European Journal of Humanities and Educational Advancements (EJHEA)
Available Online at: https://www.scholarzest.com
Vol. 3 No. 08, August 2022
ISSN: 2660-5589

HEALTH CARE FINANCING AS STRATEGY FOR POVERTY REDUCTION IN NIGERIA

Ibanga, Atauyo Edem Ph.D
Department of Business Administration and Management
Akwa Ibom State Polytechnic,
Ikot Osurua, Ikot Ekpene
Godliness Okokon Umoh, PhD
Ibom Metropolitan Polytechnic
Uyo, Akwa Ibom State
Nigeria

Article history:

Received: June, 24h 2022
Accepted: July, 24th 2022
Published: August, 28th 2022

Abstract:

Health care financing in Nigeria is very strategic to poverty reduction. Analytical survey design method was used to examine the impact of health care financing on poverty. The work highlights some health care indices and their poor consumption pattern by Nigerians which leads to low life expectancy, low infant survival rate, high maternal mortality and the prevalence of HIV/AIDS. The ratio of doctors/nurses per unit of a population is still very high, per capita health expenditure by government is low as compared to developed nations like USA and France. There are high "out of pocket" medical expenses and some Nigerians cannot afford the hospitals and health center bills. Increased healthcare financing by government is the feasible strategy for poverty reduction in that, poverty and ill health reinforce one another. It is conclusive that poverty is the main reason why people cannot afford basic health care needs such as; good nutrition, shelter/housing, available source of clean water and sanitation. The recommendation is that doctor/nurse ratio to the population should be reduced; Government should provide more health care facilities; the per capita health care expenditure by government should be increased; Not less than 10 percent of annual GDP should be budgeted for health. Government should provide enabling environment for Private participation in the provision of health care infrastructures

Keywords: Health Care Financing, Strategy, Poverty Reduction and Nigeria.

INTRODUCTION

Health can be treated as input as well as output component of economic growth and poverty reduction as it contributes to other sectors of the economy. There are many indicators of good health consumption which include: maternal health, reduced patience to doctors/nurse' ratio, easy accessibility of health facility and the reduction of personal income expenditure on health. The proximate determinant of infant mortality is ante-natal and post-natal care, supervised delivery. Others are immunization coverage, mother and child nutrition. These determinates are closely linked to the provision of reproductive health service and are directly influenced by size of Government expenditure on health care. In effect, the change in government expenditure can either increase or decrease the dependency ratio thereby altering the poverty rates of the population.

Nigeria's health indicators are far below international standards for instance, the average life expectancy is 54 years, which is far below the global average of 72 (CIA, 2008). There is prevalence of high infant mortality and vaccine preventable diseases such as measles, hepatitis, tuberculosis, diphtheria and pertussis. The most devastating health hazard in Nigeria is the scourge of HIV/AIDs. Only about 5% of HIV positive mothers receive anti-retroviral treatment. (Eneji *et.al*, 2013). The real cause of ill health is poverty and vice versa. Poverty and ill health reinforce one another to the extent that increased health care financing can go a long way in ameliorating poverty in the Nigerian society.

CONCEPTUAL ISSUES

Health Care

Health Care is the maintenance or improvement of health through the prevention, diagnosis and treatment of disease, illness, injury and other physical and mental impairment in human beings. Health Care is delivered by health professionals (providers and practitioners) in allied health professions such as nursing, medicine, optometry, pharmacy and psychology. It includes the work done in providing primary, secondary and tertiary and public health. Access to public health may vary across countries, groups and individuals. This is largely influenced by social and economic conditions as well as the health policies in operation.

Countries and jurisdictions have different policies and plans in relation to personal and population-based health care goals within their societies. Their exact configuration varies between national and sub-national entities. In some countries and jurisdictions, health care planning, occurs more centrally among governments or other coordinating bodies. According to Who, a well-functioning health care system requires a robust financing mechanism; a well-trained and adequately paid work force; reliable information on which to base decisions and policies and well maintained health facilities and logistics to deliver medicines and technologies. Health care can contribute to a significant part of a country's economy. Health care is conventionally regarded as an important determinant in promoting the general physical and mental health and well-being of people around the world. An example of this was the worldwide small pox eradication in 1980, declared by the WHO as the first disease in human history to be completely eliminated by deliberate health care interventions (WHO, 2010).

Poverty

A concise and universally accepted definition of poverty is elusive largely because it affects many aspects of the human conditions, including physical, moral and psychological. Different criteria have therefore been used to conceptualize poverty. Most analyses follow the conventional view of poverty as a result of insufficient income for securing basic goods and services. Others view poverty in part, as a function of education, health, life expectancy, child mortality etc. others identify the poor, using the criteria of the levels of consumption and expenditure. The definitions of poverty are as numerous as the schools of thoughts available in economics.

One of the popular definitions include that of Asian Development Bank (2006), that sees poverty in three main perspectives namely (i) human poverty, which is a lack of essential human capabilities, notably literacy and nutrition (ii) income poverty, which is lack of sufficient income to meet minimum consumption needs and (iii) absolute poverty, which is a degree of poverty below the minimal calorific requirement plus essential non-food components? This is often referred to as a multidimensional approach. Thus, the poor are conceived as those individuals or households in a particular society, incapable of purchasing basic goods and services such as nutrition, shelter/housing, water, and healthcare, access to productive resources including education, working skills and tools and political and civil rights to participate in decisions concerning socio-economic conditions. The first three are the basic needs/goods necessary for survival. Impaired access to productive resources (agricultural land, physical capital and financial assets) leads to absolute low income, unemployment, undernourishment etc. inadequate endowment of human capital is also a major cause of poverty.

Health Care Financing in Nigeria

In Nigeria, health care financing regulatory framework is relatively weak and depends almost entirely on government leadership as incentives. Most states in Nigeria do not have health financing policy in place. Some do however maintain certain laws that provide mechanism for financing of the health system. Health care provision in Nigeria is a direct responsibility of the three levels of government namely, Federal, States and Local Governments. Private providers of health care also have roles in health care delivery (Akhtar, 2004). The federal government role is mostly limited to co-coordinating the affairs of the University Teaching Hospitals, Federal Medical Centers (Tertiary health care) while the State governments manage the various general hospitals (Secondary healthcare) and the Local Governments focus on dispensaries (Primary health care which are regulated by the Federal Government through National Primary Health Care Development Agency (NPHCDA).

The introduction of National Health Insurance Scheme (NHIS) in May 1999 was primarily to alleviate the burden of catastrophic health expenditure on public and private health consumers. (NHIS) was totally committed to seeking universal coverage and access to adequate and affordable health care in order to improve the health status of Nigerians especially those participating in the various programmes/product of the scheme. The HNIS included family planning services in its benefit packages for Communities (Community Based Health Insurance Scheme) and the Millennium Development Goals/Maternal and Child Health Project. It was meant to cover government employees, the organized private sector and the informal sector. Legislative wise' the scheme also covers children under five, the permanently disabled and prisons inmate (Monye, 2010). The scheme is however being confronted with low rate of registration,

owing to illiteracy and lack of adequate information. So far, the scheme covers only 1.5 percent of Nigeria's population.

THEORETICAL ISSUES

Human Capital Theory on Health

The World Health Organization (WHO) defines health as a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity (Todaro and Smith, 2008). There are two measures of general health status of the population. The first is the infant survival rate while the second measure is life expectancy. The later measure has the advantage that it is available for most countries, at least as an estimate: however, this measure can be misleading. The extension of life expectancy can be provide extended years of vitality in one country while providing only addition years of extremely poor health or suffering in another. The infant survival is a better measure, but clearly omits consideration of general health status of the population beyond early childhood.

The most devastating health hazard in Nigeria and indeed the sub-Sahara Africa is the scourge of HIV/AIDS. This is final and fatal stage of infection with human immunodeficiency virus. In developing countries as a whole, AIDS is primarily transmitted by heterosexual intercourse; in addition, infected blood transfusion (from mother to fetus). Despite well over a decade of intensive effort by various governments to combat this epidemic, AIDS continues to be the major killer disease in sub- Sahara Africa. Developing the health component of human capital, therefore, becomes necessary. The reason is obvious. Poor health has direct negative effect on educational performance and productivity. The gain from good health cannot be over emphasized. Apart from increase in productivity, there are opportunities to better paying jobs and longer working lives.

Health Care and Poverty in Nigeria

A successful poverty reduction by any nation is replicated in the health status of its people. Poverty reduces the probability of visiting a modern health care provider among members of the household. Serious illness is that which makes people drop out of the labour market and become poor even if they are good workers. Health has a strong link and two way relationships with poverty. Poverty makes people more vulnerable to ill-Health and ill-health tends to lead to poverty. Thus ill-health and poverty reinforce one another and compromise quality of life and longevity. Ill-health affects productivity thereby reducing income and tends to wipe away savings and diminish ability to invest. Indeed the poor are more likely to die young (WHO,2019) Poor people are more likely to experience ill health as a result of several factors which include poor diet and poor living conditions (Ravallion and Chen 2010).

Poverty can rightly be described as the leading global health challenge and "disease" in view of its ubiquitous effects on the health status of individuals and communities in the world. The greatest cause of ill health and suffering across the global is extreme poverty. According to World Health Organization (WHO, 2005) "The world's biggest killers and the greatest cause of ill-health and suffering across the global is extreme poverty". Poverty and illiteracy are the main reason why babies are not vaccinated, why clean water and sanitation are not provided and why mothers die in child birth. Fertility rate, maternal and infant mortality reduction are outcomes of reproductive health and by-products of Health Care system in Nigeria. Poverty is the reason why curative drug and treatment are not available and why mothers die in child birth, according to Global Health Forum (2006). Effort to address poverty must necessarily consider health sector input, while improvement in health must also be seen from its poverty reduction potential (WHO, 2000). Developing countries face much more crippling disease burden than the developed countries especially infectious diseases. Nigeria's situation is not different as government still has much challenge. It has asserted by (Umoh, 2013) that the underlying disease in Nigeria is poverty.

Nigeria faces a lot of developing challenges of which poverty holds a central place. The number of the poor people tends to increase with the population. In 2005, 55 percent of the people were living in absolute poverty. In 2010, the poverty figure rose to 69 percent. In 2015, due to effective poverty management strategies by the Federal Government, poverty rates reduced to 54.4 percent. Poverty is server in the rural areas than urban centers and towns due to lack of development incentives and social infrastructures in the rural areas. Due to illiteracy and poverty in some parts of the country, the link between health and development is not fully appreciated, whereas a better understanding could have motivated private sector investment on health delivery. The health care financing regulatory framework is still relatively weak, depending mostly on strong government leadership and incentives for improvement. The situation is particularly bad in the North Eastern States where over three quarters of the population live in absolute poverty (National Bureau of Statistics, 2010).

Health care in Nigeria is influenced by different local and Regional factors that impact on its quality. There is spatial variation in terms of availability of quality facilities in relation to needs. This is largely due to the level of involvement of States and Local government in health service delivery. It is only in a few states in the Nigerian Federation that health is considered a priority through the development of SEEDS and NEEDS. Thus efforts to address poverty must of necessity consider health sector input and efforts to address health must also be seen from its poverty reduction potential.

One of the major reasons why poor people especially in rural areas are more likely to experience ill health is high fertility rate among women. According to Schultz (2008) Targeting fertility and mortality is critical to economic development as it reduces the "Dependency Ratio" of the population, thereby reducing poverty. A lower infant mortality is therefore an effective and efficient contributor to reduction of poverty in the society. Higher child mortality rate affects fertility through both biological and through behavioral mechanisms. On the biological side, infant death abbreviates lactation and hastens the resumption of ovulation, thereby increasing fertility. The behavioral mechanism has to do with

the fear of previous experience of child mortality which induces parent to go for an immediate child replacement especially where there is prevalence of low survival rates (Schoumaker, 2014, Meryerhoefar and Sahn (2007). This is based on the fact that the mother's health deteriorates with successive births.

The poor are more likely to experience ill-health as result of poor living conditions. In Nigeria, the extreme poor live in deprived rural areas and semi-urban slums like Ajegunle and Mushin in Lagos State, where there is a near absence of hygiene and quality health service. In these places, there is no clean source of drinking water and majority of residents practice open defecation. They are generally exposed to mosquito a bite which makes them highly vulnerable to malaria fever. The public health facilities are not properly utilized due to poverty, illiteracy and poor information dissemination. Indeed, there is a wide range of actions an individual could take when sick or injured such as: self-cares, consulting a traditional healer or seeking treatment from a private or public health care facility. The specific action taken is influenced by individual/household characteristics, provider characteristics, social factors and geographical factors. When poor people are ill, they are less likely to access health care service because of inability to pay the bill (FMOH), 2005).

On the other hand, there are many indicators of good health consumption which include: maternal health, reduced patience to doctors/nurse' ratio, easy accessibility of health facility and the reduction of personal income expenditure on health. The proximate determinant of infant mortality is ante-natal and post-natal care, supervised delivery. Others are immunization coverage, mother and child nutrition. These determinates are closely linked to the provision of reproductive health service and are directly influenced by size of Government expenditure on health care. In effect, the change in government expenditure can either increase or decrease the dependency ratio thereby altering the poverty rates of the population.

Another factor that is critical to poverty reduction is tackling fertility and mortality. Maternal Health interventions through prevention and curative methods, promote the welfare of families and the society (A jakaiye and Nwabu, 2007). In Nigeria, there are wide range disparities between fertility rates of urban and rural dwellers. Lower fertility rate have also helped in reducing maternal and infant mortality rate. Others are, increase per capital GDP, urbanization and economic independence among households. This trend can be seen on table 1(a) and 1(b) below where fertility rates of rural women are than those in the urban.

Table 1 (a): Fertility Rate for Urban and Rural Women in Nigeria.

VARIABLE	**TFR (2003)**	**TFR (2008)**	**TFR (2013)**
Urban	4.9	5.7	5.5
Rural	6.1	6.3	6.2
REGION	**TER (2003)**	**TER (2008)**	**TER (2013)**
North central	5.7	5.4	5.3
North East	7.0	7.2	6.3
North West	6.7	7.3	6.7
South East	4.1	4.8	4.7
South South	4.6	4.7	4.3
South West	4.1	4.5	4.6

Source: Nigeria Demographic Health Survey (NDHS, 2013).

There exists a disparity between fertility rates of women in the urban and their counterparts in rural areas. This is accounted for by some socio-economic factors such as: the use of contraceptives, literacy rate and exposure to information on maternal health care.

Table 1(b): Women Fertility Rates in Nigeria (1981-2021)

YEAR	**TOTAL FERTILITY RATE (TER)**
1981-1985	6.3
1986-1990	6.0
1990-1995	6.0
1995-2000	5.7
2000-2005	5.6
2005-2010	5.6
2010-2013	5.5
2013-2021	4.5

Source: Nigeria Demographic Health Survey (NDHS, 2021).

2013-2021 figures are extrapolated.

Health Expenditure Pattern in Nigeria

According to World Health Organization (WHO, 2010), total health expenditure of a country is the sum of public and private health expenditure which covers the provision of all health services (preventive and curative), family planning activities, nutrition activities and emergency aid designated for health which does not cover provision of water and sanitation. In Nigeria, public health expenditure consists of recurrent and capital spending from (federal, state and local) budget, external borrowings and grants (including donations from international agencies and non-governmental organizations (NGOs). Babatunde (2002) notes that Nigeria's spending on health is predicated on ensuring that there is a just and equitable distribution of health facilities and services in the country. The country also has the objective of improving health care service delivery to standards that compete with the developed nations and to meet up with the Sustainable Development Goals.

The user charges for health care in the public sector indicates significant out of pocket spending, estimate at US. $22.5 per capita. (CBN, 2013). Such spending is referred to as catastrophic health expenditure – a situation where individual health consumers spend more than 40% of their income on health after paying for subsistent needs such as food and clothing. Catastrophic health spending is not only caused by high cost of medical procedures or interventions but a relatively small payment can mean financial catastrophe to a poor person than the rich, as it reduces expenses for food, shelter, clothing or even children education. Similarly, large health care payments can lead to financial catastrophe and bankruptcy especially where individuals are not covered by any health insurance scheme (Abdulraheem et. al. 2011).

Factors that contribute to catastrophic health expenditure in Nigeria include: age of family member's and employment status. The elderly, handicapped or chronically ill persons receive medical treatment more regularly and incur medical expenses which affect the income of members of the family. Conversely, Younger and healthy people have a greater tendency of avoiding catastrophic spending (Roberts, 2013). Other factors that instigate catastrophic expenditure are the dependency ratio of the population and geographical location of health consumers. The transport cost of rural citizens to urban centers and cities for medical treatment escalates medical expenses thereby causing impoverishment. The non-working population of; 0 to 15 and 65 years and above are described as being dependent. Children and the aged members of the society need instant medical care which expenses are borne by the working population (men and women who are 16 to 64 years of age).

A comparison of the ratio of health expenditure to GDP for several developing and a few developed countries on table 2 and 3 below, indicates that Nigeria is yet to spend up to 5% of her GDP on the health sector which is not in consonance with the recommendation of the WHO, that developing countries should spend at least 8 to 10% of their GDP on health. Owing to these reasons, health cost is increasing faster than public revenue allotted to the health sector. This compels the consumers to complement government in health expenditure. The price of health consumption in the country is therefore inelastic. The ratio of health expenditure to Gross National Product (GNP) could be treated as a measure of government's effort towards the reduction of mortality and fertility rates as socio-economic measures of curbing poverty (Wang, 2007).

Table 2: Health Expenditure of some Developing Countries as Percentage of their GDP

	Expenditure as % of Gross Domestic Product (GDP		
	2004 – 2008	**2009 – 2013**	**2014 – 2018**
Nigeria	1.2	1.1	1.1
Gambia	3.8	3.7	3.6
Ghana	3.6	3.6	3.3
Egypt	2.0	1.9	1.9
Israel	4.4	4.4	4.3
Congo Democratic Republic	2.0	1.9	1.9
Kuwait	2.2	2.1	2.4
Mexico	3.0	3.3	3.2
Georgia	1.7	1.7	2.0
Malaysia	2.1	2.2	2.2
Singapore	1.4	1.5	1.8

Source: WHO, global health expenditure, data bank – 2018

Table 3: Health Expenditure of some Developed Countries as Percentage of their GDP.

	Expenditure as % of Gross Domestic Product (GDP		
	2004 – 2008	**2009 – 2013**	**2014 - 2018**
Italy	7.4	7.1	7.1
United Kingdom	7.9	7.7	7.8
U.S.A	8.1	8.1	8.0
Canada	7.7	7.7	7.6
France	8.9	9.0	9.0
Germany	8.6	8.6	8.7

Source: WHO, global* health *expenditure, data bank – 2018

Overview of Nigeria's Health care System

Nigeria is battling seriously against the scourge of malaria and other endemic diseases. As at 2012, malaria prevalence rate was 11 percent. Taking cognizance of this, Nigeria embraced the world malaria day, with the theme "end malaria for good". In year 2000, an incidence of yellow fever claimed the lives of over 1000 persons in various towns. In 2015, laser fever killed about 2500 Nigerians in different states despite the existence of its vaccine since 1939 (World Bank, 2014).

Another factor that impinges negatively on the Nigerian health system is that of migration of health personnel to other countries of the world for better salaries and improved condition of service. From the supply sector there is exodus of medical practitioners including doctors and nurses to Europe and North America. These results in brain drain to the country in that some of these health personnel were sponsored in school by the government at various levels. In 2005, 2,392 Nigerian doctors were practicing in the US while 1529 in the same year were practicing in UK. The brain drain syndromes cut across all health professionals like pharmacists, dentists and medical laboratory scientists.

CONCLUSION

The study concluded that health care is a key factor in enhancing people's overall physical and mental health and well-being on a global scale. Besides, some health care indices and their poor consumption pattern by Nigerians which leads to low life expectancy, low infant survival rate, high maternal mortality and the prevalence of HIV/AIDS.

A nation's economy can benefit significantly from the health care sector. Nigeria's health care finance regulations are comparatively lax and largely rely on strong government incentives. The government's primary responsibility in the health care system is to lessen the burden of catastrophic health costs on the public and private health systems and the Increased healthcare financing by government is the feasible strategy for poverty reduction in that, poverty and ill health reinforce one another.

Nevertheless, the ratio of doctors/nurses per unit of a population is still very high, per capita health expenditure by government is low as compared to developed nations like USA and France. Finally, it was concluded that there are high "out of pocket" medical expenses and some Nigerians cannot afford the hospitals and health center bills.

RECOMMENDATOINS

Based on the foregoing, the following recommendations are done to improve health care funding in Nigeria with a view to poverty reduction in the country.

1. Government at all level should provide the enabling environment for private participation in the provision health care service and its infrastructure in the country.
2. To avoid brain drain, there condition of service for medical personal should be tremendously improved.
3. Government at all level, Federal, State and Local should endeavour to award scholarship for the training of health personnel with a view to reducing Doctor / Nurse Ratio to patients.
4. Adequate provision should be made for the establishment of more health centers especially in the rural areas, to reduce the cost of transportation to urban places and cities for medical treatment which escalated medical expenses for the poor.
5. As obtainable in the developed nations, Nigeria should of necessity increase its annual budgetary allocation to health care to 10percent of its GDP.
6. For the sake of poverty reduction in the society, Nigeria should increase its per capita medical expenditure to the equivalent of $35 Dollars as obtainable in the USA.

REFERENCES

1. Abdulraheem, Olapipo and Amodu (2011), Primary Health Care Systems in Nigeria:Critical issues and strategies for enhancing the use of rural communities. Journal of public health epideomiology vol. 4 (1) pp 5-13. Jan 2012.

2. Asian Development Bank (ADB, 2006)
3. Bhasin, V. K. (2010). Impact of Government Expenditure on Primary Health care and Women's Education on Household Poverty in Ghana. (Working Paper, University of Cape Coast, Cape Coast, Ghana).
4. CIA (2008). *Nigeria Country Profile, African Development Report*
5. Eneji Agri Eneji, Dickson Vouke Juliana, Bissong John Onabe (2013): Health Care expenditure, Health Status and Natural Productivity in Nigeria. Department of Economics, Jos.
6. FMOH 2005 Ministry of Health (2005). National Immunization Report, vol. 5 (3).
7. Gandy, M. (2008). Water Sanitation and the Modern City: Colonial and Post-Colonial experience in Lagos and Mumbrie, Human Development Report Paper.
8. *Mey*erhoefer, C. and Sahn, D. (2007). The Relationship between Poverty and Maternal Morbidity and Mortality in Sub-Saharan Africa. Mimeo, AERC, Nairobi.
9. *NBS (National Bureau of Statistics)*, (2016).
10. Ravallion, M. and Chen, S. (2010). The Developing World is poorer than we thought, but no less successful in the fight against poverty. Policy Research Working Paper Series, No 4703, the World Bank
11. Schoumaker, B. (2004). Poverty and Fertility in Sub-Sahara Africa. Evidence from 25 countries. Population Association of America Meeting. Bostin.
12. Schultz, P. and Mwabu, G. (2008). The causes and consequences of fertility in contemporary Kenya. *University of Nairobi, Kenya*.S
13. Schultz, T. P. (2008). Population Policies, Fertility, Women's Human Capital, and Child Quality. In: Schultz, T. P. and Strauss, J. (2008) eds. *Handbook of Development Economics,* Vol.4, Chapter 52, Elsevier, Amsterdam; North-Holland.
14. Todaro, M. P. and Smith, S. C. (2009). Economic Development. Delhi: *Pearson Education Publishers*.
15. Ubek, E. E. (2020). Women and Economic Development. An Overview. Lagos: *Lisjohnson Publishers.*
16. Umoh, J. U. (2013). Human Development in Africa: An Overview. *The Nigerian Economic Society*.
17. UNDP (United Nation Development Programme) (2013). *Human Development Report*. *New York: Oxford University Press*.
18. USAID: (2007), Nigeria Water and Sanitation Profile.
19. Wang, L. (2007). Health Outcomes in Poor Countries and Policy Options: Empirical Findings from Demographic and Health Surveys. Policy Research Working Paper No.2831. *The World Bank. Washington D.C*.
20. WHO, Global Health Expenditures, Data Bank, 2019.
21. WHO/UNICEF (2010), *Joint Monitoring Programme for Water Supply and Sanitation*.
22. World Bank (2013, 2014). *World development Report*. Oxford University Press.