financing in Nigeria. Over the study period, there was a significant increase in health insurance expenditure from one year to the other, even though its contribution to THE, was relatively constant at 2% over the three years of study. Thus, health insurance expenditure which, in 2003 was about N15.66 billion, increased by 20% to nearly N18.79 billion in 2004. The corresponding value in 2005 was almost N21.34 billion, 14% above the 2004 value. This suggests that the social health insurance introduced recently in the formal sector has a high potential of success in the informal sector. This share of around 2% of THE poorly compare with the significant role health insurance assumes in Namibia, where it accounts for more than 37% of THE (MoHSS, 2008).

5. Conclusion and Recommendation

This paper examines the distribution of health financing among different stakeholders over the period 2003-2005. The findings show that the main source of financing health care in Nigeria is the household. The government share of the THE remains less than half of the what is shouldered by the household. Generally the health insurance as a source of financing health is still at its infant stage, contributing minimally to the THE. Despite, preventive health care being the corner stone of the country's national health policy, the bulk of spending within the health sector is directed to the curative care.

Government has a responsibility to lessen the burden on of health expenditure on poor households if its stewardship is not to be called to question. The

existence of catastrophic spending on health by the household, in which substantial proportion of their income is devoted to health, stands to compound the poverty situation of the poor majority of Nigerians, especially in the Northern region of the country. The trend in which the burden of financing health rests on the household is not sustainable, and can only result in poorer access to health care, thus deteriorating the health status of the people. Apart from increase commitment of funds by government, there is the need to explore alternative means that is sustainable.

The contribution of health insurance to financing of health in Nigeria is still very poor. Though social health insurance has been introduced in country since 2007, the coverage to date has been limited to a proportion those within the civil service of the federal government. There is need to cover more Nigerians through increase enrolment of civil servants at the three tiers of government: federal, state, and local governments. The health insurance scheme needs to be made inclusive by extending it to the informal sector. Fortunately the NHIS has developed early in 2009, the blueprint for implementing the Community-based Social Health Insurance Programme (CBSHIP) in the informal sector. It certainly will be quite helpful to poor households to expedite its implementation as a way of reducing the high burden of health expenditure on them as shown vividly by this study. The pockets of community health insurance for the informal sector in few communities in Kwara and Lagos states should be replicated across the country to draw more Nigerians into the coverage net.

Achieving national health care goals may remain elusive as long as priority is not accorded preventive health care. Generally primary health care is closer to the people and less expensive to execute, and considered to be most effective. However, more resources is required to increase its impact of the people and lead to improved health status.

References

Bannett C. B. Manjiri, A. K. Nandakumar and P Schneider (2001) *The Application of the National Health Accounts Framework to HIV/AIDS in Rwanda*, Special Initiatives Report No 31 Bethesda MD: Partnership for Health Reform Project Abt Associates

Berman P. 1997. National Health Accounts in developing countries: Appropriate methods and recent applications. *Health Economics* **6**: 1130.

Fouad, Samir (2005) *Egypt National Health Accounts 2001-2002*. USAID/PHR*plus* Working Paper WP013

Garg, Charu C. (2001) Financing of Health Care in India: Results of NHA from Karnataka *Journal of Health Management*, Vol. 3, No. 2, 199-237 (2001)

Magnoli, A. (2001) National Health Accounts in Latin America and Caribbean: Concepts, Results and Policy Uses: Inter-American Development bank Working Paper Series I-17UE, September

Nandakumar A. K., A. Bhawalkar, M. Tien, R. Ramos and S. De (2004) *Synthesis of Findings from NHA studies in Twenty-six countries*. Bethesda, MD: The Partners for Health Reform plus Project, Abt Associates

National Population Commission, *Nigeria Demographic and Health Survey, 2003*

NBS (2012) "The Nigeria Poverty Profile 2010 Report", Press Briefing by the Statistician-General of the Federation/Chief Executive Officer, National Bureau of Statistics, held at the Conference Room, 5th Floor, NBS Headquarters, Central Business District, Abuja on Monday, 13th February, 2012.

NDHS (2008)National Population Commission, *Nigeria Demographic and Health Survey, 2008*

NPC 2006 National Population Commission, *Population Census of the Federal Republic of Nigeria*, 2006

NPC 2008. *A review of Official development Assistance to Nigeria 1999-2007* Abuja, National Planning

Commission)

Olaniyan, Olanrewaju (2007) Poverty Eradication Activities Of The President: 2006 **Report** Submitted to the National Coordinator, National Poverty Eradication Programme Abuja, April

Orosz Eva and Morgan, David (2004)SHA-based National Health Accounts in thirteen OECD countries: A comparative analysis,*OECD Health Working Papers No. 16*

Phiri, Felix and Marie Tien. September 2004. *Zambia National Health Accounts 2002: Main Findings.* Bethesda, MD: The Partners for Health Reform*plus* Project, Abt Associates Inc.

Soyibo Adedoyin and Foluso Ladejobi(2002) "Estimation of Household Health Expenditure in Benue State, Nigeria". Report sponsored by DFID and submitted to Benue State Health Fund.

Soyibo, Adedoyin, Olanrewaju Olaniyan and A. Olayinka Lawanson 2007. National Health Accounts: Structure, Trends and Sustainability of Health Expenditure in Nigeria, *African Journal of Economic Policy,* 14(1):83-109.

Tangcharoensathien, Viroj, Adit Laixuthai, Jitpranee Vasavit, Nuan-Anan Tantigate, Wiphant Prajuabmoh-Ruffolo, Duangkamol Vimolkit and Jongkol Lertiendumrong (1999)National Health Accounts development: lessons from Thailand *Health Policy And Planning;* ***14***(4): 342353

The World Bank(2005) *Nigeria: Health, Nutrition , and Population Country Status Report.* Washington, D.C: World Bank, June.

Ministry of Health & Social Services (MoHSS) [Namibia] and Health Systems 20/20 [Bethesda]. August 2008. Namibia National Health Accounts 2001/022006/07. Windhoek, Namibia and Bethesda,

MD, USA: Health Systems 20/20 project, Abt Associates Inc.WHO (2003) Guide to Producing National Health Accounts: with special applications for low-income and middle income countries.

WHO (2006) Country Health System Fact Sheet 2006 Nigeria: World Health Statistics 2006http://www.who.int/whosis/en/ Accessed:4 March 2009

WHO (2009) **Do health expenditures meet health needs?** *WHO/NHA Policy Highlight No.1/April 2009*

Biographical Note

Akanni Olayinka LAWANSON holds a Ph.D (Economics) degree, with specialty in "Health Economics". He is a lecturer in the Department of Economics, University of Ibadan, and also a Research and Training Programme, Department of Economics, University of Ibadan, Ibadan. He anchors lecturers at both undergraduate and postgraduate (Masters) levels, including health economics in department, as well as teaches "Health Economics" at the Ph.D level, under the Ph.D Collaborative Programme for Ph.D students in Africa at the Joint Facility or Elective (JFE) in Nairobi, Kenya, facilitated by African Economics Research Consortium.

Email: *ao.lawanson@ui.edu.ng*