

Socioeconomic and Policy Context of the Nigerian Health Care Financing System: A Literature Review

Omotunde Omotosho
Department of Economics, University of Nigeria

Abstract

This paper deals with the socioeconomic and policy context of the Nigerian Health Care financing system. The paper is divided into; Introduction, dealing with the Nigerian Health System, Nigerian Health Care Financing System, the Nigerian Health Sector Reforms, Policies in place for financing health care in Nigeria, Sources of health care financing in Nigeria and brief health profile of the Nigerian Population. The paper finds that the constitution of the Federal Republic of Nigeria is silent on the roles the different levels of government plays in health care financing. Hence, there is need for the constitution to be explicit on the roles the different levels of government should play in healthcare financing through legislative clarification. The paper also finds that the Nigerian health care financing system is dominated by excessive reliance on out-of-pocket expenditure for financing healthcare. The paper concludes that a health system dominated by excessive reliance on out-of-pocket expenditure such as Nigeria will find it difficult to achieve universal health coverage for her population. Hence, the paper recommends that government should adhere to the 15% total budget commitment to health care as required by the Abuja Declaration 2005.

Introduction

The Nigerian health system is in principle decentralized into three tier structure with responsibilities at the federal, state and local government levels. All the tiers are involved to some extent in all the major health system functions; stewardship, financing and service provision. The federal level most specifically, the FMOH is responsible for policy and technical support to the overall health system, international relations on health matters, the national health management information system and the provision of health services through the tertiary and teaching hospitals and national laboratories (WHO, 2011).

The State Ministry of Health (SMOH) is responsible for secondary hospitals and for the regulation and technical support for primary healthcare services. Primary healthcare is the responsibility of the local government where health services are organized through the wards. Each local government is subdivided into seven to fifteen wards (WHO, Corporation Strategy, 2014). Healthcare provision is the responsibility of the three tiers of government that made up the federation.

Nigerian Health system has been characterized by lack of coordination, fragmentation, dearth of resources including drugs and supplies, inadequate and decaying infrastructure, inequality in resource distribution and access to care and very deplorable quality of care, this situation has been further compounded by lack of clarity of roles and responsibilities among the different levels of government (Awosika, 2005). The problems bedeviling the Nigerian health system has further compounded the challenges of inequality in access to healthcare especially among the poor.

In 2005, FMOH estimated a total of 23,670 health facilities in Nigeria of which 85.8% are primary health care facilities, 14% secondary and 0.2% tertiary. 38% of these facilities are owned by private sectors, which provide 60% of health care delivery in Nigeria. While 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 (National Strategic Health Development Plan (NSHDP), 2009). There exists limited equity in access to healthcare in Nigeria as out-of-pocket expenditure is the dominant means of financing health care needs in Nigeria. This account for why out-of-pocket expenditure in Nigeria accounts for over 70% of the estimated \$10 per capita expenditure on health (NSHDP, 2009) leading to inequality in access to healthcare. Onwujekwe et al., (2010) noted that public expenditure on health in Nigeria accounts for just 20-30% of total health expenditure and private expenditures accounts for 70-80% of total health expenditure and the dominant private expenditure is out-of-pocket spending.

Although, the public health service is organized into primary, secondary and tertiary levels, the constitution is silent on the roles of the different levels of government in health services provision, the National Health Policy ascribed the responsibilities of primary healthcare to the 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, National Primary Health Care Development Agency (NPHCDA) are currently engaged in primary healthcare services, development and provisions; 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 independent in financing and management of health services under its jurisdiction (NSHDP, 2009).

The Nigerian Health System was rated by the WHO (2000) to be 187th out of it 191 member states.

Primary health care which constitute 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 local government level, which is the main implementing body (NSHDP, 2009). The National Population Commission (NPC), (2013) reported immunization coverage to be just 25%; only 12% of the under-five sleeps under Insecticide Treated Net (ITNs), about 20% of children in urban areas and 14% of residents in rural areas with fevers are appropriately treated with anti-malaria at home and just 38% of women delivers under the supervision of qualified attendants. This was far lower in three states of Jigawa (7.6%), Kano (13.7%), and Bauchi (16.3%). Health indicators have also been shown to vary with regions in Nigeria. wide regional variations exist in infant and maternal mortality across zones, infant mortality 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 maternal mortality in the north west and north east is 6 times and 9 times respectively the rate of 165 to 100,000 recorded in the south west (NSHDP, 2013). These are consequences of inequality in access to healthcare services in Nigeria.

THE NIGERIAN HEALTH FINANCING SYSTEM

The governance structure of the Nigerian Health System shows that healthcare is financed by both the public and private sectors. The private sector is made up of non-governmental organization, private for-profit providers, community-based organization and religious and traditional care givers. The responsibility of health services provision in the public sector rest on the government. Government financing of healthcare has for many years contributed less than 20% of total health financing in the country, while out-of-pocket financing has been constantly higher than 67% of total healthcare financing (Olaniyan, et al., 2013). This account for unequal access to healthcare as the poor will be unable to meet healthcare needs, and where they meet these needs it will be done at great ‘displacement effects’ of other essential household needs (Ichoku, et.al, 2009). The dominance of out-of-pocket health financing in the Nigerian Health System is thus, responsible for the unequal access to healthcare in the country.

Table 1: Indicators of health expenditure in Nigeria

	1997	2001	2005	2009	2013
Total expenditure on health as % of GDP	4.6	5.2	6.6	5.8	3.9
General expenditure on health (GGHE) as % of THE	23.5	31.4	29.2	36.3	15.6
Private expenditure on health (pvtHE) as % of THE	76.5	68.5	70.8	67.3	66.8
Out-of-pocket expenditure as % of pvtHE	94.6	91.4	95.8	95.6	95.8

Source: <http://apps.who.int/nha/database>

The table above shows that government expenditure on healthcare has been generally low. Government expenditure as a percentage of GDP was 4.6% in 1997; it rose in 2005 to 6.6% and fell to 5.8% in 2009. It fell further in 2013 to 3.9%. Government expenditure as a percentage of total health expenditure has been fluctuating, it was 23.5% in 1997, it rose to 31.4% in 2001 and it fell again in 2005 to 29.2%. It rose again in 2009 to 36.3% and fell drastically in 2013 to 15.6%. This is an indication of inadequate commitment towards the financing of the Nigerian health system. It is seen in the Table that in 1997 government expenditure as a percentage of THE stood at 23.5%, private health expenditures then increased to supplement the inadequate public sector health expenditure on health, it stood at 76.5% of THE. Out-of-pocket expenditure is the largest component in the Nigerian health financing system; it has consistently stood at over 90% of private health expenditure in all the years.

Table 2: Total Federal Allocation to Health (2009-2014): Recurrent vs. capital

Year	Recurrent Expenditure (NGN billion)	Capital expenditure (NGN billion)	Total expenditure (NGN billion)	% recurrent	% capital
2009	103.8	50.8	154.6	67	33
2010	111.9	53.0	164.9	68	32
2011	203.3	63.4	266.7	76	24
2012	217.8	65.0	282.8	77	23
2013	215.0	64.2	279.2	77	23
2014	216.4	46.3	262.7	82	18

Source: Budget Office of the Federation, Federal Ministry of Finance, 2015

From the above table, the proportion of recurrent expenditure allocation to health in Nigeria has increased from 67% in 2009 to 82% in 2014 and the capital expenditure to health decreased all through the years from 33% in 2009 to a far smaller 18% in 2014.

Table 3: Federal Allocation to health in relation to the total budget and GDP

Year	Total allocation (NGN billion)	Allocation to health (NGN billion)	As percentage of total budget	GDP (NGN billion)	As percentage of 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, 2015

Federal government allocation to health increased drastically from NGN154.6 billion in 2009 to NGN279.2 billion in 2013. Health expenditure as a percentage of total budget is far less than the 15% commitment required by the Abuja and Gaborone declaration. The highest was in 2012 and it stood at 5.8%.

THE NIGERIAN HEALTH SECTOR REFORMS

Before Nigeria's independence in the 1960, a ten year development plan was launched to facilitate and enhance healthcare delivery. This was incorporated in the first attempt at planning for health services in Nigeria. Since Nigeria's independence successive Nigerian government (civilian and military) have come up with 2nd 3rd and 4th National Development Plans all of which has substantial portion dedicated to addressing issues related to national healthcare. Several health schools and institutions (Ministry of Health, several clinics and health centers) were developed according to these plans. By the 1980s, there had been great development in healthcare, general hospitals and several health centers (over 10000) had been introduced (Aderounmu, 2013).

In August 1987, the federal government of Nigeria launched its Primary Healthcare plan with the following objectives; improving the collection and monitoring of health data, Improving personnel development in healthcare, ensure the provision of essential drugs, improvement on immunization programme, promotion of the treatment of epidemic diseases, improvement of food supply and nutrition, improvement in maternal and child care and family planning, educate people on prevailing health problems and the methods of preventing and controlling them. The primary healthcare plan has continued to suffer from major infrastructural and personnel deficit, in addition to poor health management (Menizibeya, 2011). This is evident by inadequate financing of the healthcare system especially the Primary Healthcare.

The genesis of the National Health Insurance Scheme (NHIS) in Nigeria dates back to post independence era of 1962, universal and free healthcare was initially funded by government from oil exports and general taxation. A slump in oil prices in the 1980s, exert a drain on government revenue base as government could no longer finance healthcare free of cost. Privatization of health sector and other cost recovery mechanism based on out-of-pocket charges were introduced. Also the introduction of the Structural Adjustment Programme (SAP) in 1986 reduced health sector budgets, the general poor state of the nation's healthcare services, over dependence and pressure on government provided health facilities, dwindling funding of healthcare in the face of rising costs among others, led to the introduction of the NHIS (Odeyemi & Nixon, 2013). The principal objective of the scheme is to ensure universal coverage and access to affordable and adequate healthcare so as to improve the health status of Nigerians.

POLICIES IN PLACE FOR FINANCING HEALTH CARE IN NIGERIA

Over the years the Nigerian government has put in place various policies and plans to address healthcare financing. Uzochukwu, et al., (2015) highlighted these policies and plans to include; the National Health Policy, Health Financing Policy, National Health Bill and the National Strategic Health Development Plan.

National Health Policy

The main thrust of the National Health Policy as stipulated in the Revised National Health Policy (2004) are to expand financial options for health care and strengthen the contribution of private sector and prepayment based approaches for financing. Engage communities and households in community-based schemes for financing Primary Health Care (PHC) services in Nigeria, Increase government funding to international standards, prioritization of PHC and rural poor in funds allocation, increasing allocative efficiency by redistributing resource allocation between levels of care to ensure adequate allocation to preventive and promotive care.

National Health Financing Policy

This policy seeks to promote equity and access to quality and affordable healthcare and to bring about a high level of efficiency and accountability in the health system through developing a fair and sustainable financing system (Uzochukwu et al., 2015). The revenue mobilization and pooling strategies aimed at increasing the fiscal space for healthcare financing as embedded in this policy was stipulated by Uzochukwu, et al., (2015) they include;

- a. Ensuring that federal, states and local governments allocates at least 15% of their budgets to health in

- line with the Abuja declaration.
- b. Establishing State Health Insurance (SHI) and Community-Based Health Insurance (CBHI) schemes under the ambit of the NHIS so as to ensure coverage to the informal and rural populations, which make up 70% of the population, as strategy towards universal coverage.
 - c. Providing supports to states to develop their own health insurance schemes to be regulated by the NHIS
 - d. Providing support for voluntary (private) health insurance and discouraging retainership.
 - e. Identifying, adapting and scaling up drug revolving fund schemes, deferrals, exemptions and other issues that can expedite universal coverage.
 - f. Promoting domestic philanthropy
 - g. Harmonizing external aid and partnership for health financing
 - h. Minimizing the burden posed by out of pocket expenditures this negates universal coverage and lead to catastrophic health expenditure.

The National Health Bill

The National Health Bill (NHB) is the first attempt at providing legislative clarification and funding sources to support the Primary Healthcare (PHC) in Nigeria. The NHB make provision for a Basic Health Care Provision Fund (Uzochukwu, et al., 2015). The bill will significantly increase government funding of PHC.

The National Health Bill created the National Primary Health Care Development Fund (NPHCDF). The National Health Bill provide a framework for the development and management of the Nigerian health system, it provide minimum standard for health services delivery in Nigeria. The bill in addition to defining clear roles for the three tiers of government, provide for the creation of the Primary Health Care Development Fund (WHO, 2014).

The primary healthcare is the bedrock of the Nigerian health system; however, it has been in shamble for several years, with it dismal state having a negative effects on the entire health system (Olakunle, 2012). The poor state of the Nigerian primary healthcare system has been attributed to poor funding (WHO, 2014). Hence, addressing the inadequate funding that has crippled the Nigerian Primary Health Care System is the focus of the National Primary Health Care Development Fund (NPHCDF) as evidenced in the National Health Bill.

The NPHCDF is financed from consolidated fund of the federation; grants from international donor partners and funds from other sources. The fund is required to allocate 50% of its resources for the provision of basic minimum package of health services to all citizens in Primary Health Care facilities through the National Health Insurance Scheme, 25% of the fund shall be used to procure essential drugs for primary health care, 15% of the fund shall be used for the provision and maintenance of facilities, equipments and transport for primary health care and finally 10% for the development of human resources for primary health care (National Health Bill, 2008).

SOURCES OF HEALTH CARE FINANCING IN NIGERIA

Healthcare financing involves the strategies used by a country in generating, allocating and utilizing funds for healthcare purposes. According to Olakunle, (2012) healthcare financing has it functions to include; collecting revenues, pooling resources, and purchasing services. A critical determinant of universal coverage is the strategy used by a country in financing her healthcare system. This is because whether healthcare services are affordable or not to those who need them is a function of the country's health care financing (Uzochukwu et.al.2015). The most common mechanisms used in financing healthcare in Nigeria are tax-based financing, out-of-pocket payments, donor funding and health insurance (social and private) (Olakunle, 2012).

Health care financing mechanism ideally, should provide adequate financial protection so that no household is impoverished because of the need to use health services (Uzochukwu, et.al.2015). However, in Nigeria healthcare financing represent majorly transfer of funds from the households to the healthcare providers. The various means of health financing in Nigeria are discussed below;

Tax Revenue

A healthcare financing system where government revenue dominates other financing mechanisms is referred to as the tax-based system. Funds are usually generated through taxation or other government revenues. Although the Nigerian government generates revenue through taxation, the bulk of the revenue is derived from the sale of oil and gas. The health system is generally funded from the federation account to the states and local governments, both of which generate about 20% internal revenue from taxes, levies and rates. However, the federally generated revenue which is shared according to a formula fixed by the Revenue Mobilization and Fiscal Commission (RMFC) forms the majority of the funds for the other tiers of government (World Bank, 2003).

The World Bank (2003) also explained that RMFC formula assigns 48.5% to the federal government, 24% to the states and 20% to local governments while 7.5% are set aside by the federal government for solely federally determined projects. Since states and local governments are closer to Primary Health Care PHC, they are expected to provide adequate funding for PHC, but owing to their low internal revenue generation capacities,

most of them still largely depend on the allocation from the federal government. States and local governments are not required to provide budget and expenditure reports to the federal government (Olakunle, 2012) this shows that the federal government does not play a supervisory role in ensuring that healthcare funds are properly expended in states and local governments for the purpose they are meant.

The revenue allocation to the health sector by the Nigerian government is very low even when compared with less endowed African countries. For example, in 2005 Uganda allocated 11% of her total budget to healthcare, while Nigeria in 2006 budgeted 5.6%. Despite the high prevalence of HIV among her citizens, Uganda was ranked 149 out of 191 countries and came 39 steps ahead of Nigeria (WHO, 2010).

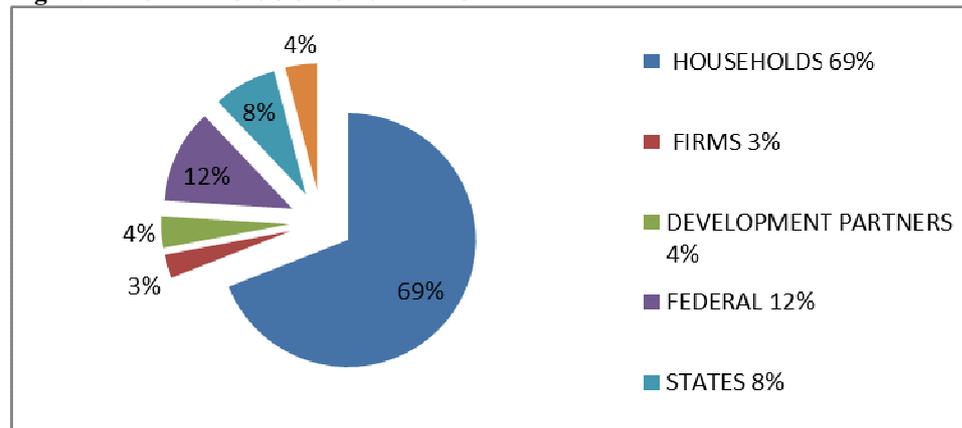
Out-of-pocket payments

Out-of-pocket expenditure refers to payment for health services at the point of seeking care. In 2007 out-of-pocket expenditure as a percentage of private health expenditure increased from 92.5% to 95.9%. This is regarded as one of the highest in the world (Onwujekwe, et al., 2010). This shows that out-of-pocket expenditure is the dominant means financing health care services in Nigeria.

According to Elgazzara, et.al., (2010) out-of-pocket spending on healthcare has become a policy concern for three reasons; first; households may be made poor as a result of out-of-pocket payment for healthcare at point of service, second; households facing these health expenses may cut back on other essential household needs such as food and clothing, third; households may choose to forgo necessary healthcare services rather than face the unfavourable financial consequences, thus, creating a vicious cycle of ill health, disability and poverty.

Most studies in Nigeria have shown that out-of-pocket expenditure really does exert impoverishing effect on households and also intensify the poverty situation of already poor households, while others as a result of paying out-of-pocket for healthcare prefer not to seek care at all, since they cannot afford the cost (Ichoku, et al., 2009; Olaniyan et al., 2013 Ichoku & Fonta, 2006; Onwujekwe, et al., 2012; Onoka, et al., 2011; Osungbade, et al., 2014). Moving away from out-of-pocket healthcare payments to prepayments mechanisms is the key to reducing financial catastrophe (Xu, et al., 2007).

Figure 1: FUNDING SOURCES IN NIGERIA



Source: Uzochukwu, et al., (2015) as extracted from the National Health Account

The above diagram shows clearly that of the various financing sources for health, out-of-pocket payments by the Nigerian households remains the major financing source for health in Nigeria.

Social Health Insurance

In Nigeria the NHIS is suppose to guarantee easy access to healthcare for the working population. The NHIS was established to facilitate pooling of resources and management of health risks, however, the current level of participation is very poor as only the formal sector scheme was launched covering only federal civil servants. Community base health insurance targeted at the larger informal sector is yet to gather momentum (Nwali & Egunjobi, 2006).

Participation in the programme involves a contributor registering with NHIS approved Health Maintenance Organization (HMO) which are limited liability companies which may be formed by private or public establishments registered by the scheme to facilitate provision of healthcare benefits to the contributors. The contributors are expected to register with a primary healthcare provider of their choice (private or public) from an NHIS approved list of providers. The HMO will make payments for services rendered by the healthcare providers (Onotai & Nwankwo, 2012). Under the NHIS scheme, 15% of workers basic salaries are expected to be deducted for health needs. Of the total contribution of 15% the employer are expected to contribute 10% and the employee 5% (NHIS, 2005). This is to say that only persons registered with the NHIS will have easy access to healthcare services since their resources is being pooled overtime. Hence, health risk is reduced in the case of eventualities.

The NHIS is subdivided 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 (NHIS, 2005). It is only the formal sector that is operational (Nwali & Egunjobi, 2006). Registration for membership is mandatory for federal government employees and about 90% coverage has been achieved so far (Olakunle, 2012) this shows that those at the states and informal sector are largely left out.

The NPC, (2013) explains that the practice of purchasing health insurance is basically urban-centered and is more common among those living in the South West and North Central than among those residing in the other zones. Health insurance coverage is also more common among better-educated women and men and those in the highest wealth quintile.

Community Base Health Insurance

Community based health financing has been recognized as a community-friendly and community driven initiative that has a wider reach and coverage of the informal sector especially if well designed (Adinma & Adinma, 2010). Community based health insurance is a private form of health insurance. The community is probably the most important link in healthcare delivery. It forms the support structure for the implementation of the primary healthcare delivery (WHO, 2005). Designing, implementing, managing, and especially sustaining Community base health insurance is complex. It requires a strong institutional capacity, technical expertise, and management skills. These impose a restriction to the success of the scheme in Nigeria.

Among the main factors hampering the development of community based health insurance in developing countries includes, problems of affordability of premium, trust in the integrity and competence of managers, the attractiveness of benefit package and the quality of care offered by the providers (Carrin et al., 2005). In Nigeria, the need for awareness-raising, essentially in the rural areas and finally, government funding support to ensure the financial viability of Community based health insurance has been advocated (Adinma & Adinma, 2010). This will help to close the inequality in access to healthcare as the poor will be able to access health care services with little or no cost.

Donor Funding

This refers to financial assistance given to developing countries to support socioeconomic and health development (Olakunle, 2012). Donor funding had not lived up to expectation in Nigeria. This is because according to (United Nations Development Programme, 2011) a review of the official development assistance to Nigeria between 1999-2007 was estimated to be annually on average of US\$337.31 million and US\$676.04 million, respectively over the period 1999-2007. These represent US\$2.335 and US\$4.674 per capita. These are very low figures compared to the Sub-Saharan African average of US\$28 per capita. The contribution of development aid to healthcare 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 as cited in Olakunle, 2012). This is to say that donor agencies assistance to the Nigerian health system as a percentage of total health expenditure has been declining.

The World Health Organization (2009) identified the major challenges to donor funding as coordination of the funds and tracking donor resource flow. The National Planning Commission has the statutory responsibility of coordinating the use of external development assistance at all level of government (Federal, State and Local government). At the state level, the Ministry of Finance, Economic Development and Planning form the pivot for coordinating external assistance to the state and local government areas. The capacity to coordinate however varies greatly among states. Other challenges with donor funding in Nigeria include the following: high cost of technical assistance, donor-driven approach to aid delivery, proliferation of aid agencies, uneven spread of donors' activities, institutional weaknesses, and problem of counterpart funding (Olakunle, 2012).

Assistance from donor agencies had always been received with suspicion of ulterior motives on the part of the donors; nevertheless, it is an important source of financing healthcare in developing countries such as Nigeria.

BRIEF HEALTH PROFILE OF THE NIGERIAN POPULATION

One major indicator for health in any developing country should be to determine the probability that a child will die before celebrating his/her first birthday. The Nigerian Demographic and Health Survey (2013) reported infant mortality for Nigeria to be 69 deaths per 1000 live births, this figure compared to the previous survey shows that Nigeria has achieved a decline in infant mortality by 26 percent, from 93 deaths per 1000 live births to 69 deaths per 1000 live births. Nigeria is still far from achieving the Millennium Development Goal target of 30 deaths to 1000 live birth for infant mortality by 2015.

One target of the Millennium Development Goals (MDGs) is to reduce under-five mortality to 64 deaths per 1000 live births and infant mortality to 30 deaths per 1000 live births by 2015 (NPHCDF, 2009). The under-five mortality in Nigeria according to the NPC (2013) declined by 31 percent from the previous survey

from 183 deaths per 1000 live births to 128 death per 1000 live births. This shows that Nigeria is still behind at achieving the MDG target of 30 deaths per 1000 live births for infant mortality, hence, considerable efforts made at achieving this MDG goal of 30 deaths per 1000 live births for infant mortality has been futile.

Table 2.4: Mortality differences by place of residence, zone and households wealth is presented below:

Background characteristics	Neonatal mortality	Infant mortality	Under five mortality
Residence:			
Urban	34	60	100
Rural	44	86	167
Zone:			
North central	35	66	100
North East	43	77	160
North West	44	82	185
South East	37	82	131
South South	32	58	91
South West	39	61	90
Wealth Quintile:			
Lowest	45	92	190
Second	45	94	187
Middle	39	71	127
Fourth	37	65	100
Highest	30	48	73

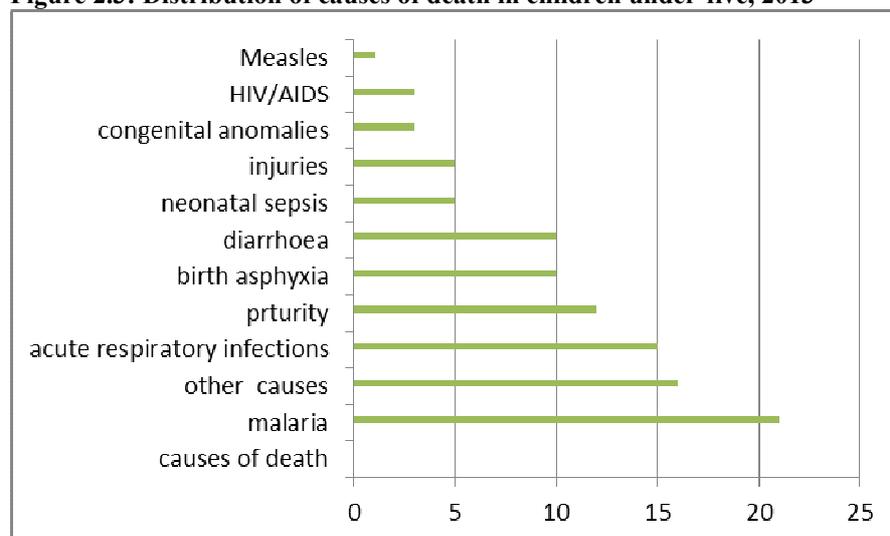
Source: National Demographic Health Survey, 2013.

The table above shows that early childhood mortality rates vary with geopolitical zones in Nigeria. As expected the rural areas experienced higher rates of these mortalities; infant mortality, under-five mortality and neonatal causes of death more than the urban area. The highest prevalence of infant mortality in the North West and North East compared to other geopolitical zones of the country. Also from the table it is shown that the lowest income quintile suffers high prevalence of infant mortality, under-five mortality and neonatal mortality than the highest income quintile. This is a reflection of inequality in healthcare access resulting in unequal health outcomes.

Infant mortality is 43% higher in the rural areas (86 deaths per 1000 live births) than in the Urban are (60 deaths per 1000 live births), the Rural-Urban difference is even more pronounced in the Under-five mortality (167 to 100 deaths to 1000 live births). There are regional differences in under-five mortality as well. Under-five mortality rates range from a low 90 deaths per 1000 live births in the South West to a high 185 deaths per 1000 live births in the North West. Under-five mortality is also relatively high in the North East and the South East as evidenced in the table.

According to the Global Burden of Disease Study of 2010 as reported by the World Health Organization Corporation Strategy (2014) malaria is the major cause of deaths in Nigeria. Even among the under-five malaria had been identified as the major cause of death, this is evident in the figure below;

Figure 2.3: Distribution of causes of death in children under-five, 2013



Source: World Health Organization Statistical Profile, 2015

WHO Corporation Strategy (2014) observed that despite progress made in the control of communicable

diseases, they remain major causes of death throughout the life cycle, especially in childhood. The controls of communicable diseases through various national programmes remain a priority, and accelerating progress in this goal can significantly improve the health status of populations in Nigeria. The WHO corporation strategy also reported that the country is on course to eliminate the transmission of malaria, wild poliovirus, measles and some neglected tropical diseases. This is evident in the fact that Nigeria is recently Guinea Worm free (WHO Corporation Strategy, 2014) and most recently polio free.

Immunization coverage in Nigeria is still poor. Nationally the proportion of fully immunized children aged 12 to 23 months ranging from 4.7% in the North-West zone to 40.7 % in the South West zone. Coverage in rural area was 13.4% compared with 32.6% in the urban areas. Nigeria is facing difficulties in progress towards achieving the measles vaccination target of 95% by 2015 and large equity gap persist among zones and between urban and rural areas (WHO Country Co-operation Strategy, 2014).

The Strategic Health Development Plan Framework (2012) recorded life expectancy to be 49years for an average Nigerian, while disability life expectancy at birth was 38.3years. Nigeria has the highest tuberculosis burden in the world. Nigeria is responsible for 29% global gap in reaching 90% of women with HIV who need antiretroviral therapy for the prevention of mother to child transmission (WHO Country Corporation Strategy, 2014).

CONCLUSION

From the foregoing it has been seen that Private Health Expenditure accounts for 70-80% of Total Health Expenditure (THE) in Nigeria and the dominants private expenditure is from household out-of-pocket expenditure accounting for over 70%. The Nigerian Health Care system is decentralized into Primary, Secondary and Tertiary healthcare, still the constitution is silent about the roles different levels of government should play in healthcare financing. The constitution needs to be explicit on the roles different levels of government should play in the financing of health care in Nigeria. This could be done with the help of legislative clarification. The total health expenditure as a proportion of total budget in Nigeria has been consistently below 7%. Hence, there is need for an increase in the total budget committed to healthcare in Nigeria. In particular government should ensure that it adhere to the Abuja declaration that requires 15% total budget commitment to healthcare financing.

REFERENCES

- Aderounmu, A. O. (2013). The National Health Insurance Scheme in Nigeria. Retrieved from www.oauife.edu.ng
- Adinma, E. D., & Adinma B. J. (2010). Community Based Health Financing: An Untapped Option to a More Effective Health Care Funding in Nigeria. *Nigeria Medical Journal*, 51(3), 95-100.
- Awosika, I. (2005). Health insurance and managed care in Nigeria. *Ann Ibadan Postgrad. Med*3, 40-46
- Carrin, G., Waelkens M., & Criel, B. (2005). Community Base Health Insurance in Developing Countries: A Study of Its Contribution to the performance of Health Financing Systems. *Tropical Medicine and International Health*, 8, 799-888.
- Elgazzara, H., Raada, F., Arfab, C., Matariac, A., Saltid, N., Chaaband, J., ...Majbouri, M. (2010). Who Pays? Out-of-Pocket Health Spending and Equity Implications in the Middle East and North Africa. Washington DC: World Bank.
- Federal Ministry of Health Reports 2004 retrieved from www.fmh.gov.ng
- Ichoku H. E., & Fonta W. M. (2009) Catastrophic healthcare expenditure financing and poverty: empirical evidence from Nigeria. *Journal of Social and Economic Development*. 12(2).
- Ichoku H.E. (2005). *The redistributive effect of healthcare financing in Nigeria*. A technical report submitted to Poverty and Economic Policy Research Network, University of Laval, Canada.
- Ichoku, H. E., & Fonta, W. M. (2006) *The Distributional Impact of Healthcare Financing in Nigeria: A Case Study of Enugu State*. PMMA Working Paper No. 17: 3-22.
- National Health Bill. Federal Republic of Nigeria.
- National Health Insurance Scheme (Nigeria): <http://www.nhis.gov.ng>
- National Population Commission (NPC), (2013) *Nigeria Demographic and Health Survey*
- Odeyemi A O., & Nixon, J. (2013) Assessing equity in health care through the National Health Insurance Schemes of Nigeria and Ghana: A review-based comparative Analysis. *International Journal of Equity in Health*, 12, 9. doi:10.1186/1475-9276-12-9
- Olakunle, B. O. (2012). Public Health Care Financing in Nigeria: Which Way Forward? *Ann Nigeria Med*, 6, 4-10. doi: 10.4.4103/0331.3131.100199.
- Olaniyan, O., Oburota, J., & Obafemi, N (2013). Equity in health care expenditure in Nigeria. *International Journal of finance and banking studies*, 2(3), 76-88.
- Onotai, L.O., & Nwankwo, N. (2012). A Review of the Nigerian Health Funding Syatem and How it Compares to that of Europe, South Africa and America. *Journal of Medicine and Medical Sciences*, 3(4), 226-231.

- Onwujekwe, O., Hanson, K., & Uzochukwu, B. (2012). Examining Inequities in Incidence of Catastrophic Health Expenditures on Different Healthcare Services and Health Facilities in Nigeria. *PLOS ONE*7(7): e40811. doi:10.1371/journal.pone.0040811
- Onwujekwe, O., Uzochukwu., E. N., Obikeze, I., Okoronkwo, O., Ochonma, C., Onoka, G., Madubuko and Okoli, C., (2010). Investigating Determinants of Out-of-Pocket Spending and Strategies for Coping with Payments for Healthcare in Southeast Nigeria. *BMC Health Services Research*. 10:16. Retrieved from www.biomedcentral.com/1472-6963/10/67.
- Osungbade, K. O., Olaniyan, O., & Olayiwola, S. (2014). *The distribution of households' health expenditure: Implications for health care reforms*. Retrieved from <http://www.unilag.edu.ng>
- Strategic National Health Development Plan Framework 2009-2013, July, 2009 retrieved from www.health.gov.ng/doc/NSHDP.pdf.
- Uzochukwu, B.S.C., Ughasoro, M. D., Etiaba, E., Okwuosa, C., Envuladu, E., & Onwujekwe O. E (2015). Health Care Financing in Nigeria: Implication for Achieving Universal Health Coverage. *Nigeria Journal of Clinical Practice*, 18(4), 437-444. doi:10.4103/1119-3077.154196
- World Bank data base 2015. (see <http://apps.who.int/nha/database>)
- World Bank. (2000). *Attacking Poverty: World Development Report 2000/2001*. Washington, DC: Oxford University Press.
- World Health Organization (2000). Geneva, Switzerland: World Health Organization.
- World Health Organization (2009). *MDGs needs assessment and financial strategy for Nigeria. policy brief*. Retrieved from <http://www.ng.undp.org/mdgs>.
- World Health Organization (2010). National Health Account Data Base. (See <http://apps.who.int/nha/database>)
- World Health Organization (2012). Nigeria: HealthAccount database (see <http://apps.who.int/nha/database> for the most recent updates).
- World Health Organization. World Health Statistics 2015. Available online http://www.who.int/healthinfo/EN_WHS2015_Full.pdf.
- World Health Statistic (2014). World Health Organization Country Corporation Strategy retrieved from <http://apps.who.int/nha/database>
- Xu, K., David, B.E., Aguilar-Rivera A. M., Musgrave, P., & Evans, T (2007). Protecting Households From Catastrophic Health Spending. *Health Affairs*,26(4), 972-983. doi: 10.1377/hlthaff.26.4.972