REVIEW ARTICLE

# Health care financing in Nigeria: Implications for achieving universal health coverage

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## Abstract

The way a country finances its health care system is a critical determinant for reaching universal health coverage (UHC). This is so because it determines whether the health services that are available are affordable to those that need them. In Nigeria, the health sector is financed through different sources and mechanisms. The difference in the proportionate contribution from these stated sources determine the extent to which such health sector will go in achieving successful health care financing system. Unfortunately, in Nigeria, achieving the correct blend of these sources remains a challenge. This review draws on relevant literature to provide an overview and the state of health care financing in Nigeria, including policies in place to enhance healthcare financing. We searched PubMed, Medline, The Cochrane Library, Popline, Science Direct and WHO Library Database with search terms that included, but were not restricted to health care financing Nigeria, public health financing, financing health and financing policies. Further publications were identified from references cited in relevant articles and reports. We reviewed only papers published in English. No date restrictions were placed on searches. It notes that health care in Nigeria is financed through different sources including but not limited to tax revenue, out-of-pocket payments (OOPs), donor funding, and health insurance (social and community). In the face of achieving UHC, achieving successful health care financing system continues to be a challenge in Nigeria and concludes that to achieve universal coverage using health financing as the strategy, there is a dire need to review the system of financing health and ensure that resources are used more efficiently while at the same time removing financial barriers to access by shifting focus from OOPs to other hidden resources. There is also need to give presidential assent to the national health bill and its prompt implementation when signed into law.

**Key words:** Health care financing, out-of-pocket payment, universal access to health care

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## Introduction

Health care financing system 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.[1-3]

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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

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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[4] and most recently ensure that the money is spent wisely so that the millennium development goals (MDGs) could be achieved.

A health care financing mechanism should provide sufficient financial protection so that no household is impoverished because of a need to use health services. One-way of providing such protection is by incorporating a risk-sharing plan in the health care financing mechanism, whereby the risk of incurring unexpected health care expenditure does not fall solely on an individual or household.[5] One aim of universal health coverage (UHC) is how to ensure that all have adequate access to their health care needs without making significant OOP at the point of receiving care.[6,7] One-way to achieve this is through risk pooling either through tax-funded or social health insurance (SHI).[6,8] Introduction of National Health Insurance Scheme (NHIS): A SHI program, is one-way countries can enhance universal coverage. The NHIS was introduced in Nigeria in 2005 to guarantee accessibility to healthcare for Nigerians. Since the inception NHIS, only those employed in federal formal sector, which <5% of the working population of Nigeria have been enrolled. The plan was that state governments will adopt the program for their employees, and this action promise to expand the coverage of the insurance scheme. However, 9 years after its inauguration, only two states have adopted the program. Therefore, efforts are being made to devise a strategy to extend the coverage to other states as well as those employed in other formal sector outside this federal formal sector, as well as those employed in the informal sector. If such is achieved, the primary aim of NHIS, which is universal coverage, can then be achieved. Several approaches have been suggested of how to improve universal coverage in areas where those employed in formal sector are small. Among the options are "contributory schemes" like community-based health insurance (CBHI), where households in a particular community contribute to insurance scheme; another is tax-funded health scheme, where health services for those outside are funded from tax.[9] In neighboring the country; Ghana, has proposed the introduction of a "one-time NHIS premium payment (OTPP) policy" as an avenue to financial risk protection to those not employed in the formal sector.[10]

The way a country finances its health care system is a critical determinant for reaching UHC. 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[1] 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.

In Nigeria, revenue for financing the health sector is collected majorly from pooled and un-pooled sources. The pooled sources are collected from budgetary allocation, direct and indirect taxation as well as donor funding. However, the un-pooled sources contribute over 70% of total health expenditure (THE) and this can be: OOPs in the forms of fees (informal or formal direct payments to healthcare providers at the time of service) about 90% and payments for goods (medical products such as bed-nets, or condoms) and about 10%. Despite these health financing options in Nigeria, the finances are still disproportionately distributed across the health system and with regional inequity in healthcare expenditure.[11]

Therefore, achieving successful health care financing system continues to be a challenge in Nigeria. This review draws on available and relevant literature to provide an overview and the state of public health care financing in Nigeria.

## Methodology

Data for this publication were generated through two approaches: A review of relevant literature and the authors' experiences. A systematic review of the literature, policy documents and grey articles was conducted. Documents reviewed provided information on health care financing, especially in Nigeria. We searched PubMed, Medline, The Cochrane Library, Popline, Science Direct and WHO Library Database with search terms that included, but were not restricted to health care financing Nigeria, public health financing, financing health and financing policies. Further publications were identified from references cited in relevant articles and reports. We reviewed only papers published in English. No date restrictions were placed on searches. Extra information was obtained from the experiences of the authors. These comprised of experiences gathered from working with different level of health care: Primary, secondary and tertiary health care, as well as interaction with private health sectors workers, participating in workshop and conference presentations and interaction with the population during field work. One focus group discussion was organized during which the authors discussed their different experiences with regards to UHC and overview

of Nigeria health care financing. Their contributions were included in the different thematic areas.

## Results and Discussion

### What policies and plans are in place for the financing of health care in Nigeria?

The review showed that the Nigerian government has put in place various policies and plans addressing health care financing. These documents focuses on how to move closer to UHC with issues related to how and from where to raise sufficient funds for health; how to overcome financial barriers that exclude many poor from accessing health services; and how to provide an equitable and efficient mix of health services. These policies and plans include the National Health Policy, Health Financing Policy, National Health Bill and National Strategic Health Development Plan (2010–2015).

**Table 1: Total federal allocation (2009-2014) to health: Recurrent versus capital**

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

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

**Table 2: Federal allocation to health in relation to the total budget and GDP**

| Year | Total allocation (NGN billion) | Allocation to health (NGN billion) | As percentage of total budget | GDP (NGN billion) | As percentage of GDP |
|---|---|---|---|---|---|
| 2009 | 3557.7 | 154.6 | 4.3 | 25,102.44 | 0.6 |
| 2010 | 4427.2 | 164.9 | 3.7 | 30,980.84 | 0.5 |
| 2011 | 4971.9 | 266.7 | 5.4 | 36,123.11 | 0.7 |
| 2012 | 4877.2 | 282.8 | 5.8 | 42,132.16 | 0.7 |
| 2013 | 4920.0 | 279.2 | 5.7 | 63,504.00 | 0.4 |

Source: Budget Office of the Federation, Federal Ministry of Finance. GDP=Gross domestic product

**Table 3: Federal Capital Health release and utilization 2009–2011**

| Year | Allocation | Total released (NGN billion) | % released | Amount cash backed (NGN billion) | % cash backed | Amount utilized (NGN billion) | % performance |
|---|---|---|---|---|---|---|---|
| 2009 | 54.5 | 48.6 | 89.2 | 48.7 | 100 | 24.5 | 50.4 |
| 2010 | 57.1 | 33.6 | 58.8 | 33.6 | 100 | 32.8 | 97.6 |
| 2011 | 63.4 | 38.8 | 61.2 | 38.8 | 100 | 26.0 | 67.1 |

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

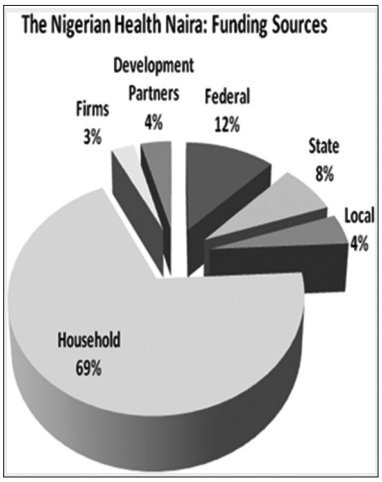


**Figure 1**: Funding sources in Nigeria. Source: NHA 2003–2005

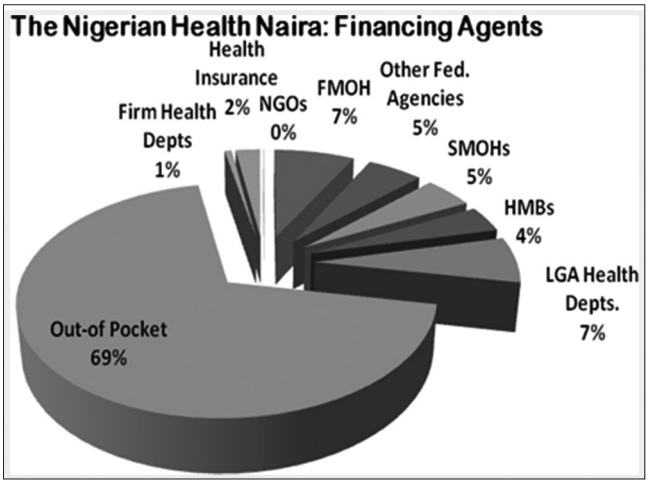


**Figure 2**: Financing agents in Nigeria. Source: NHA 2003–2005

***National Health Policy***

The key thrusts of the National Health Policy[12] in relation to health financing are to expand financial options for health care and strengthen the contribution of the private sector and prepayment based approaches for financing. It also seeks to engage communities and households in community-based schemes for the financing of primary care services. Public-private partnerships are also presented as strategic approaches for the expansion of health financing options at all operational levels. Specific provisions include increasing government funding to international standards, prioritization of primary health care (PHC) and rural poor in funds allocation and increasing allocative efficiency by redistributing resource allocation between levels of care to ensure adequate allocation to preventive and promotive care.

***National Health Financing Policy***

The Federal Ministry of Health enunciated a National Health Financing Policy in 2006.[13] The policy seeks to promote equity and access to quality and affordable health care, and to ensure a high level of efficiency and accountability in the system through developing a fair and sustainable financing system. The overall goal is to ensure that adequate and sustainable funds are available and allocated for accessible, affordable, efficient, and equitable health care provision and consumption.

The revenue mobilization and pooling strategies to increase the fiscal space while ensuring fair financing, including risk protection of the vulnerable financing include:

- Mandating federal, state and local governments to allocate at least 15% of their total budgets to health in line with the 2000 Abuja declaration
- Establishing SHI and CBHI schemes; within the context of the NHIS so as to expand cover to the informal and rural populations, which make up 70% of the population, as a strategy toward universal access
- Support to states to develop state health insurance schemes to be regulated by the NHIS
- Support for voluntary (private) health insurance and discouragement of retainership
- Identifying, adapting and scaling up of financing schemes shown to expedite universal coverage, such as drug revolving fund schemes, deferrals, exemptions etc
- Harmonization of external aids and partnerships for health financing
- Promotion of domestic philanthropy
- Minimization the burden of out-of-pocket expenditure as this negates fairness in financing and promotes catastrophic health expenditure. The policy stipulates that "as much as possible efforts will be made to discourage out-of-pocket health expenditure" and improve funding of disease specific interventions. At present, <5% of national budget goes to health and <5% of the Nigerian population is covered by NHIS and state health insurance scheme is only inaugurated in two states out of 36 states of the federation.

***National Health Bill***

The National Health Bill,[14] which is still awaiting presidential accent represents the first attempt to provide legislative clarification and funding sources to support PHC. It includes provisions for a Basic Health Care Provision Fund; if passed, will significantly increase government financing for PHC. The Bill targets universal coverage with at least basic services. Specifically, the fund is to be financed from:

- The consolidated fund of the federation, an amount not <1% of its value
- Grants by international donor partners; and
- Funds from any other source.

It is proposed that:

- 50% of the fund shall be used for the provision of basic minimum package of health services to all citizens, in eligible PHC facilities through the NHIS
- 25% of the fund shall be used to provide essential drugs for primary healthcare
- 15% of the fund shall be used for the provision and maintenance of facilities, equipment and transport for primary healthcare
- 5% of the fund shall be used for the development of human resources for eligible PHC facilities; and
- 5% of the fund shall be used by the Federal Ministry of Health for National Health Emergency and Epidemic Response.

The Bill proposes that National Primary Health Care Development Agency has responsibility for disbursing the funds for essential drugs for PHC, facility maintenance and human resource development through State Primary Health Care Boards for distribution to Local Government Health Authorities. The Bill indicated that for any state or local government to qualify for federal government block grant, the state and Local Government Area (LGA) must contribute not <10% and 5% respectively of the total cost of the project.

***National Strategic Health Development Plan 2010–2015***

National Strategic Health Development Plan (National Health Plan) - reflects shared aspiration to strengthen the national health system and to vastly improve the health status of Nigerians. The plan is the overarching reference health development document for all actors toward delivery on a shared results framework, to which each and every one will be held accountable for achieving the goals and targets as contained in the results framework. The health plan, which was also developed in tandem to the guidelines of the National Planning Commission – Vision 20:2020 process (including the V20:2020 implementation plan), is

the compass or reference for the health sector Medium Term Sector Strategy and annual operational plans and budgets at all levels.[15] The overall goal is to ensure that adequate and sustainable funds are available and allocated for accessible, affordable, efficient, and equitable health care provision and consumption at local, state and federal levels.

The strategic objectives are:

- To develop and implement health financing strategies at federal, state and local levels consistent with the National Health Financing Policy
- To ensure that people are protected from financial catastrophe and impoverishment as a result of using health services
- To secure a level of funding needed to achieve desired health development goals and objectives at all levels in a sustainable manner
- To ensure efficiency and equity in the allocation and use of health sector resources at all levels.

**Health expenditure pattern and fiscal context**

One of the issues preventing quality health care delivery in Nigeria and this achieving UHC is the inadequate general government expenditure on health (GGHE) as a percentage of the government general expenditure (GGE).[16] In 2012, 6% of GGE was proposed as GGHE contrarily to the agreement of the African Union's Abuja declaration of 2001 (appropriating 15% of the government's budget for health). Over the years federal government allocation to health is equivalent to 3.2% of the total federal spending.[17] In addition, the GGHE as a percentage of THE increased from 32% in 2000 to 35% in 2009.[18]

The total budget allocation to health at the federal level has increased by 67% from NGN154.6 billion in 2009 to NGN266.7 billion in 2011 and the federal budget allocation to health, accounts for 5.4% of the total federal budget and 0.7% of the national gross domestic product. The federal level allocation for health is far short of the Abuja declaration target of 15% of the national budget. As shown in Table 1, the proportion of recurrent expenditure has increased from 67% in 2009 to 82% in 2014, although the capital expenditure decreased from 33% in 2009 to 18% in 2014.

As shown in Table 2 below, the federal government's allocation to health increased dramatically from NGN154.6 billion in 2009 to NGN164.9 billion in 2010 to NGN279.2 billion in 2014. The equivalent capital allocations were NGN54.5 billion, NGN57.1 billion and NGN63.4 billion for 2009, 2010 and 2011 respectively. Of these, NGN48.6, 33.6 and 38.6 were released constituting 89.2, 58.8 and 61.2% respectively for those years.

The total federal level capital budget allocation for health that was released was NGN38.8 billion out of the NGN63.4 billion budgeted (61.2%) for 2011 [Table 3]. Of this, only NGN26.02 billion (67%) was utilized. The absorptive capacity for released funds is moderate.

In most states of the federation, the proportion of states' and LGAs' budgets allocated to health remains below 15%. It is as low as 2% in Ondo and as high as 15% in Bauchi State.[18] The per capita health expenditure of $10 is far below the $34 recommended by the Macro-economic Commission on Health as required for provision of basic package of essential health care services.[19] However, there has been significant improvement in funding for some diseases/programs e.g. immunization, AIDS, tuberculosis, malaria, MSS, SURE-P MCH.

Although states allocate reasonable budgets to their health sector; there is evidence of erratic and nonrelease of the allocated budgets. In many states of the federation, the nonrelease affected both recurrent and capital budgets and this led to significant poor implementation of program activities. At the LGA levels, the financial allocations do not extend beyond the payment of salaries and consequently not much, if anything to pursue health programs, including the issue of monitoring and supervision and logistics support for outreach services.

**Sources of financing for Nigerian health care system**

In Nigeria, the financing of health come from different sources and from different financing agents as shown in Figures 1 and 2.

**Revenue contribution**

***Source of funds***

The most common source of healthcare financing is OOP from the households, which is estimated at 69% as shown in Figures 1 and 2 and next is government funding with allocation from the federation account's general revenue allocated to the various levels of government based on an agreed revenue allocation formula.

***Out-of-pocket payments***

This is payment for health care (user fees) at the point of service and about 70% of healthcare payments in Nigeria are made out-of-pocket. In 2007, OOPs increased from 92.7% to 95.9% of private expenditure. This is regarded as one of the highest in the world. On an average, about 4% of households spend more than half of their total household expenditures on healthcare and 12% spend more than a quarter. For example, 15% of households studied in Southeast Nigeria experienced catastrophe. The catastrophic consequences thus push some into poverty, and aggravate the poverty of others. Although not all health services are charged e.g. the user fees have been removed by the federal government and some states for the treatment of malaria in the under-5s and pregnant women.[20] OOP has remained the dominant mode of financing healthcare in developing countries[21]

and a major limitation if an expensive healthcare service is to be accessed.[22] This can lead to poor health seeking behaviors[23] and inequity.[24] At the threshold level of 40% of nonfood expenditure and the poorest quintiles often experienced catastrophe.[25] In situations where proportion of THE contributed by OOP is below 15–20%, the incidence of financial catastrophe caused by out-of-pocket health expenses is negligible.[26]

*Tax-based revenue*

Health financing systems where government revenues are the main source of health care expenditure are referred to as tax-based systems.[27] The health system is generally funded from federation account to the states and LGAs, both of which also generate about 20% internal revenue from taxes, rates and levies. The allocation of federal revenues is fixed by the Revenue Mobilization Allocation and Fiscal Commission and the allocation formula assigns 48.5% to the federal government, 24% to the states and 20% to local government, with 7.5% retained for "special" federally determined projects with limited room for maneuvers on fiscal policy.[28]

*Donor funding*

This refers to financial assistance given to developing countries to support socioeconomic and health development and may be in the form of loans or of aid grants. The donor countries were given the target of 0.7% of their gross national product as Official Development Assistance (ODA) to developing countries.[22] The annual average ODA inflow from 1999 to 2007 was estimated at US$2.335 and US$4.674 per capita, respectively.[29,30] Debt relief attached to financing of programs for achieving the MDGs, which is a form of donor funding has also contributed greatly to the financing of PHC in Nigeria. Some of the funds released from the debt relief agreement were used to sponsor free distribution of insecticide-treated bed nets and antimalarial drugs to pregnant women and children under five. There are major challenges of an effective coordination of the funds and tracking donor resource flow.[31]

**Pooling arrangements**

Pooling is essentially the accumulation and management of prepaid health care revenue on trust for the population, ensuring that the cost of health care is distributed among all the members of the pool. One major means of pooling is through health insurance.

**Social health insurance**

Health insurance stands for a pooling of health risks, in order for the participants to get benefits due to the uncertainty underlying ill-health occurrence and payments for treating such ill-health. This is because the need for health-care is often highly unpredictable and very costly for the individual although it is predictable for large groups.[32] It is a system of financing health care through contributions to an insurance fund that operates within the framework of government regulations.[33] The NHIS will reduce the financial burden of OOP for health care services.[34] It only covers 4–5% of Nigerians (largely federal government employees): Urban self-employed; rural community; children under-five; permanently disabled persons; prison inmates; tertiary institutions and voluntary participants; and armed forces, police and other uniformed services. Membership with the formal sector SHIP is mandatory for federal government employees.

The beneficiaries are expected to pay 15% of their monthly salary to the scheme but the federal government pays 10% of this while the remaining 5% is paid by the beneficiary. The payroll deduction of 15% basic salary has not been attained; and majority of the formal sector (federal, state, local government and organized private sector) are yet to subscribe to the scheme. Buy-in by the states remains low; only Cross River and Bauchi States have enrolled and have said to have achieved full coverage,[35] whereas Abia, Enugu, Imo, Gombe, Lagos, Ondo, Oyo, Jigawa, and Kaduna States that have indicated interest are yet to come on board.

Some private companies have health insurance cover for their employees covering about 1% of Nigerians. The contribution of NHIS to health funds remain low at about 2% of overall health expenditure and it is plagued by poor penetration, low acceptance and narrow benefit packages.[36]

**Community-based health insurance**

Community based health financing is referred to as a mechanism, whereby households in a community finance or co-finance the costs associated with a given set of health services, at the same time participating in the management of the community financing scheme and the organization of the health services.[37] It is designed for people living in the rural area and people in the informal sector who cannot get adequate public, private, or employer-sponsored insurance.[38] Usually, it is voluntary compared with SHI schemes which tend to be mandatory.

The Nigerian government intends to use CBHI to cover people employed in the informal sector and in the rural area.[39] CBHI has been piloted on a small scale in Anambra,[40] Lagos and Kwara States,[40] but most recently, it was officially rolled out in Nigeria. About 110 communities across the country have been identified to benefit from this and there are about 100 others that have approached the NHIS to roll out the scheme in their communities. The scheme is contributory in which individuals are expected to make regular financial contributions of N150 per head into a pool.

However, low enrolment rates greatly undermine the sustainability of CBHI as it is affected by factors such as trust by the community in the organizer or manager of the

scheme, attractiveness of the benefit package, affordability of the premium, and the quality of the health care.[25] There are also equity issues in CBHI, for example despite the smallness of premium paid by the enrollees in the Southeast Nigeria, CBHI scheme enrolment was very low and contributions were observed to be retrogressive.[25]

### Private health insurance

Private health insurance (PHI) is directly and voluntarily funded by prepayment by the insured members. In Nigeria, an estimated 1 million people are covered in the PHI and this is <1% of the population. PHI can also involve some form of medical retainer-ship. This is when employees of an establishment receive medical care from stipulated health facilities at a cost to the employers.[17]

### Projected solutions to the barriers in the attainment of health financing goals; a means to achieving universal health coverage

There are lots of barriers to the attainment of our financing goals and they include:

- Inadequate political commitment to health, leading to poor funding of health in general, and PHC in particular
- Gaps in the area of stewardship and governance as evidenced by lack of clarity of the role of government, at all levels in financing health care
- Absence of a health policy that clearly spells out how funds are to be allocated and spent in the health sector
- Governance issues with the NHIS and poor buy-in by the states limiting coverage
- Dominance of OOPs presents possibilities of under/oversupply of services depending on financial abilities
- Nonexploitation of other sources of health financing
- Several stakeholders, including development partners finance health independently and not in accordance with governments' policy thrust. This has led to inefficient use of scarce resources and duplication of efforts.

A lot of countries have been devising innovating health financing mechanism in other to achieve UHC. These responses, which have attracted considerable controversy involve the questions of whether to pay for health care through general taxation or contributory insurance funds to improve financial protection for specific sections of the population, whether to use financial incentives to increase health care utilization and improve health care quality, and whether to make use of private entities to extend the reach of the health care system.[41] As proposed in Ghana, the introduction of a "OTPP policy" as an avenue to financial risk protection to those not employed in formal sector.[10]

## Conclusion

Lack of success in achieving health care financing, has continued to be a challenge in achieving UHC in Nigeria. The review has identified barriers to efficient health care financing and the following strategies are recommended if Nigeria is to achieve UHC: (i) Replacement of OOPs with more equitable modes of financing; (ii) articulate clear policies on PHC financing; (iii) there is currently a lack of clarity as to the roles of different levels of government in financing PHC, and which components are to be financed by each level of government; (iv) governments should give higher priority to health in their budget allocations; (v) pass the national health bill and implement it; (vi) explore innovative ways of mobilizing funds and financing health. Tax-based health financing is recommended. The excise, value added tax or "sin taxes" on products such as alcohol and tobacco (products that pose risks to health) can be extended to include unhealthy foods such as sweets, sugary drinks and foods high in salt and trans-fats. Other possibilities for innovative fund-raising include solidarity levies on mobile phone call tariffs (over 90 million Nigerians own and use mobile phones), raising diaspora bonds (from our large diaspora population), and taxing specific profitable sectors of the economy like banking, oil and gas. Nigeria is already exploring fund-raising from diaspora bonds.[42] Other measures are; extending the NHIS to the informal sector through the CBHI; mobilize the private sector (telecommunications and banks) and local philanthropists-for the telecommunications an arrangement whereby a certain percentage (to be determined) of each recharge card purchased goes into the revenue pool for financing health. Donors should do more to meet their stated international commitments for ODA and to provide more predictable and long-term aid flows in Nigeria. They should align their support with Nigeria's national development strategies, in line with the Paris declaration on aid effectiveness; more money for health: Though raising overall general government revenues will translate into more money for health, new means of raising direct funds for health are also needed. The "more money for health, and more health for the money" includes mechanisms designed to raise funds in excess of conventional means as well as mechanisms that improve how these funds are used[43] should be uphold.

## References


1. Gottret P, Schieber G. Health Financing Revisited: A Practioner's Guide. Washington DC: The International Bank for Reconstruction and Development/The World Bank; 2006.
2. Carrin G, Evans D, Xu K. Designing health financing policy towards universal coverage. Bull World Health Organ 2007;85:652.
3. Murray C, Frenk J. World Health Report 2000: A step towards evidence-based health policy. Lancet 2001;357:1698-700.
4. Palmer N, Mueller DH, Gilson L, Mills A, Haines A. Health financing to promote access in low income settings-how much do we know? Lancet 2004;364:1365-70.
5. McIntyre D. Reducing Fragmentation in Health Care Financing and Promoting Solidaristic Societies. Paper Presentation, 6th International Health Economics association, Copenhagen Denmark, July 2007.

6. World Health Organization. World Health Report 2010, Health Systems Financing – The Path to Universal Coverage. Geneva: World Health Organization; 2010.
7. Carrin G, James C. Reaching Universal Coverage via Social Health Insurance: Key Design Features in the Transition Period, Discussion Paper. Geneva: World Health Organization; 2004.
8. Kutzin J. Myths, instruments, and objectives in health financing and insurance. In Extending social protection in health: Developing countries' experiences, lessons learnt and recommendations. Eschborn, Germany: Deutsche Gesellschaft fur Technische Zusammenarbeit (GTZ); 2007. p. 87-95.
9. Tangcharoensathien V, Patcharanarumol W, Ir P, Aljunid SM, Mukti AG, Akkhavong K, *et al.* Health-financing reforms in southeast Asia: Challenges in achieving universal coverage. Lancet 2011;377:863-73.
10. Abiiro GA, McIntyre D. Achieving universal health care coverage: Current debates in Ghana on covering those outside the formal sector. BMC Int Health Hum Rights 2012;12:25.
11. Lawanson AO, Olaniyan O. Health expenditure and health status in Northern and Southern Nigeria: A comparative analysis using National Health Account Framework. Afr J Health Econ 2013;2:31-46.
12. FMOH. Revised National Health Policy. Abuja, Nigeria: Federal Ministry of Health; 2005.
13. FMOH. National Health Financing Policy. Abuja, Nigeria: Federal Ministry of Health; 2006.
14. Saka MJ. An overview of the Nigerian National Health Bill. Savanna Journal of Medical Research and Practice 2012;1:1-9.
15. FMOH. The National Strategic Health Development Plan (National Health Plan) 2010-2015. Abuja, Nigeria: Federal Ministry of Health; 2010.
16. World Health Organization. World Health Statistics 2012. Geneva: World Health Organization; 2012. Available from: http://www.who.int/healthinfo/EN_WHS2012_Full.pdf. [Last accessed on 2013 Mar 17].
17. Obansa SA, Orimisan A. Health care financing in Nigeria: Prospects and challenges. Mediterr J Soc Sci 2013;4:221-36.
18. Sambo, *et al*. International Archives of Medicine 2013;6:5-17. Available from: http://www.intarchmed.com/content/6/1/10). [Last accessed 2014 Apr 12].
19. FMOH. Joint Annual Review of the National Strategic Health Development Plan (2009-2013), Draft Report. Abuja, Nigeria: Federal Ministry of Health; 2013.
20. Onwujekwe OE, Uzochukwu BS, Obikeze EN, Okoronkwo I, Ochonma OG, Onoka CA, *et al.* Investigating determinants of out-of-pocket spending and strategies for coping with payments for healthcare in southeast Nigeria. BMC Health Serv Res 2010;10:67.
21. O'Donnell O, van Doorslaer E, Rannan-Eliya RP, Somanathan A, Adhikari SR, Akkazieva B, *et al.* Who pays for health care in Asia? J Health Econ 2008;27:460-75.
22. World Health Organization. Nigeria – National Expenditure on Health. Geneva: World Health Organization; 2012.
23. Goudge J, Russell S, Gilson L, Gumede T, Tollman S, Mills A. Illness-related impoverishment in rural South Africa: Why does social protection work for some households but not others? J Int Dev 2009;21:231-51.
24. Wagstaff A, van Doorsaler E. Equity in healthcare financing and delivery. In: Culyer AJ, Newhouse JP, editors. Handbook of Health Economics. 1st ed., Vol. B. Ch. 34. North Holland: Elsevier; 2000. p. 1803-62.
25. Onoka CA, Onwujekwe OE, Hanson K, Uzochukwu BS. Examining catastrophic health expenditures at variable thresholds using household consumption expenditure diaries. Trop Med Int Health 2011;16:1334-41.
26. World Health Organization. The World Health Report – Health Systems Financing: The Path to Universal Coverage 2010. Geneva: The World Health Organization; 2010. Available from: http://www.who.int/whr/2010/en/index.html. [Last accessed on 2014 May 20].
27. Savedoff W. Tax-based financing for health system: Options and experiences. Geneva: WHO; 2004.
28. World Bank. Making Services Work for Poor People. World Development Report 2004. Washington DC: A Co-publication of the World Bank and Oxford University Press; 2003.
29. World Health Organization. Country Cooperation Strategy: Federal Republic of Nigeria 2002-2007. Brazzaville: World Health Organization Regional Office for Africa; 2007. Available from: http://www.who.int/countries/nga/about/ccs_strategy02_07.pdf. [Last accessed on 2013 Mar 14].
30. United Nations Development Programme (UNDP). MDGs Needs Assessment and Financing Strategy for Nigeria: Policy Brief 2007. Available from: http://www.ng.undp.org/mdgs/policy_brief.pdf. [Last accessed on 2013 Mar 14].
31. World Health Organization. WHO Country Cooperation Strategy: Nigeria 2008-2013. Brazzaville: WHO Regional office for Africa; 2009.
32. OECD. The Reform of Healthcare: A Comparative Analysis of Seven OECD Countries. Paris: OECD; 1992.
33. Kutzin J. Health insurance for the formal sector in Africa: "Yes, but…". In: Beattie A, Doherty J, Gilson L, Lambo E, Shaw P, editors. Sustainable Health Care Financing in Southern Africa. Washington, DC: World Bank; 1998. p. 61-73.
34. National Health Insurance scheme (NHIS). Available from: http://www.nhis.gov.ng/. [Last accessed on 2011 Dec 12].
35. Kannegiesser L. National Health Insurance Scheme to boost generics market in Nigeria. Available from: http://www.frost.com/prod/servlet/market-insight-top.pag?Src=RSSanddocid=155485216. [Last accessed on 2011 Dec 12].
36. Lawan UM, Iliyasu Z, Daso AM. Challenges to the scale-up of the Nigerian National Health Insurance Scheme: Public knowledge and opinions in urban Kano, Nigeria. Ann Trop Med Public Health 2012. Available from: http://www.atmph.org/text.asp?2012/5/1/34/92878. [Last accessed on 12 Apr 2013].
37. Carrin G. Community based health insurance scheme in developing countries: Facts, problems and perspectives. Discussion paper No 1. Geneva: World Health Organisation, Department of Health System Financing, Expenditure and Resource Allocation (FER); 2003.
38. Uzochukwu B, Onwujekwe O, Eze S, Ezuma N, Obikeze E, Onoka C. Community Based Health Insurance Scheme in Anambra State, Nigeria: An analysis of policy development, implementation and equity effects. 2009. Available from: http://www.crehs.lshtm.ac.uk. [Last accessed on 2011 April 18].
39. Adinma ED, Adinma BJ. Community based healthcare financing: An untapped option to a more effective healthcare funding in Nigeria. Niger Med J 2010;51:95-100.
40. Ayeleso O. Lagos govt introduces community based insurance scheme. Nigerian Tribune. 13 April 2011. Available from: http://www.tribune.com.ng/index.php/insurance/20352-lagos-govt-introduces-community-based-insurance-scheme. [Last accessed on 2011 Apr 14].
41. Mills A. Health care systems in low- and middle-income countries. N Engl J Med 2014;370:552-7.
42. Aderinokun K. Federal Government to Float $100 m Diaspora Bond in 2013. This Day Newspaper, June 2012.
43. Le Gargasson J, Salomé B. The Role of Innovative Financing Mechanisms for Health. World Health Report, Background Paper, No12. 2010.


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