Out-of-pocket payment for health services: constraints and implications for government employees in Abakaliki, Ebonyi state, South east Nigeria

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Abstract

Background: Each year, 100 million people are impoverished globally as a result of expenditure on health.

Objective: To assess the constraints and implications of out-of-pocket payment for health services among government employees in Abakaliki, Ebonyi State, south east Nigeria.

Method: This was a cross-sectional descriptive study. The study instrument was a pre-tested, semi-structured self administered questionnaire.

Results: Over half of the respondents (62.8 %) reported a history of illness in their household in the preceding four weeks before the study. Sixty-nine percent of these respondents relied on out-of-pocket payment in order to pay for health services at the moment of seeking medical treatment for themselves or their dependants; while 28.4 % and 2.6 % relied on a pre-payment package (National Health Insurance Scheme) and borrowed money respectively to pay for health services at the moment of seeking medical treatment for themselves or their dependants. The vast majority of respondents (63.6 %) who relied on out-of-pocket payment reported their difficulties in accessing quality health care services as a result of financial hardship at the moment of seeking medical treatment. Most of them (47.7 %) resolved to self medication, while 28.4 %, 17.1 % and 6.8 % of them delayed seeking health care, patronized herbalists and ignored their illness respectively.

Conclusion: This study brings to the fore the fact that most government employees and their dependants in Abakaliki have difficulties in accessing quality health care services via paying for them out-of-pocket.

Key words: Health services, payment, constraints, government employees

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Introduction

The dramatic increase in health care expenditures worldwide has prompted societies everywhere to look for health financing arrangements which ensure that people are not denied access to care because they cannot afford it.[1] Each year, 100 million people are impoverished globally as a result of expenditure on health.[2] Against this background, health systems are therefore not just concerned with improving people's health but with protecting them against the financial costs of illness.[2] While most high income countries rely heavily on either general taxation or mandated social health insurance contributions, low income countries depend far more on out-of-pocket financing.[1] In 60 % of countries at incomes below $1,000 per capita, out-of-pocket spending is 40 % or more of the total public health care expenditures whereas only 30 % of middle and high income countries depend so heavily on this kind of financing.[1] The challenge facing governments in low income countries is to reduce the regressive burden of out-of-pocket expenditure on health by expanding pre-payment schemes which spread financial risk and reduce the spectre of catastrophic health care expenditures.[1] A good health financing system raises adequate funds for health, in ways that would ensure that people can use needed services and are protected from financial catastrophe or impoverishment associated with having to pay for them.[2] The poor state of the health system in Nigeria has been traced to several factors especially the gross under funding of the health sector.[3] Nigeria relies on a disaggregated mixture of health financing, including government budgetary allocation, health insurance (social and private), external funding and private out-of-pocket spending to finance health care.[4] Pre-payment via health insurance is seen as one of the viable options that are available to broaden sources of health care financing and hence reduce the dependence and

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pressure on the government budget.[5,6] The National Health Insurance Scheme (NHIS) was established by the federal government of Nigeria under decree number 35 which was signed into law on May 10th, 1999 for the purpose of providing health insurance which shall entitle insured persons and their dependants to the benefit of prescribed good quality and cost effective health services without financial hardship.[5] The formal sector scheme of the NHIS was launched in June 2005 by the then president of the Federal Republic of Nigeria who flagged off the registration of federal civil servants and their dependants.[7] The question of viability of the scheme within the country's socio-cultural context remains a burning issue. This study was therefore conducted to assess the constraints and implications of out-of-pocket payment for health services among government employees in Abakaliki, Ebonyi State, south east Nigeria.

Methods

This is a cross-sectional descriptive study conducted in February 2009. The study population consisted of government employees residing in Nkwagu, a peri-urban community within the Abakaliki capital territory in Ebonyi State. A simple random sampling technique was undertaken to sample one hundred and twenty-eight houses from a sampling frame of houses in Nkwagu community. From these sampled houses, 247 respondents who gave informed consent were selected.

The study instrument was a pre-tested, semi-structured self administered questionnaire. The questionnaire schedule elicited information in respect of the demographic characteristics of the respondents- age, sex, marital status, income status, type of occupation; history of illness in the household in the previous one month prior to the study, mode of payment for health care services, and financial viability in seeking health care. The ability to pay for and to access quality health care services by the respondents were assessed by six questions. They were asked:

(i) "In the past four weeks, have you or any member of your household been ill?"
(ii) "If yes, where did you receive care?"
(iii) "Do you have financial difficulty paying for health care services?"
(iv) "Do you budget monthly for health care expenditure?"
(v) Has not being financially viable affected your seeking quality health care?"
(vi)"If yes, how?" The data generated were analyzed using Statistical Package for Social Sciences (SPSS 15.0 version) Computer Software and were presented in simple frequency tables. The chi-square test was used to assess the associations between variables, and the associations were considered significant at $p< 0.05$.

Ethical approval for this study was obtained from the Ethics and Research committee of the Ebonyi State University Teaching Hospital Abakaliki.

Results

The results of this study were obtained from 247 government employees selected from Nkwagu, a peri-urban community within the Abakaliki capital territory in Ebonyi State.

Demographic characteristics of respondents

The age range of the respondents was 27-64 years. The majority of them were within the age group of 31-40 years (42.1 %). There were 129 (52.2 %) males and 118 (47.8 %) females. The male: female ratio was 1.1:1. While the majority of the respondents were married (76.1 %), 16.6 % and 7.3 % of them were singles and widows respectively. Over two fifth (41.7 %) of the respondents were civil servants, while 31.6 %, 22.7 %, 2.4 %, 0.8 % and 0.4 % were uniform personnel, nurses, doctors, pharmacists and lectures respectively in descending order. Over half of the respondents earned less than ₦ 25,000 (less than $ 164) monthly. See table 1.

Table 1: Demographic characteristics of respondents

Characteristics	Frequency	Percentage (%)
Sex		
Male	129	52.2
Female	118	47.8
Total	247	
Age group(years)		
21-30	59	23.9
31-40	104	42.1
41-50	59	23.9
51-60	24	9.7
> 60	1	0.4
Total	247	
Marital status		
Single	41	16.6
Married	188	76.1
Widowed	18	7.3
Total	247	

Continuation of table 1

Characteristics	Frequency	(%)
Occupation		
Teacher	78	31.6
Nurse	6	2.4
Doctor	2	0.8
Pharmacist	1	0.4
Civil servant	103	41.7
Uniform personnel	56	22.7
Lecturer	1	0.4
Total	247	
Income status		
< ₦10,000 (< $ 66)	43	17.4
₦10,00 ($ 66) - < ₦ 25,000 (< $ 66)	87	35.2
₦25,000 ($ 66) - < ₦ 40,000 (< $ 263)	75	30.4
₦ 40,000 ($ 263) - < ₦ 55,000 (< $ 362)	27	10.9
₦ 55,000 ($ 362) - < ₦ 70,000 (< $ 461)	8	3.2
₦ 70,000 ($ 461) - < ₦ 85,000 (< $ 559)	2	0.8
₦ 85,000 ($ 559) - < ₦ 100,000 (< $ 658)	2	0.8
>₦ 100,000 (> $ 658)	3	1.2
Total	247	

History of illness in the household in the preceding four weeks, mode of payment for health services and budgeting for health care services among respondents

Over three fifth of the respondents (62.8 %) reported a history of illness in their household in the preceding four weeks before the study. The modes of payment for health care services recorded in this study were by out-of-pocket payment, pre-payment package (NHIS) and borrowed money. Over three fifth (69.0 %) of the respondents paid out-of-pocket for health services, while 28.4 % and 2.6 % paid for health care services via pre-payment package (NHIS) and borrowed money respectively. About four fifth (76.9%) of the respondents did not budget monthly for health care services expenditure as shown in table 2.

Table 2: History of illness in the household in the preceding four weeks, mode of payment for health services and budgeting for health care services among respondents

Characteristic	Frequency	(%)
History of illness in the household in the preceding 4 weeks		
Yes	155	62.8
No	92	37.2
Total	247	
Mode of payment for Health care services		
Out-of-pocket payment	107	69.0

Continuation of table 2

Characteristic	Frequency	(%)
Prepayment package (NHIS)	44	28.4
Borrowed money	4	2.6
Total	155	
Budget for health services		
Yes	57	23.1
No	190	76.9
Total	247	

The outcome of financial hardship among respondents who reported a history of illness in their household in the preceding four weeks before the study

About half of the respondents (47.7 %) who reported their difficulties in accessing quality health care services as a result of financial hardship or difficulty at the moment of seeking health care resolved to self medication; while 28.4 %, 17.1 % and 6.8 % delayed seeking health care, patronized herbalists and ignored their illness respectively as indicated in table 3.

Table 3: The outcome of financial hardship among respondents who reported a history of illness in their household in the preceding 4 weeks before the study

Outcome	Frequency	(%)
Ignored the illness	6	6.8
Delayed seeking health care	25	28.4
Self medication	42	47.7
Patronized herbalists	15	17.1
Total	88	

Financial viability in relation to the modes of payment for health services (access to health services)

Over three fifth (63.6 %) of respondents who relied on out-of-pocket payment reported their difficulties in accessing quality health care services as a result of financial hardship at the moment of seeking health care for themselves or their dependants; while 36.4% and 100% of the respondents who relied on pre-payment package (NHIS) and borrowed money respectively reported their difficulties in accessing quality health care services as a result of financial hardship at the moment of seeking health care for themselves or their dependants. The association between the modes of payment and access to quality

health care services was statistically significant ($p< 0.05$) as shown in table 4.

Table 4: Access to quality health services in relation to the mode of payment

	Has financial hardship affected your access to health care services		
Mode of payment	**Yes (%)**	**No (%)**	**Total**
Out-of-pocket payment	68 (63.6)	39 (36.4)	107
Prepayment package (NHIS)	16 (36.4)	28 (63.6)	44
Borrowed money	4 (100)	0	4
Total	88 (56.8)	67 (43.2)	155
	$X^2 = 12.5$; df = 2; p = 0.001		

Discussion

Ensuring that people are not denied access to health care services because they cannot afford it has long been a cornerstone of modern health financing systems in many countries.[1] The purpose of health financing is to make funding available to ensure that all individuals have access to effective public health and personal health care.[1] This means reducing or eliminating the possibility that an individual will be unable to pay for such care, or will be impoverished as a result of trying to do so.[1] This study revealed that over three-fourth of the respondents did not budget for health care services and that individual out-of-pocket payment and NHIS were the major reported mode of payment for health care services among the respondents.

Over half of the respondents relied on individual out-of-pocket payment in order to pay for health care services at the moment of seeking medical treatment for themselves or their dependants. The vast majority of the respondents who relied on individual out-of-pocket payment in order to pay for health care services reported their difficulties in accessing quality health care services as a result of financial hardship compared to those who relied on a prepayment scheme via NHIS. Although it was not within the scope of this study to explore the cost of health services, evidences from previous studies has shown that a health system where individuals have to pay out of their own pockets for a substantial part of the cost of health services at the moment of seeking medical treatment clearly restricts access only to those who can afford it and is likely to exclude the poorest members of society.[8-10] Inability to pay for health services is therefore a major factor determining the utilization of health services. Under utilization of health services especially by the poor and disadvantaged remains a chronic problem in developing countries even though there is a huge unmet need for health care.[11] Out-of-pocket payment a widely used strategy to supplement governmental resources further aggravate the situation as willingness to pay for health care services does not reflect ability to pay for health services.[11] Consistent evidences has also shown that reduction or removal of out-of-pocket payment at the point of use enhances the utilization of health care services.[12] In Tanzania, public hospitals saw attendance drop by 53 % in 1994 when individual out-of-pocket payment was introduced. Evidence from other low income countries including Uganda, Burundi, Zambia and Niger revealed how abolishing out-of-pocket payment at point of use can have an immediate impact on the tupake of health services and it literally saves lives.[12]

This study further revealed that the vast majority of respondents who relied on a prepayment package via NHIS had no difficulties accessing health care services compared to those who relied on individual out-of-pocket payment. This observation is in keeping with the findings of previous studies which revealed that there has to be prepayment via health insurance for there to be an effective access to health services especially, highly costly personal care.[11] In addition to affording protection against having to pay out-of-pocket and as a result facing barriers to access health services, prepayment makes it possible to spread financial risk among members of a pool. Individual out-of-pocket financing does not allow financial risk to be shared in that way.[1]

This study brings to the fore the fact that most government employees and their dependents in Abakaliki have difficulties in accessing quality health care services via paying for them out-of-pocket. It is suggested that the government should renew its commitment to scaling-up the pre-payment scheme

(NHIS) in order to promote universal access to quality health care among government employees.

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