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HEALTH CARE FINANCING AND SERVICES UTILIZATION IN CROSS RIVER STATE, NIGERIA

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ABSTRACT

The average annual budgetary allocation for health in Nigeria is about the lowest in Africa at 5.7% as the total health expenditure is only 0.7% of GDP against the WHO recommended 4%-5%. The out-of-pocket spending by Nigerians is more than 60% of total health expenditure instead of WHO recommended 30-40%, while the national coverage of the National Health Insurance is below 5% which poses a serious problem to health care service utilization. In Nigeria, the ever rising socioeconomic costs of healthcare and the limited or complete lack of supportive public financing is a major challenge to the attainment of the sustainable development goals (SDGs) recently adopted to reduce poverty and improve the wellbeing of all citizens of the world. This paper examined health care financing in Cross River State and determined the extent to which it poses problems to services utilization. The paper reviewed literature relevant to the study while the Marxist conflict theory of healthcare utilization was employed. The design for the paper was Expost facto which relied on secondary data from Cross River State Ministry of Health. The study reviewed various sources of health care financing in Cross River State and the impact of these sources on health care system strengthening or quality health care provision. From the study or discourse and review of health expenditure and its related challenges, it was found out that, out-of -pocket expenditure or user-fee charges, community-based financing, private donor agencies financing and tax-based public health financing sources in the state have not significantly impacted on good services provision to individuals. From these findings, it was recommended among others that government should encourage the establishment of village/ward development committees whose responsibilities should include taking initiative to assist government in building health post (in communities where such do not exist), Government should maintain existing health facilities and provide proper logistics during health campaigns and monitoring of health workers activities at the health facilities.

KEYWORDS: Health care, financing, health service utilization, out-of-pocket payment, primary health care

INTRODUCTION

The rising number of rural households worldwide that now live below poverty line as a result of high costs of medical services in relation to illness constitute a major challenge to the attainment of the new Sustainable Development

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Goals (SDGs) (UN, 2014). This has led to the growing need for substantial healthcare investments to reduce poverty and improve the wellbeing of the world's poorest people through different sources of health care financing (Russell, 2004). As important as this social good (health) is, access to it as an integral part of the overall health system has been fraught with some difficulties in terms of financing and cost of billing for the services received. Consequently, like many public services, it is not equally accessible to all people (Joseph & Phillips, 1984), and so, limited physical access to basic health care continues to be a major impediment to achieving the goal of health care for all. In the light of the foregoing, governments all over the world consciously attempt through policy formulation and implementation to bring health care services closer to people across economic divides and different social strata to help reduce cost of Medicare through financing services delivery-health care financing.

Health care financing as it is in Cross River State and elsewhere in Nigeria, is a process by which revenues are collected from primary and secondary sources, e.g., out-of-pocket payments (OOPs), indirect and direct taxes, donor funding, co-payment, voluntary prepayments, mandatory prepayment, which are accumulated in fund pools so as to share risk across large population groups and using the revenues to purchase goods and services from public and private providers for identified needs of the population, e.g., fee for service, capitation, budgeting and salaries (Uzochukwu, et al, 2015). Ultimately, whether through OOPs, taxation or health insurance, financing for the health system originates mostly from the households. Therefore in a most basic form, health care financing represents a flow of funds from patients to health care providers in exchange for services. The way a health system is financed shows if the people get the needed health care and whether they suffer financially at the point of receiving care. A good healthcare financing strategies must be able to mobilize resources for healthcare; achieve equity and efficiency in use of healthcare spending; ensure that healthcare is affordable and of high quality; ensure that essential healthcare goods and services are adequately provided for and most recently ensure that the money is spent wisely so that the millennium development goals (MDGs) could be achieved.

The way a state finances its health care system is a critical determinant for reaching Universal Health Coverage. This is so because they determine whether health services exist and are available and whether people can afford to use health services when they need them. This can be achieved by a well-planned combination of all healthcare financing mechanisms, which include: Tax-based financing, OOPs, donor funding, health insurance exemptions, deferrals and subsidies. The main thrust is how to generate adequate revenue to finance health services from a diversified group of people, without over tasking the formal sector workers. Since in Nigeria, the formal sector workers are the group that their contributions are its tax or agreed deduction, can easily be access from source and this constitutes 47% of the working population. The situation is different when informal sector (about 53% of the working population) is considered, due to infective tax collection system, inefficient formula to calculate the amount to collect, and lack of confidence on those that will be mandated to collect the fund.

Healthcare financing can be defined as the mobilization of funds for healthcare services (Oyefabi, et al, 2014). In other words, it is the provision of money, funds or resources to the activities designed by government to maintain people's health. These activities encompass the provision of medical and related services geared toward maintaining good health, especially in the aspect of disease prevention and curative treatment. The concept of health care financing succinctly deals with the quantity and quality of resources a country expends on health care. This is proportionate to the country's total national income. The amount of resources earmarked for health care in a country is said to be a reflection of health value placement vis-à-vis other categories of goods and services. It has been opined that the nature of health care financing defines the structure and the behaviour of different stakeholders and quality of health outcomes (Metiboba, 2012). The pattern of health financing is therefore intricately connected and indivisibly linked to the provisioning of health services (Rao, et al, 2009 & Riman & Akpan, 2012). The duo, Riman & Akpan argued that the definition of health care financing cannot be narrowly conceived and confined to raising enough resources to fund health care needs of people alone, but also entails the questions of affordability and equitable access to health care services by them, including guaranteed financial risk protection.

In Nigeria, the average annual budgetary allocation for health is about the lowest in Africa at 5.7%, the total health expenditure is only 0.7%

of GDP against the WHO recommended 4%-5% (Archibong, et al 2020). The out-of-pocket spending by Nigerians is more than 60% of total health expenditure instead of WHO recommended 30-40%, while the national coverage of the National Health Insurance is below 5% (Onwujekwe, 2013). For Nigeria therefore whose predominant population is poor living under 1.25 USD daily, impoverishing healthcare spending is certainly a huge tax on the poor whose wellbeing is already compromised, and makes for urgent interventions to prevent the poor from getting poorer (World Bank, 2015).

Furthermore because of the prevailing poverty in Cross River State, the only visible and attractive option individual or poor people have for healthcare is primary healthcare. Even this is hampered by the very poor health financing indicators and low public funding for healthcare (Archibong, et al 2020). The annual allocation for the health sector has persistently been below 6% against an expected 11%. The performance for healthcare institution is poor while the universal healthcare coverage is below 5% of expected national standards. Until recently there was minimal or lack of fiscal allocation for the health sector (Uzochukwu, 2015)

Statement of the problem

The funding of health care in Nigeria has often been described as inadequate with budgetary provision to health hardly exceeding 3% of the nation's total budgetary provisions (Fathalla, 2015). Health care spending in Nigeria is segmented into private and public spending. While public expenditures in Nigeria account for just 20-30% of total health expenditures, private expenditures accounts for 70-80% of total health expenditure. The dominant private expenditure is through out-of-pocket, and this accounts for more than 90% of private health expenditures (Fadeyi, 2015). Health indicator of IMR for Cross River State is estimated to be in the region of 140 per 1,000 live births. Under five mortality rate (U-5MR) is over 200/1,000 live births. Cross River State has a maternal mortality rate between 1,500 - 2,000 per 100,000 live births, perhaps the highest in the South-South Zone of the country which may be quite worrisome to achieving good health coverage (Fadeyi, 2017). In the State, the budgetary allocation for health in 2003 to 2019 represented 2% and 1.2% respectively, out of the total budgetary estimates for those years. This allocation falls below the World Bank recommendation of 15%. Budgetary allocation to the health sector since then has not exceeded 2%. In the State, there seem to be uneven distribution of finance and facilities due to poor services utilization, especially in the primary health care. This in most cases may have contributed significantly to high maternal mortality rate in the State which is more pronounced in Ugep, Cross River State with the maternal mortality ratio of l200/100,000 (Nigerian Partnership for Safe Motherhood, 2018). Many facilities lack basic equipment such as drugs, bed spaces, syringes, power supply, cooling refrigerators amongst others.

Despite the budgetary provision from donor agencies like FHI 360 (USAID), UNICEF, WHO among others on health in Cross River State, many of the health institutions still lack adequate personnel and facilities to provide quality care for the citizenry. There is gross inadequacy in the number of these facilities and adequate funding, and the few available are unevenly distributed. The question this research seeks to answer are (a) what are the various alternative financing strategies adopted by clients to cushion the effect of unavailable, and inaccessible medical services, particularly, at the rural areas? (b) what are the factors that determine the financing of health care system by the Cross River State government, given the state lean financial resources? (c) can the proportion of health sector financing in Cross River State be equated with the demand for health care services? (d) what specific role do non-for-profit (donor agencies) organization play in enhancing health care delivery in the state? These questions shall also guide the study and examine health care financing and services utilization in Cross River State, Nigeria.

Justification of Study

This study examines health care financing and services utilization in Cross River State, Nigeria. In the past, a number of studies has been conducted on this subject using different nation states but these studies have faced heated criticism on the basis of methodology used for conversion of national currencies (Moore, et al, 1992; Oyefabi, et al 2014), statistical reliability of data used for the studies (Hansen and King, 1996) conversion factor of pooled cross-country and time series data and methodology of measurement of GDP (World Bank, 2015). Thus, the result obtained from these studies had short coming of disaggregation of impact of health expenditure on health outcomes. This study therefore intends to use data from the Cross River State Ministry of Health from 2004 to 2010 aggregate the impact of health financing on

health outcomes in Cross River State. Comparison will thereafter be made between the result obtained from this study and this obtained from previous studies.

Overview of Cross River State and State of Health system

The study was conducted in Cross River State. The state located in Southern Nigeria with its capital in Calabar, created on May 27, 1967. It shares boundaries with Benue State to the north, Enugu and Abia States to the west, Cameroon Republic to the east, and Akwa-Ibom and the Atlantic Ocean to the south. The 2005 census estimated the population of Cross River at approximately 3 million. The state has 18 LGAs: Abi, Akamkpa, Akpabuyo, Bakassi, Bekwarra, Biase, Boki, Calabar Municipal, Calabar South, Etung, Ikom, Obanliku, Obubra, Obudu, Odukpani, Ogoja, Yakuur, and Yala (FMOH 2010).

The state faces a number of development challenges including a weak industrial base and a low rate of investment which has left much of the economic resources of the state largely underutilized. Socioeconomic progress is further depressed by a poor infrastructure for communication, transportation, electricity supply, water supply and sanitation, in addition to continued communal conflicts within and across state boundaries. Over 70 percent of the state's population lives below the national poverty line, and health care service delivery is below international standards (SMoH, 2010). Cross River state, like the rest of Nigeria, has a broad health care delivery system, comprising a wide range of service providers, including public, private for-profit, and faith-based organizations. Health care providers vary, from traditional birth attendants and medicine hawkers to specialists in teaching hospitals. The majority of 78.4 percent of the 735 health facilities in the state are PHC facilities, 21.4 percent are secondary, and 0.3 percent are tertiary health care facilities. The majority (81 percent) of health facilities in the state operate as public institutions owned by either the federal, state, or local government while privately owned health facilities (19 percent) are owned by private individuals and NGOs. All PHC facilities are owned by the LGAs, with the exception of the Comprehensive Health Centre at the University of Calabar Teaching Hospital, which is owned by the federal government.

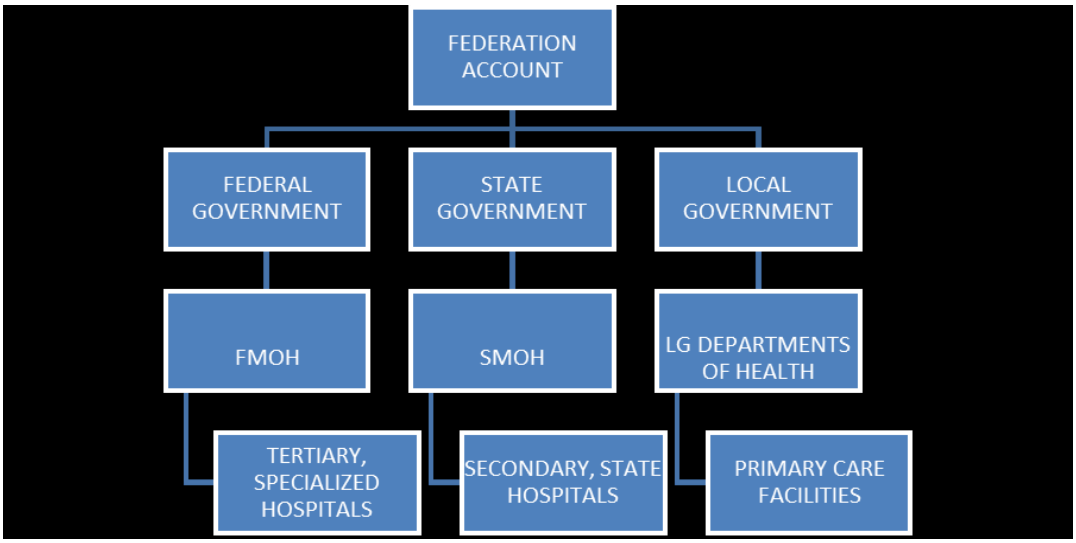
TABLE 1: HEALTH FACILITIES IN CROSS RIVER STATE

Type of facility	Ownership					
	Federal	**State**	**LGA**	**Public**	**Private**	**Total**
Tertiary	2	0	0	2	0	2
Secondary	1	16	0	17	140	157
Primary	1	0	575	576	0	576
Total	4	16	575	595	140	735

Source: Cross River State Ministry of Health

The administrative structure of the public health system in the state is informed by the provisions of the National Health Policy (FMoH 1988, FMoH 2004a, FMoH 2004b). Within the decentralized system established by these policies, the LGAs are responsible for PHC facilities and the state government is responsible for secondary health facilities, while the responsibility for tertiary health facilities belongs to both the federal and state governments. Apart from the SMoH and LGAs, other important actors in the state's public health sector are the Ministry of Education, State Agency for the Control HIV/AIDS, Ministry of Social Welfare, Ministry of Rural Development, Department of International Donor Support under the Office of the Governor, and the Border Communities Development Agency (a federal agency that ensures the sustainable social, economic, and infrastructural development of border communities in Nigeria). These organizations provide funding for health infrastructure and programs or serve as a channel through which donor funds are passed to the health sector. It has been challenging for Cross River state to coordinate these varied and often fragmented sources of health funding. Health status indicators reveal the poor health status of Cross River state. Maternal and child mortality rates rank Cross River state among the worst in Nigeria. The common causes of infant mortality include preventable diseases such as malaria, measles, malnutrition, diarrhea, and pneumonia. Available data indicate a malaria prevalence of 19.8 percent and a TB prevalence of 0.07 percent. The state's HIV prevalence of 8 percent is the highest in the country (SMoH,

2010). All aspects and components of the state's health care system presently require improvement: infrastructure, equipment, power, water, and manpower development. There is a large brain-drain of health workers, hospitals are ill-equipped, and training policies are weak. The National Health Insurance Scheme is still in its infancy and has yet to have significant impact on the health of Cross Riverians.



Source: El-Khoury, Marianne, Elizabeth, Chinyere and Oluwaseun (2012)

Figure 1: Diagrammatic Representation of the Flow of Public Expenditure in Health

Budgetary Analysis of Cross River State health care financing and Expenditure

In some states (e.g., Cross River), health funds flow through other MDAs in addition to the SMoH. These include the Ministry of Education, State Agency for the Control of HIV/AIDS, Ministry of Social Welfare, Ministry of Rural Development, Department of International Donor Support under the Office of the Governor, and the Border Communities Development Agency. In other cases, the federal government funds and runs certain model primary health care centers through National Primary Health Care Development agencies. These funds are typically received for initial logistical support. See table 2 below for state budget allocation on health.

TABLE 2: CROSS RIVER'S STATE BUDGET, 2007–2010 State total budget

	Health allocation		**Health allocation (in % of total)**
2007	42,888,255,050	3,067,603,230	7.2%
2008	104,450,087,020	8,105,415,860	7.8%
2009	107,021,984,521	4,019,630,998	3.8%
2010	78,032,669,068	3,807,510,541	4.9%

Cross River State Ministry of Health

Cross River State Health care budget planning at the LGA level

In Cross River state, the PHC coordinator(s) at the local government receive input from health facilities regarding their budget needs. The PHC coordinator and LGA department heads then form a budget planning committee to identify priority activities and line items to include in the draft budget sent to the chairman. Following the chairman's review, the result, at least on paper, is an approved budget. After the budget is approved, the LGA department heads and PHC coordinator send proposals to the chairman for line items in the approved budget. Upon approval from the chairman, funds are released by the LGA for spending (USAID, 2012). Similar to the state's revenue situation, local governments receive most of their funding from the Joint Account (which mainly derives from the FA). In 2009, on average, 63 percent of total revenue for LGAs in Cross River was allocated from the FA.

It is important to note that the process for allocating funds from the FA to LGAs in Cross River varies from the allocation process for other states in Nigeria discussed in a previous section. The state, rather than the federal government, determines the amount of FA funding each LGA receives.

In summary**,** while the budget preparation process at the state level follows a strategic plan and CSO members are involved in setting strategic priorities, the lack of political will to support health service delivery and strengthen the health system is reflected in the limited budgetary commitment of the state. On paper the budget preparation process in the LGAs takes into account input from health facilities, however, the prerogative for budgeting and planning ultimately lies with the LGA chairman and legislators. This may partly explain why per capita health budgets vary significantly across LGAs. For both the state and the LGAs, the majority of revenues originate from the FA, raising concerns about the state's and LGA's ability to sustain their priorities and respond to the demand of their population. In Cross River, the state rather than the federal government determines the amount of FA funding each LGA receives.

Cross River State health care budget execution at the state level

The state does not maintain consolidated records on health spending. In addition to the SMoH, other MDAs in Cross River appropriate funds to implement health-related activities. These MDAs include the State Ministry of Education, State Agency for the Control HIV/AIDS, Ministry of Social Welfare, Ministry of Rural Development, the Department of International Donor Support under the Office of the Governor, and the Border Communities Development Agency. While these other MDAs are implementing health activities, the state does not coordinate or track all health-related spending across the MDAs. It is therefore difficult to know the actual amount of spending that goes to health.

A significant portion of the SMoH's health budget is not actually spent. According to data provided by the Budget Office and Office of the Accountant General in Cross River state, health spending by the SMoH ranged from 63 percent of the health budget in 2007 to 73 percent in 2010. This is not particular to the health sector – in fact, according to state figures, only 62.5 percent of the total budget of the state is actually spent. These large variances in budgetary executions may be attributed to changes in leadership at the state level and corresponding shifts in political priorities and funds disbursed.

In Cross River State, health care spending differs according to expenditure type. While recurrent spending averaged 86 percent of the budget from 2007 to 2010, capital spending averaged. In 2009, the health capital budget for the state was estimated around 2 billion Naira, of which less than 1 billion Naira were spent (about a 38-percent execution). The exception is 2008, in which capital spending was 76 percent.

Cross River State health care budget execution at the LGA level

In many LGAs of Cross River State, health spending is largely dependent upon the priorities of the LGA chairmen. In Cross River, health facilities must submit an application to the LGA chairman when funding is needed, even when funding relates to previously identified activities in the approved LGA budget. Although some LGAs release funds to PHC facilities based on the prescription and priorities of the MTSS, in many LGAs, funds are released based on the prerogatives of the individual LGA chairmen.

Consistent with the trends observed at the state level, health spending at the LGA level averages approximately 59 percent of the budget. Table 4 shows total health budget allocations and actual spending in each LGA. There is a wide variation in spending across LGAs. Actual spending in health ranges between a low of 14 percent of total budgeted funds (in Akampka) to a high of 100 percent (in Boki). This variation is seen at the level of both recurrent spending and capital spending (Figure 9). In some LGAs, such as Calabar Municipal, low budget execution is primarily driven by low capital spending, while in other LGAs, such as Yakurr and Yala, low spending is driven by the recurrent portion of the budget.

TABLE 3: TOTAL HEALTH FUNDS IN 2009, BUDGET VERSUS ACTUAL SPENDING (IN NAIRA), SELECTED LGAS

LGA	Budget	Actual Spending	Actual Spending as % of Health Budget
ABI	104,632,378	75,316,653	72
AKAMPKA	99,308,054	14,063,333	14
BOKI	143,774,467	143,774,467	100
CALABAR MUNICIPALI	238,984,650	211,634,160	88
OBANLIKU	104,838,972	95,804,903	91
OBUDU	139,716,198	78,521,193	56
OGOJA	162,663,592	84,818,412	52
YAKURR	51,540,000	23,872,577	46
YALA	347,743,359	80,965,797	23

Cross River State Ministry of Health

Cross River State health care facility governance and finances

The majority of surveyed facilities reported having a health committee or a management board (67 percent of tertiary facilities, 64 percent of secondary facilities, and 90 percent of PHC facilities). These committees meet regularly and discuss a variety of issues relevant to the management of the facility, such as service delivery, facility maintenance, human resources, and capital projects. On average, 11 people serve on the health committees in tertiary facilities, 25 in secondary hospitals, and 13 in PHC facilities. Committees/boards across all facilities met an average of 15 times per year over the past two years. Table 4 shows the composition of these committees, as reported by the facilities. Thus, 50 percent of tertiary facilities, 67 percent of secondary facilities, and 79 percent of PHC facilities reported having district or community representatives on their health committees (El-Khoury, et al 2012).

TABLE 4: COMPOSITION OF HEALTH COMMITTEES OR MANAGEMENT BOARDS BY TYPE OF FACILITY (IN PERCENTAGES)

	Tertiary (n=2)	Secondary (n=9)	Primary (n=96)
Officer in charge of facility	100.0	100.0	96.9
Other staff	50.0	77.8	75.0
District/community representatives	50.0	66.7	79.2
Parent representatives	50.0	33.3	61.5
Mosques/churches/NGOs	0.0	22.2	71.9
Local politicians	50.0	66.7	63.5

Source: El-Khoury, et al, (2012) and Cross River State Ministry of Health

Staff meetings are held at the majority of facilities, and they occur between 4 to 10 times per year, depending on the facility. Attendance is decent: 85, 75, and 67 percent of staff attended the meeting in the last staff meeting held in tertiary facilities, regional hospitals, and primary facilities, respectively. Contrary to tertiary and secondary facilities that have some degree of decision-making responsibility, decision making at the PHC level falls almost exclusively on the LGA (Table 5). At 93.5 percent, the overwhelming majority of PHC facilities reported that the primary responsibility for decision making for most of the facility-level provisions for PHC falls under the LGAs. This includes planning and preparing the budget, implementing the budget, monitoring and evaluation of the budget, setting the levels of user fees, choosing the staff to hire, and, to some extent, assessing the performance of staff and deciding on maintenance work. This

probably explains why almost none of the PHC facilities reported having a budget of their own (as addressed in the next section). As seen in Table 5, the health committee/board in fact has no effective decision-making power.

TABLE 5: PRINCIPAL DECISION MAKERS FOR PHC FACILITY FUNCTIONING (IN PERCENTAGES) State

		LGA	Facility Head	Health Committee / Board	Local Politician	Community
Planning and preparation of budget	8.3	91.7	0.0	0.0	0.0	0.0
Budget implementation	5.9	94.1	0.0	0.0	0.0	0.0
Designing of procedures and protocols	3.7	95.1	0.0	0.0	0.0	0.0
Budget monitoring and evaluation	7.1	90.5	0.0	1.2	0.0	0.0
Setting the level of fees at the facility	3.7	93.8	2.5	0.0	0.0	0.0
Choosing the staff to hire	7.1	92.9	0.0	0.0	0.0	0.0
Assessing staff performance	2.9	97.1	0.0	0.0	0.0	0.0
Deciding on maintenance work	4.4	94.2	1.5	0.0	0.0	0.0
Overall	**5.49**	**93.56**	**0.47**	**0.16**	**0.0**	**0.0**

Source, El-Khoury, et al (2012) and Cross River State Ministry of Health

Cross River State like every other state receive the financing from internally generated revenue and periodic allocations from the federation account. Sources of internally generated revenue include taxes, fines and fees, licenses, earnings and sales, rent received on government properties, interest repayment and dividend and miscellaneous. The table above shows the summary of the estimated and actual revenue of Cross River State. The table indicates that in 2004 the State had a deficit percentage variance of 20 percent of actual receipt over estimated receipts for internally generated revenue. This figure dwindled remarkable over the coming years to 125 percent as noticed in 2006. This situation therefore leaves the State Government to depend heavily on allocation that comes in from the federation account and grants and aids. For instance, the State receipt from the federation account amounted to a surplus of 43. This figure declined to 19 percent in 2005 and further worsened to a deficit of 129 percent. Over all, Cross River State had a deficit revenue receipt of 55 percent in 2006 with grants and taxes having a surplus of 26percent and 27 percent respectively. It is important to note that the expenditure of the State depends heavily on the amount of revenue receipts. When the revenue receipts declines, the State Government often would adjust it sectorial allocations to the various departments, with the department that rack it more funds from its internally generated revenue receiving priority attention. From table 2 the study highlights that the budgetary allocation to the health sector had not been impressive.

The budgetary expenditure of health in 2004 stood at 1.16 percent of total expenditure, while education received 2.61 percent of total expenditure. In 2005, the budgetary estimated allocation to health sector increased to 3.65 percent while education expended about 8.42 percent of total budgetary estimate. While the health sector benefited immensely form the previous years budget estimate, in 2006 the budgetary estimate to the health sector plummeted to 0.95 percent. The health sector has since then been experiencing deficient funding from government, however placing more reliance on the external funding that comes from the donor support. This result accounts for the poor performance of the health sector in Cross River State.

LITERATURE REVIEW

Sources of Health Care Financing in Cross River State

In Cross River State like any other state in Nigeria, there are various sources of healthcare financing. These sources include, but not limited to tax-based public sector health financing, household out-of-pocket health expenditure, the private sector (donor funding),community-based health expenditure, and social health insurances. External financing of health care includes grants and loans from donor agencies like the World Bank, the World Health Organization (WHO), Funds and Foundations among others (Dutta & Charles, 2013).

i. **Tax-based Public Sector Health Financing**: In Cross River this source of health care financing is derived from proceeds of tax-based revenue of government across all levels and sectors. At the federal level, the pool of taxes entails crude oil and gas export proceeds, petroleum profit tax, royalties and the component proceeds of domestic crude oil sales/other oil revenues, companies' income tax, customs and exercise duties, Value-Added Tax (VAT), tax on petroleum products, education tax among others (Obansa & Orimisan, 2013; Yunusa et al, 2014; Onotai & Nwankwo, 2012). In Cross River State, financing of the healthcare by the government is largely a function of its revenue base. In essence, there is a strong positive relationship between the proportions of tax-based health spending and the progressivity of total health expenditure.

ii. **Household Out-Of-Pocket (OOP)** Health Expenditure: in Cross River State, the Household Out-Of-Pocket (OOP) expenditure is also referred to as individual user-charges. The health facility owners or management of the health care system (Cross River State Ministry of Health) impose some charges on individuals for healthcare services up-take. OOP health expenditure could be incurred directly by a patient to a health service provider without reimbursement. This covers on-the spot payment for health care services received. The scope of individual health user-fees could
be an admixture of drug costs, medical material costs, entrance fees, and consultation fees (Yunusa et al, 2014). Out-of-pocket payment, otherwise known as private health expenditures accounted for more than 90% cost in accessing health in Cross River State and Nigeria in general. Consequent upon this, it was noted that over-reliance on the ability to pay through OOP has the potency of reducing health care up-take or service delivery or utilization. This can exacerbate the already inequitable access to quality care (Riman & Akpan, 2012; Uzochukwu & Uju, 2012). In Cross River State, OOP expenses also comprise user-fees in public health facilities and any other private payments to healthcare providers for medicals and other treatment received. Oyefabi, Aliyu & Idris (2014) further noted that significant number of people footed their health bills based on user-charges. Similarly, healthcare financing across the less developed and developing countries is still characterized by OOP health expenditure and this affect service utilization. Given the resonating poverty situation in Cross River State and Nigeria, health care spending on some debilitating illnesses can be catastrophic. It is catastrophic if OOP exceeds the household income or its capacity to pay for healthcare services received. In other words, if the large proportion of the household budget goes into health expenditure thereby leaving little to meet other basic health components like food, shelter, education, hygiene, etc. In terms of measurement criteria, catastrophic health expenditure can be determined when OOP healthcare expenditures exceed a pre-specified fraction of the household total expenditure. That is, OOP healthcare expenditures exceeding 40% of non-subsistence expenditure. Catastrophic health expenditure for any household may further push it into poverty (Ahmed & Mesbah, 2015). In like manner, Abayomi (2012) argued that OOP health expenditure is a major barrier to seeking orthodox healthcare services. Out-Of-Pocket health spending can negatively affect people's health seeking behaviour. Its negative consequences can be analyzed in two ways: (i) how many people are impoverished by out-of-pocket spending. (ii) What is the percentage earmarked by households for health expenses? Medical impoverishment and catastrophic health expenditures are the likely outcome of over-reliance on OOP health spending. Incidence of catastrophic health expenditure is said to be generally greater in the rural areas compared to the urban areas. Similarly, the socioeconomic status of a household is coterminous with its monthly catastrophic total household health spending with the poorest having the highest incidence of catastrophic expenditures (Onwujekwe, et al, 2011). Other issues associated with OOP health expenditure include gender, age, income level, family size, nature of illness, healthcare services utilization among others (Apere & Karimo, 2014).

iii. **Private Sector (Donor Funding)**: In view of the enormous demand for the funding of healthcare, government alone cannot shoulder the responsibility of good and quality health care provisioning given the dwindling economy culminating in an abysmally poor budgetary allocation to health sector. Therefore, it has become imperative to engage the private sector in financing of healthcare in Nigeria (Ejughemre, 2014). Private sector health financing include donor funding as well as Public-Private Partnership (PPP). Some of the health donors are UNICEF, the World Bank, WHO, UNDP UNAIDS, etc. The international community's contributions to global health come in various forms, namely: financial assistance (loans and grants), commodities (drugs, medical equipment), technical expertise, training, study tours and fellowship, research funding among others. It is on record that government donations and concession loans that include at least a 25% non-reimbursement component are referred to as official development assistance, and they serve as the major source of external financing for the health sector in the developing world (Ravishankar, et al, 2009). Lending for health and nutrition averaged USD 825 million a year over the first decade of 2000s (Ravishankar et al, 2009). Examples of some health-oriented donor agencies are United States (USAID) through FHI 350 in Cross River State, United Kingdom (DFID), Switzerland (SDC), Austria (ADA), France (AFD), Netherlands (DGIS), etc. Although, there have been efforts tailored towards increasing public funding to health sector in Nigeria as statutory allocation to health will not address the burgeoning health needs for about 170 million people (Ejughemre, 2013). However, private sector health financing is not without its challenges. One of the persistent challenges is duplication of financing efforts by the donor agencies and foundations coupled with lack of global coordination among donor agencies in sending health care aids to the developing countries

iv. **Community-Based Health Financing (CBHF)**: this is also referred to as Community-Based Health Insurance (CBHI). It is designed to provide financial protection from the cost of seeking health care. It has three main components, namely: prepayment for health services by community members, community control, and voluntary membership (Mladoysky, & Mossialos, 2008). Community-based health funds have existed for centuries. The earliest ones were largely financed by local religious organizations such as churches and synagogues. Community health financing scheme comes in various forms such as direct subsidy to individuals, cooperative healthcare, community-based third party insurance, provider sponsored insurance, and producer or consumer cooperative, personal services fees, drug sales, community and individual labour among others (Hsiao, 2001; Metiboba, 2012). A good example of CBHI in Nigeria is Hygeia Community Health Plan (HCHP) to be run in Lagos and Kwara states respectively under the auspices of an international health Non-government Organization (NGO) (Odeyemi, 2014). It has been noted that CBHI is plagued with myriads of problems, namely: (1) small size of contributions has been usually inadequate due to high inflation rates, for financing the basic health needs of most low income families. Again, the size of the schemes is too small to enjoy economies of scale. (2) Lack of mechanism in CBHF for assessing the quality of care offered by health care providers which may undermine efficiency. (3) Reimbursements in the absence of negotiated fee schedules may also be difficult to determine. (4) Sustainability is a very potent challenge faced by the CBHF. (5) Poor legal framework by the CBHF may lead to collapse in event of unforeseen mishap on key members of board of directors; or financial insolvency (Omoruan, Bamidele & Phillips, 2009)

Theoretical analysis: The conflict theory

The proponent of the conflict perspective as deferred to this study is Karl Marx (1859). He maintains that society and social change can only be explained in terms of perpetual conflict - a perpetual competition for scarce resources. Arising from this, Marx considers health as a component of labor while healthcare is a commodity to be competed for (Ritzer 2012). The major assumption for health and healthcare from the perspective of conflict is that social inequality characterizes the quality of health, healthcare and indeed its cost implications. Katikhin (2010) explained this perspective in the context of commodity-money relationships. The process for the rise and development of commodity-money relations manifests as a virtue of buying and selling for profit with exploitation. It destroys the value of natural economy of communalism, self-help and social capital among the people and entrenches individual particularism.

For Marx, the rising cost of healthcare is a function of commodity-money relations (Katikhin 2010). He defines health as a commodity or a

component of the labor power or value the worker exchanges for money. The worker expects to remain healthy in order to work, so he needs both healthcare and the capacity to procure it. So healthcare is a commodity. In a capitalist oriented commodity-money relation, the worker is subordinated (exploited) and alienated from this commodity (quality healthcare) which he rightly deserves for his work. But capitalists would not want that because doing so will reduce the profit accruing to the capitalist. So the worker seeks and pays for it sometimes at intolerable costs and at risk of further impoverishment and poverty. In the alternative, he assesses cheaper but inappropriate care. The tendency to make more profit increases the cost of healthcare through increasing commercialization and medicalization of healthcare (Katikhin 2010). The worker suffers the burden of this relationship and may have to abandon or delay seeking for healthcare to such a time or stage when the cost has become too high with poorer outcomes. So by Marx conflict theory, capitalism is detrimental to health and wellbeing and the forces of capitalism operating through continuous commercialization and medicalization of health act to increase cost of ill health, the burden of which is more on the poor because of already existing social inequality in living conditions (Goudge & Govender 2000)

Marx's analysis is proposed for this study to draw attention to the increasing procurement of healthcare as a commercial rather than social service; the lack of equity in social policy, the unacceptable burden on the poor and the need to foster more egalitarian, humanitarian and less expensive models of service provision among poor people especially those afflicted by HIV or other chronic ailments. The global focus is on primary healthcare as such a model (WHO, 1978). Marxian economic determinism has been classically criticized by Weber in his work on the rise of capitalism as being deficient in arguing that capital or the means of production - the economy of buying and selling to make profit is the only determinant in any social process (Charles 2010). Healthcare delivery being a social class system should be subjected to further micro analysis to understand health and indeed the cost of ill health from the perspective of those experiencing them. They argue that insiders' perspectives that focus on encounters, interactions and the subjective experience of illness will more appropriately provide meaning in the interpretation of the social world of the sick (Charles, 2010).

Healthcare expenditure and service utilization in Cross River State

Over the last few years there has been an increasing interest in measures that might protect wellbeing of the poor from further impoverishment associated with the socioeconomic cost of ill health. To inform policy development, there is a continuing need to understand better the interactions of poor people with health systems in different contexts. There is documented evidence from many studies that showed that the poor have serious difficulties in utilizing health care, and that policies are ineffective in reaching them. For example, Fabricant, Kamara & Mills (1999) provided evidence that the poor receive a lower level of benefit from public health sector spending than the wealthy in Cross River State. Where there is a policy of providing free care, substantial costs still remain (such as travel, food expenses, unofficial medical charges, loss of income of patient and carer etc) that deter the poor from seeking or utilizing health care services (Onwujekwe et al, 2009).

Many of international health policy has focused on identification of interventions that will reduce the burden of ill-health in the most cost-effective way, with the assumption that governments are able to define and implement policies that make these interventions available to the poor (Goudge & Govender, 2000). This assumption often results from cost-effectiveness studies that take into account the costs of the government of the intervention, and improvement in health should the sick receive the care intended, but not the often considerable costs at the household level. It is the inability often to meet these costs that can prevent the poor from obtaining access to care (Goudge & Govender, 2000).

Recently in Cross River State under the former State Commissioner for Health, Dr Beta Edu debates about the efficiency and equity of charging user fees for health care has emphasized how little information there is still no positive impact of lesser few for rural dweller, hence poor service utilization (Onwujekwe, et al, 2009). Although in theory, it is better to direct household expenditure towards the public rather than private sector, thus enabling the former to provide a better service, there is evidence to suggest that fees reduce utilization and impact on the household budget '(pushing) those at highest risk of ill health and death, the young and the poor, further out of the system' (Fabricant, Kamara & Mills 1999). Gertler and van der Gaad's study (1990) show that the price elasticity

for fees and transport is twice as high for the poor, suggesting that these factors do impact on utilization of the poor considerably more that the wealthy. However, little of the evidence examining the impact of user fees is disaggregated by income level, and changes in utilization may not simply be due to price changes but also quality, making it difficult to draw conclusions (Onwujekwe, et al, 2009).

In Cross River State, health policy makers both past and present have long been concerned with protecting people from the possibility that ill health will lead to catastrophic financial payments and impoverishment with the diversion of consumption from basic household needs of food, health and education. Yet catastrophic expenditure is not rare. Every year, in most rural Cross River, a thousand of n households still depend on alternative medicare for survival or to cater for their ill health due to high cost of service delivery

In the state, private expenditure accounts for almost 70% of total expenditure on health of which 90% is out-of-pocket (Onwujekwe, 2009). This high level of out-of-pocket expenditure implies that health care can place a significant financial burden on households. At the same time, observed evidence recognizes that ill health is rarely the only factor that affects poverty dynamics; ill health interacts with a multitude of non-health factors, which makes detection and attribution challenging (WHO, 2002). In Nigeria with a high HIV burden and where many income-generating activities are characterized by low productivity and unreliable rural markets for the poor and low-income households, addressing these issues is critical to improving the livelihoods of rural households and helping them move out of poverty and low wellbeing (WHO, 2002).

Unfortunately, literature is lacking on the pathways and circumstances by which households are made poorer or impoverished by ill health in Cross River State and Nigeria in general. Where research is available, data on rural livelihoods and access are typically scarce, lacking a comprehensive view of relevant health system functions at the micro level. The limited data and analysis of the situation of rural poor contributes to their invisibility and neglect in policy processes in many rural communities of Cross River State and even urban areas Onwujekwe (2009). In the state, though in theory services such as HIV/AIDS, TB, Hepatitis B, Malaria, Cancer and diabetes Miletus are said to have been free, but practically, indirect cost and out of pocket expenditure affects service utilization in the state. Due to user or out of pocket expenditure, maternal care is still low patronage among the rural people due to cost of service.

CONCLUSION

This study brought out very important findings in healthcare financing issues in Cross River State. Generally, from the study, service utilization is affected by the type of healthcare financing available in Cross River State. The expenditure incurred to access healthcare by individual from the primary level to the tertiary level of care was shown to significantly affect services utilization and the choice of Traditional Medical Services as an alternative care. Among women of reproductive age, due to the cost of medical services, most women prefer TBA as services outlets. Due to this high cost, poor households have therefore a greater risk of increasing poverty as a result of healthcare utilization.

From the review, the study had attempted to examine the pattern of healthcare financing in the state as well as consider that factors that determine the health seeking behavior of client in Nigeria. From the study analysis, the study had concluded that household income and out-of-pocket payment has continued to exert negative effect on the health status of the population in both the rural and urban areas. The situation is worse with the clients in Cross River than the urban areas (where most of the populations are living below $1 per day). Particularly, payment for health services has continued to threaten the consumption and livelihood pattern of the rural dwellers than the urban dwellers, especially as payment for health services reduces the amount available for other household consumption, often throwing the families into perpetual borrowing habit, that is, if they must survive, thus further worsening the poverty level of the population. Furthermore, the study had observed that the spatial dispersion of health facilities between the urban and rural areas is discriminatory (with more health facilities located in the urban areas than the rural areas). Residents of the rural areas often will need to trek over 5km to reach the nearest health facility. This situation which usually discourages the clients from seeking health services from government health facilities rather it encourages the clients to seek other forms of available and cheap healthcare services, which more often than not, are inimical to the health population. Healthcare financing in the study has not been particularly encouraging.

The study had observed that most health care facilities in Cross River State do not receive sufficient impress from the government to run the clinics. Although funding of health facilities tend to favor the clinics located in the urban settlement, the clinics located in the rural areas are strongly affected by fund drought. However, the facilities in the rural areas are periodically supported by funds that trickle in from the limited donor agencies, community health committees and personal support from some prominent indigenes of the community, but such funds are intermittent and irregular. It is worthy to mention here that the state government had established some initiatives that are expected to enhance the health status of the population. Such initiative which include, free medical services to children under five years and pregnant mother, establishment of drug revolving funds, community health insurance scheme, and periodic renovation and building of health facilities in both the rural and urban areas, these initiatives (some of which are expected to have long run impact on health status) though commendable, but are still insufficient considering the vast growing population of the areas. Conclusive, indirect medical cost incurred by the poor in accessing healthcare is significant in determining service utilization.

RECOMMENDATIONS

Based on the findings, the following recommendations are made

1. The government should employ and empower more of the poor so that they can enroll in the NHIS Scheme to help mitigate health related financial burden.
2. The government should planned, managed and effectively implement the NHIS, this is likely to improve the overall health outcomes of Nigerians as well as nudge the country towards achieving the Millennium Development Goals.
3. Government should establish a more virile political framework and democratic governance that will be impartial in policy formulations, especially, as it concerns healthcare provision in the state.
4. Government should build more health clinics, health posts in rural settings to make service delivery more accessible.
5. The communities should awaken to a shared sense of responsibilities, through the establishment of local community health insurance schemes. Although, this scheme has been kick started by the state government, many communities have not yet awakened to the responsibility of owning the programme.
6. Efforts should be made by the government to reduce costs in the delivery of social services, as well as increase the efficiency in resources allocations to the primary level, must be considered prior to the introduction of cost sharing. Cost sharing if it must be maintained should be accompanied by special measures that effectively protect the poor.
7. Efforts by the Cross River State government should be made to provide sufficient impress towards the running of health care facilities.
8. The government should encourage the establishment of village/ward development committees whose responsibilities should include taking initiative to assist in government in building health post (in communities where such do not exist), maintenance of established health facilities, provision of logistics during health campaigns and monitoring of health workers activities at the health facilities.

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