

## **A Study on Sources of Health Financing in Nigeria: Implications for Health care Marketers and Planners**

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### **Abstract**

There have been increasing difficulties in providing qualitative health care services to the public in Nigeria. The development has called for the need to examine ways through which government and other stakeholders resolve these crises in the health sector. The objective of this paper is to examine the level of Government spending to total Health expenditures in Nigeria. This study basically employs secondary data for analysis. The secondary data are provided from the World Bank Development indicators and Internet. The data was analyzed using the Pearson Correlation Coefficient Statistical technique. The result revealed a strong positive Correlation ( $r = 0.634$ ) between Government Health Spending and Total Health Spending. This indicates that Government Health Spending constitutes a significant proportion of the Total Health Expenditures in Nigeria; despite complains about inadequate health financing. In conclusion, the Nigerian Health sector would become more vibrant, if the Government and the Private sector are ready to

give the necessary commitments required to achieve the laudable objective of qualitative health for all. The study recommends for more Government Health funding towards tackling the prevalence of some chronic diseases such as HIV, Asthma, Tuberculosis, Meningitis and Paralysis, etc.

**Keywords:** Health care Marketing, Health financing, Users fee, Health Expenditures & Burden of Disease

### **Introduction**

In the last two decades, government of most countries in the Sub Saharan African region have been facing great difficulties in providing qualitative health care to the total population, most especially the underserved and vulnerable groups. This is as a result of recurrent cost problems in health in most of these countries, leading to inadequate supply of drugs, chemicals, medical equipment and other essential consumables. In some countries there are also no payment of salaries, non replacement of retired staff and retrenchment of essential personnel as a result of problem of inadequate health financing. This development has consequently made the 2015 Millenium Development Goals for Health Programme a myth and not a reality in most of these countries (Igbuzor, 2011). The world economic situation and general recession in the economies of most African countries further compounded the picture. Many of these countries have severely reduced their health budget at a time when they need more resources to build and sustain the national health systems. In 1990, healthcare cost at least 8% of world income (Murray, Govinderaj and Musgrove, 1994).

On the average, 60% of this is public spending and it must be stated that this substantial public role is pronounced in high income countries, in contrast to what happens in poorer countries where the State usually finances small share in health cost (Musgrove, 1996).

The improvement in Nigerian health care system has been very slow because primary health care services are compromised by limited resources spent on factors that suppose to maintain and improve this quality. The Federal government expenditure allocation to health have not yet resolved the recurring problems of inadequate and inappropriate staffing, scarce supplies and equipment, and deteriorated facilities that are facing the health sector. This prevalent situation therefore calls for

immediate government attention, which is necessary to bring about increase access and quality, with regard to preventive care at the Primary Health Care Level. The primary objective of this paper is to examine the level of Government Spending to total Health expenditures in Nigeria. The paper also assesses the role of Health care Marketers and Planners to effective delivery of health services in Nigeria.

### **Literature Review**

#### ***The Health Care System***

The current state of health in Nigeria is intertwined with her history of political governance. However, there are four health care settings identified by the Department of Health, Education and Welfare. These are: ambulatory, impatient short term, impatient long term and home. Within each setting, health resources are identified. Resources are those general categories of facilities in which care might be given. Kelman (1975) offers a schema that tries to show how various parts of the system are intertwined. The schema identifies essentially four parts in health care: the Primary providers, secondary provider, financing mechanism and consumers. The primary providers are those institutions that actually deliver health services to given population. The secondary providers are health care organization that train or support health care personnel in primary provider institutions e.g. professional association that certify practitioners, offer continuing education to practitioners etc.

Organizations that provide equipment and supplies necessary to the delivery of care and planning agencies are also secondary providers. Financial mechanisms pay for the service of both primary and secondary providers. The consumer, the passive recipients of the interactions of the other three, constitutes the final component. Therefore, the schema representing the major components and interactions of the health system: financing mechanisms, direct provider facilities, educational/training institution, professional associations and accrediting groups, equipment supplies and pharmaceutical houses, consumer/patients lobbying groups and government agencies. Health care expenditures are those household, government and private institution income that are spent on health services. In health sector, we have curative and preventive health care.

The distinction is useful because it further gives us insight into the different uses of investment expenditure as a concept in economic analysis of health care financing (FMH, Abuja; 1988).According to

Dunlop and Martins (1995) the level of the health expenditure is affected by the Nation's health status via several path ways. First the poorer a nations health status, the heavier the burden of disease (BOD). This is due to the prevalence of disease that affect infants, mother and children and are easy to prevent or treat at relatively low cost. Also, if a country's health status is low and it has a high burden of disease, the average labor productivity of the population will be lower and via the relationship between Gross Domestic Product and health spending, health expenditure will be concomitantly less. A country's health status may be higher or lower than it would be otherwise. This will definitely affect the level of health expenditure (Dunlop and Martins, 1995). Health status is determined by human consumption and welfare, including health care, nutrition, education, housing, water supply, environmental pollution, life style and income.

#### ***Health Care Marketers and Health Care Planners***

In most Health care organizations, there are staff that play key roles and form part of the decision making body for the organizations. They are the Healthcare marketers and Health care Planners. The Healthcare marketers are appointed to position of authority where they shape the organization by making important decisions. These decisions include: recruitment and development of staff, acquisition of technology, service additions and reductions, allocation and spending of financial resources (Buchbinder and Thompson, 2010). The Health care Planners on the other hand can be described as those responsible for planning, coordinating and administering major projects through all phases of health care planning activities in Healthcare organizations.

According to Buchbinder et al. (2010); many Health Care Organizations (HCO) have both, planners and marketing staff, and there is sometimes confusion about their separate roles. They argued that the role of the planner is to take a somewhat neutral position and to coordinate the entire business plan process. This includes balancing of interests not only of the marketing groups, but also of other groups involved in the business plan (i.e. operations, personnel and finance). Health care marketing therefore involves building sustainable and profitable health care organizations, through meeting the needs and wants of patients by strategically planning and executing processes based on the analysis of products, services, pricing, location and methods of promotion. The main purpose of health planning is to

minimize the negative effects of future uncertainty and changes in both, external and internal management environment (NOUN, 2010). Thus healthcare planners make decisions that would ensure effective and efficient utilization of resources for better healthcare delivery (Pahuja, 2015).

The development in healthcare services and medical technology has brought about a dramatic change in the role play by both, the health marketers and planners in health care delivery to the people. They are now involved in decision making that would ensure the bringing of the health care needs to the people (Awa and Eze, 2013). In Nigeria, there have been very few Health care Marketers and Planners in both, Private and Public Health sector. This has consequently led to low performance of these key staff in some of the Health Care Organizations where they work. It is hoped that as many people are taking up these professions, their impact and roles will become more pronounced. In some Government hospitals in Nigeria, there are personnel in administrative unit, who try to perform both, marketing and the planning functions; while in most Private Healthcare Organizations this is non - existing.

In developed countries, the Healthcare marketers and planners are committed towards bringing about improvement in the level of healthcare delivery to their patients. The health care marketers try to inform and educate patients about changes that are taking place in their environments. This may be in terms of changes in regulation, technology and competition from within and outside the industry.

The healthcare planners also try to direct, control, organize resources and monitor health planning activities towards achieving the Healthcare Organizations' goal.

The Healthcare Marketers and Planners are doctors, nurses, pharmacists, administrators and other categories of health workers that have decided to take up career in Health Care Marketing and Planning Jobs. They need effective marketing strategies and management knowledge to build long term doctor – patient relationship for their Health Care Organizations.

### ***Government Roles in Health***

It is very important we consider the role of government in health matters, since large share of health expenditure is financed by public spending. Therefore consideration will be given to the instrument

of public intervention, what role government should play, what government should not do and how to spend public money on health care. Most of what will be discussed in this section will be based on the work of Musgrove (1996). According to him, there are five distinct instruments of public intervention. These include:

Information - This may be in form of persuasion without requiring any one doing something, for example when government publicize the health risk of smoking, this include health and basic hygiene education in public schools etc.

Regulation - this determines how a private activity may be undertaken, for example government regulate medical profession by setting standard for Doctors or accrediting hospitals, importation of medical equipments, drugs and supplies, insurance industry, protection of food and water quality.

Mandate - This involves government obligating someone to do something and pay for it. For example, requirement that employers provide health service or insurance for their employees contribute to social insurance funds and requiring that children entering schools should be immunized.

Finance - Government finance health care with public funds, for example, tax particular activities or good such as alcohol or tobacco for health reasons.

Provision or delivery of service - this is done by the government, by using publicly owned facilities and civil service staff. Ministry of Health in most poor countries does this, so do various governmental bodies in many countries at all income level.

The government should play the following roles: the government should regulate activities when merely improving people's information will not be enough and deliver services when it is infeasible to finance private providers equitably. Competition should be stimulated by the government in the provision of health care. This should be extended a fortiori to non-medical component of health care such as 'hotels' services of hospitals. There should be competition among suppliers for medical purchase, but it should be done in such a way that it will not add to administrative cost and competition among insurer, which may lead to risk selection. The government should put incentive for cost containment on the supply side of the market rather than on customers. However, theory has indicated that an optimal payment should use supply side measure to control cost and reimbursing providers fully

according to cost is never the best solution (Ellis and McGuire, 1990, 1993). There is also need to deal with the pervasive problems of government failure and to improve the capacity to do whatever government ends up doing.

The government needs to do better, particularly in poor countries where much private medical practice may be of low quality. The government should use regulation, mandate training and other interventions to make the private sector function better. According to Musgrove (1996) what the government should not do include: the government should not use the tax system or any system or fees at public facilities, to make the poor subsidize the health care of the rich. Government should not tie public finance to public provision. The competition between public and private providers should be based on cost and on quality and not on price to the consumer. Government should not pay for health care by fee for service, unless other mechanisms are used to control expenditures. The government should not finance whatever people demand when care is free to consumers, if the government means to provide better health at lower costs. There should be limitation on what will be paid for public. Musgrove gave the following rules on how to spend public money on health care: priority should be given to highly cost effective public goods; most especially in poor countries where these activities could absorb all what the state now spend on health.

The government should maintain a smaller essential package which will not exhaust the available public fund and leave more discretion to provider as to what to do with public money subject to overall spending controls. United Kingdom that uses direct finance system and Germany that uses mandate social insurance have followed this approach. Feldman (1994) noted that the total welfare loss to the society may be less than when such controls are absent and some resources are wasted on excess use of medical care. The government should circumscribe public funding to a small essential package and allow everything else to be financed private, subject to some combination of mandate and regulation. The poor would be covered only, for the essential package using this approach. There may be problem of controlling adverse selection or holding health expenditure steady as a share of income.

### ***Source of Financing Health Care***

The following sources of financing health care will be briefly considered: user fees/charges, prepayment schemes, revolving fund, direct government/private financing, health insurance, community self help projects, aids/grants and others.

**User fee or charges.** These fees are paid in different ways; often as a minimum fee for registration per episode of illness or only one per annum, as a lump sum for certain services or prescribed drugs. The latter being the basis of the Bamako Initiative concept for medical charges. According to Witter (2002) user payments are direct, out of pocket payments made by patients for use of health facilities (both public and private). User charge has been seen as one of the means of financing health care that can bring improves in health services in most Sub-Saharan African countries. Most patients are able to raise money for the hospital fee by selling their cereals, stocks or other products, loan from friends, neighbor/community or family.

There is a fear that the poor may be prevented from seeking health care if they are compelled to expend their subsistence budget for some of the care. Out of pocket payment made by households at the point of services for items as medicines, tests and hospitalization have been between 40 – 45% of total health expenditure in many countries in Sub-Saharan African (Korte et al., 1992; Korte, 1994). The remaining fund where provided by government from external sources such as donors and multilateral lending institutions. In Uganda, all the used fees at first level government health facilities were removed in 2001 (Xu et al., 2005). In Ghana the percentage of the budget collected by Ministry of Health through charges range from zero to 15%, in Kenya it was only 5% (Vogel, 1989; 1993).

Exemptions are given to certain categories of patients: children under 5, prisoner, patients from charitable homes, homes for mentally handicapped, STD patients, tuberculosis and leprosy patient. Grosh (1992) maintained that by exempting the destitute from fees not have to be expensive. Government spending on health in Sub Saharan Africa is inadequate, insufficient, inequitable and unsustainable, hence substantial parts of the medical bill are through out of pocket payments (Ekwochi, et al., 2014; Hoare, 1987). The following are some of the argument against the introduction to user charges: the revenue collected through user charges is negligible (World Bank, 1991), large proportion of the population is poor and cannot pay, it reduces utilization rate,



other public service have introduced fee as well, for example education, water supply, agricultural extension services, lack of management capacities for the proper administration and spending of the fee collected and misuse of direct accessible cash.

The following important arguments are raised in favor of user charges. Fees make the patient conscious of the service they ask for. It contributes to financing even though small, it keeps the service running, it serves as the starting point of revitalizing basic health service, it is a demonstration of self help of the health staff and the community and it stimulates central government and donors to contribute and fulfill their obligation.

**Prepayment Schemes:** This form of financing is being tested by more and more countries in recent time. The payment scheme was introduced in Zaire in 1986 as a result of difficulties in paying for hospital care as well as the increasing financial gap for the hospital management that showed a need for change (Moens, et al., 1992).

The prepayment scheme is in the form of a small co-payment in cash followed with premium per household member collected once or twice annually, by Health Centre Staff and Village Committee. The scheme is different from insurance option because the premium from prepayment can be related to the revenue from selling crops and is based on the existence of the notion of risk sharing in the community. Prepayment Schemes entitle users to certain number of visits or drugs; it is a form of user's fee which incorporates risk spreading and some degree of risk sharing (Witter, 2002).

**Saving based:** This is characterized by risk spreading but not risks pooling. The users do bear cost in proportion to their use of facilities, but are assisted in setting money aside to cover health cost as and when they occur. The users have medical scheme that cover some ambulatory and minor hospital costs over their life time. The schemes are used in Singapore, United States and China (Nichol, L., Prescott, N. and Kai Hong Phua, 1997). The following are some of the achievement of the plans: higher coverage, administrative efficiency, financial efficiency, doubled cost recovery and higher admission rates of members than non-members. The problems include: no solidarity between different income groups, moral hazard or unnecessary hospital admissions and inflation. The scheme offers a better alternative of financing health care at health district level. The Zaire experience offers good challenge for future health care financing in poor countries.

**Lotteries and Betting:** It is not recognized as a major source of health care financing in developing countries (Hoare, 1987). It also provides a ready source of money to government in financing health care.

**Revolving fund.** These methods started in the late 1980's to tackle the shortage of essential drugs at health facilities in developing countries (Witter, 2002). The revolving fund allows certain amount to be committed or allocated for drug supplies or procurement. The National Policy on health state that users shall pay for curative services while preventive services shall be subsidized. Teaching and Special hospitals in Nigeria are therefore, encouraged to make essential drug fully available by supplementing routine budget allocations with the establishment of drug revolving fund or other cost recovery mechanism. The drug fees should be affordable by the majority of patients. Essential drugs are those that satisfy the health care needs of the majority of the population.

In low income countries, there is adequate supply of drugs and supplies in lower level facilities. Foreign exchange constraints severely limit purchase of drugs by central ministries and poor distribution systems further restrict the regular availability of drugs at lower facilities in outlying areas (World Bank, 1993). There is a correlation between drug availability and use of services. This is supported by a World Bank study of health facility demand in Nigeria, which found that there was increased use of facility with the percentage of time during the year when drug were available (Akin; Denton; Guilkey; Vogel and Wothers, 1991).

**Direct government/private financing.** This is done by both private and public sector employers. The public sector employers in most cases use government hospitals or provide their own clinics for their staff, while most private employers enter into either full time or part-time retainership with private hospitals or have their own hospitals. In Nigeria, only very few private employers are not making this provision for their staff and effort is on by the Federal Government to mandate all employers to provide health care services for their workers in term of Social Insurance or Health Insurance. The government is setting the pace by its National health Insurance Scheme Public Enlightenment Campaign currently on air both in the Radio and Television Stations across Nigeria. In most private companies, the workers through their collective bargaining make their employers

provide them health care services; this is in addition to other welfare benefits given to them. The intent of most employers especially the Private, in providing health care services to their staff is to increase their productivity.

**Community Self Help Projects:** in this type of financing, the community enters into either voluntary or compulsory contribution to provide for their health facilities. They sell their stocks, land, live stock and other products and use the proceeds as their contributions. It can also take the form of labor or fund raising. The community, organizations or Non Governmental Organizations may use funds from an income generating scheme to support health facilities at the grassroots level. The villagers may assist in the building of clinic (Witter, 2002). Most communities in Nigeria through self help projects have constructed bridges, hospitals, dispensaries, schools, police stations and so on. For example, in Kwara State, Oro community is noted for their self help projects.

The community built their General Hospital, Police Station, Schools etc, before handing it over to government for approval. This is not peculiar to Nigeria alone, it is also happening in other Sub-Saharan countries, most especially in the rural communities.

**Informal payment.** They are payments by patient to health staff or support staff in health facilities which are not officially recognized or authorized. This takes many different forms such as payment advance for a service, gifts after a procedure has been carried out or bringing drugs, supplies or food in to the clinic (Witter, 2002). This also forms a significant element in transitional and developing countries. Kornal and Eggleston (2001) found in Poland that 38% came from official sources and 62% from “gratuities”. Bangladesh, Uganda and Kyrgyzstan are examples of some countries where public health system are being funded through informal payment (Asiimwe, McPake, Mwesigye and P. Streefland, 1997; Ensor, Hossain and Miller, 2001; Witter, 2002). In Nigeria, this form of payment is in use mostly in private hospitals.

**Health Insurance:** This is one of the alternatives for financing health care (Deferranti, 1985; World Bank, 1987). It may be in form of private health insurance or social insurance. Health care financing through social health insurance or tax funded schemes has become a very important tool in achieving universal financial protection for health care in most developing countries. Community based and mandatory health insurance seems to be gaining ground in Africa (Gajate – Garrido

and Owusua, 2013). Social Insurance is the mandated insurance policy for workers, in which certain percentage of their wages are contributed to the scheme, while at the same time their employers are also mandated to contribute somewhat higher payroll tax to the scheme and in some cases the government can be the third contributor. Social insurance is often referred to as social security.

The private health insurance on the other hand is distinct from social insurance in two ways. It covers only health care alone and does not include pensions for invalidity and old age, and it is financed through premium which is based on the nature of the illness of the individual covered by the policy. Private health insurance can be either profit or non-profit, bought by either groups or individuals. In Nigeria, the Federal government has been able to enroll her employees for the scheme, while only few states have been able to follow suit.

Only large firms provide health care services for their employees at the workplace and the Federal Ministry of Health and Social Services at the initial stage had considered the problems of implementation of a National Health Insurance Scheme (NHIS) amongst which include these four main issues: who will be covered, the Capitation Scheme, cost sharing provisions and the lack of catastrophic coverage. It will be better if the Federal Government can encourage the establishment of private and community based insurance scheme in addition to national schemes such as NHIS. Most developing countries especially in Africa have tried the social insurance option: Kenya, Zimbabwe, Burundi, Uganda, Zaire Tanzania and Ethiopia. It is founded that rural areas might not be suitable for the establishment or insurance schemes in these Sub-Saharan countries because of the following reasons: high premium, too much bureaucracy, problem of identifying the beneficiaries, genuine claim, lack of relations between insurance carriers and providers of health services etc. According to World Bank (1991) while the development of institutions of this kind is entirely desirable, they affect access to health care for only a small number of people. However, health insurance may in the next millennium become a popular source of financing health care in developing countries. (Kraushaar, 1994).

**Aids and Grants**, are local or foreign. The local one can be in form of donations in kind or cash from local charitable organizations or philanthropic individuals or organizations like Rotary Club, Lions Club, Island Club, Community Development Association, Guinness Nigeria

PLC and others. Other major sources of charitable organizations include wealthy individuals, business enterprises and religious groups. On the other hand, the foreign aids and grants are usually from foreign donors like the World Health Organizations, World Bank, UNICEF, Multinational Companies like Mobil or Shell petroleum Development Company, Chevron, United Trading Company (UTC) and others. They help in financing health care services in these developing countries in order to bring about improvement in the delivery system and also alleviate poverty.

Other sources of health care financing include sales tax revenue, the general tax revenues and deficit financing. The sales tax revenue are obtained from the tax imposed by State and Local Government in developing countries on some commodities while general tax revenues are in form of duties on imports and exports in low income countries. The deficit financing is used to augment general tax revenue. Deficit financing involves borrowing from either local or international creditors. This loan is usually repayable from future general tax revenue; which may definitely affect funds available for future expenditures. Domestic borrowing is usually done through the insurance and sales of debt certificates or bonds with guaranteed interest rate to the public. Debt financing is normally used for capital projects like construction of hospital, maternity, health centre, bridges, bore-hole etc.

### ***The current trend of Health Care Financing in Nigeria***

Nigeria's National Policy on health emphasizes the reallocation of health resources in favor of preventive services and primary health care, as the most effective and least expensive for the under-served communities (Denton and Kail, 1995, World Bank Reports, 1996). The government is now trying to incorporate the strategy in the current budgetary allocations on health. But as a result of the present economic situation, the Federal Government expenditures on health has not shown any significant improvement over the previous years, on the average the allocation to the health sector has been about 2% of the national budget. There is emphasis by the Federal Government on the training of community Health Cadres which form the backbone of Health Care Delivery in the rural areas, since the inception of the programme in 1979. All the States of the Federation now have School of Health Technology and these institutions have produced an average of 2,000 Community health workers every year as at 1987, 15,400 Community

health Workers have been trained and posted to the rural health centers. There is revision in the training programme of nurses, midwives, doctors and other health workers to incorporate relevance components of Primary Health Care however, there problem is getting most of these cadres of health workers to go and work in rural areas as a result of lack of incentives, which make life in rural area more attractive to them (World Health Organization, 1987). In 2014, \$1.7 US billion was allocated to Health in Nigeria of which 82% was recurrent expenditure. This is about 6% of the total budget and second to defense, education and finance, less than in 2013 (Nigeria's Health Watch, 2013).

The quality of Nigeria Public Health Sector has become so poor now that only very few choose to use it while majority seek health care from private clinics/hospitals, traditional healers, chemists, religions homes and others in their preference for affordability or low cost, perceived quality, proximity and promptness of service (Centre for Health Policy and Strategies Studies, 1999; Denton and Kail, 1995). The health Research Reports concluded that low cost of care in government hospitals and clinics would make them prime sources for health care to majority of citizens if concerns about low quality of care are not addressed; private clinics and hospitals would gain significance as sources of care.

### **Methodology**

This study basically employs secondary data for analysis. The secondary data are extract from Nigeria Bureau of Statistics, World Bank Development indicators; publications from Federal Ministry of Health and other relevant information from the Internets. The secondary data obtained from published or original data available in an archive, have been used effectively in past studies (Gibbon, 1971; Church, 2001). This form of data is primarily used in fields where there is a large amount of data and the cost of collection is particularly high, such as we have in this study (Church, 2001). The data obtained from some of the secondary sources used in the study are also reliable, objective and valid. The World Development Indicators dataset obtained from the World Bank are compiled from officially recognized International sources, which is the most current and accurate global development data available in all continents of the world. The data on Nigerian Health Expenditure was analyzed using Pearson Correlation Coefficient Statistical techniques. The Statistical Package for Social Sciences

(SPSS), Version 20 software was employed to perform the analysis. The hypothesis raised for the study is:

H<sub>1</sub>: Government health spending does not constitutes a significant proportion of the Total Health Expenditures in Nigeria

### Results and Discussion

Table no. 1 provides information on Nigeria Public Health Expenditures from 2009 to 2013.

**Table no. 1:** Nigeria Public Health Expenditures (2009 – 2013)

Public Health Expenditure	% of Gov Exp	% of Total Health Exp
2009	15.56605213	31.27630253
2010	11.59623127	26.06346626
2011	17.96992994	31.10804656
2012	17.96992994	33.1591495
2013	17.96992994	27.58376418

**Source:** World Development Indicators, 2015

The Government Health Spending represents the Independent variable, while the Total Health Expenditures for each year represents the dependent variable. The variables were analyzed using Pearson Correlation Coefficient and the result revealed a strong positive Correlation ( $r = 0.634$ ) as shown in Table no. 2.

**Table no. 2.** Correlation between GHE and THE

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics	
					R Square Change	F Change
1	.634 <sup>a</sup>	.402	.203	2.48498	.402	2.019

**Note:** GHE are the Government Health Expenditures and THE Total Health Expenditures

**Source:** Computer Printout, 2015.

This indicates that Government Health Spending constitutes a significant proportion of the Total Health Expenditures and therefore, we reject the null hypothesis which stipulated that it does not constitute

a significant proportion of the total health expenditures. This result shows that despite the fact that the Government health spending is inadequate, it still constitutes a greater proportion of the Total Health Expenditures.

This is not the case only in Nigeria, but in other developing countries in the Sub Saharan African region where the poverty level is very high and the Government needs to subsidize these essential services for it to get round to all. According to Africa Health Workforce Observatory (2008), health is on concurrent list in Nigeria, this means each level of Government budgets for its own responsibility of health care service delivery. The Federal Government is responsible for tertiary care services; the State Governments handles secondary health care services and the Local Governments handle primary health care services delivery. The financing agents for Healthcare include the Federal and its parastatals, State and Local Governments and Insurance companies.

Funding also come from companies, households and partners. The National Health Insurance is gradually growing, but covers only the formal sector, both public and private.

The Insurance coverage has not been expanded to the poor, unemployed and the rural dwellers (Africa Health Workforce Observatory, 2008). It is hope that if the Government can increase its funding to Health and the resources judiciously used, that will bring about improvement in health care delivery in Nigeria

### **Policy Options and Conclusions**

In considering the foregoing analysis, it will be observed that despite the recent increase in the Federal expenditure allocations, there is no feasible solution to the problems militating against efficient delivery of health care services in Nigeria. In order to put right this situation the following policy options are recommended:

A Federal Government in conjunction with the Federal Ministry of Health and Social Services to focus more on expenditure priorities within the health sector and the best way to utilize the available resources. They should also increase funding towards tackling the prevalence of some chronic diseases such as HIV, Asthma, Tuberculosis, Meningitis, Paralysis etc.

There should be adequate supply of safe drugs to Government hospitals by injecting more funds towards drug procurement. Effort



should be made to put in place an efficient system that will ensure an adequate supply of safe drugs to both, Government and Public Health facilities. It is also necessary to create understanding and acceptance among patients and health professionals about the introduction of drug fees, most especially in Government hospitals, where there were no fee payments or services highly subsidized. Most health facilities are in poor physical condition, there is need to refurbish existing buildings rather than build new ones in order to conserve resources. The Primary health care should be given priority because it provides the greatest access to the population. There should also be emphasis on increasing health facilities, access to safe water, sanitation and regular electricity.

The Government needs to increase private sector participation in health care delivery and encourage alternative payment systems, such as health insurance schemes.

The government should employ more efforts to inform and educate people about the benefit of National health Insurance scheme most especially, in the “un served” private sector. The other major stakeholders in Privates health sector such as traditional herbalists, religious homes and chemists should be integrated into the formal health system because of their growing influence in the Nigerian health sector.

Government and Private Hospitals should create functional Marketing and Health Planning Departments to enable those who are willing to take up careers in these emerging and lucrative fields.

Finally, if the existing constraints to the efficient delivery of health care already mentioned are overcome and the Federal Government exploits the various sources of finance to increase the allocation of health budget, there would be better and efficient delivery of health care services to the people, including the under-served. Also, the Nigerian health sector is likely to become promising and vibrant, if the Government and the Private sector give the necessary commitment that is required to achieve the laudable objective of qualitative health for all.

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