

Sustainable Development Goals and Universal Health Coverage: Issues and Options for Sustainable Health Financing in Nigeria

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Abstract

The attainment of the Post-2015 health agenda requires that health financing options are developed within the macroeconomic, socio-cultural and political context of each country. Therefore, health financing mechanisms that separate utilization from direct payment are essential. However, each health financing option has limitations that can endanger the achievement of the set Post-2015 health objectives. The study carries out an exploratory analysis of the viability of general tax, out-of-pocket expenditure and insurance financed health system in Nigeria. The analysis shows that insurance financed health system can guarantee universal health coverage irrespective of individuals' social-economic strata. Hence, universal health coverage can be pursued through the expansion of health insurance in Nigeria.

Keywords: Sustainable development goals, universal health coverage, health financing

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Introduction

Countries are developing different mechanisms of financing health care to achieve universal health coverage (UHC). This has brought numerous changes to the methods of financing health services. Implicit in the attempts to find adequate and sustainable financing methods is a genuine desire to

do better with the health care resources at the disposal of government and to ensure adequate access to health care facilities by the populace. However, these efforts have attracted considerable controversy involving the questions of whether to pay for health care through general taxation, direct payment or contributory insurance funds, whether to use financial incentives to increase health care utilization, and whether to use private organizations to extend the coverage of the health care system. This is because any method employed determines the extent to which the available health services are affordable, how much money is available to the health sector and who bears the financial burden and controls the funds. The tracking survey reports of the 2015 Millennium Development Goals (MDGs) performance shows that Nigeria fell short of achieving the MDGs health targets (NBS and FGN, 2015). The reports showed that Nigeria made progress in the reduction of child mortality and weak progress in combating HIV/AIDS but failed to meet the required MDGs target on both. The explanation given for this non-satisfactory performance was inadequate financial resources available to the health sector among others. This underscored the importance of adequate financing in accomplishing significant improvement in health services coverage. The 2001 Abuja Declaration of committing at least 15% of the annual budget to health sector by each African country and also urging donor countries to fulfil their target of committing 0.7% of their Gross National Income (GNI) as official Development Assistance (ODA) as well as increase their funding levels for the health sector of low-income countries were evidence to support the need for adequate financing. One can therefore, concludes that inadequate and weak health financing was a key factor behind the poor performance of many African countries to meet the MDGs target.

While considerable health gains were achieved in the MDGs years, many low and middle-income countries were unable to meet the MDGs health targets. This informed the need for continuous commitment to accelerating the progress related to MDGs health goals beyond 2015 (SDSN, 2014). Societies echo commitment to eradication of extreme poverty, social inclusion, environmental sustainability and good governance by prioritizing sustainable development. While each of these contributes to the others, health is critical to achieving these four pillars. More evidence of the importance of health to sustainable development are the increasing number of reports such as the WHO Commission on Macroeconomics and Health (1999) emphasizing the importance of greater investment in health through more public financing (SDSN, 2014). Therefore, health and wellbeing for all

at all ages was adopted as the core of sustainable and inclusive development goals strategy. This task necessitates large-scale health investments with adequate and sustainable financing. However, various countries intend to achieve this with different health financing mechanism. Some countries aimed to attain it through national health insurance systems that purchase services from public and private providers, while others worked toward providing access to health services through public financing. This being a laudable commitment, the critical issue is that the resources available to the health needs of the people is extremely insufficient. As a result, the selection of adequate and efficient method(s) of financing health services is indispensable for meeting the sustainable development health goals (SDGs) health targets in low and middle-income countries. This study carries out an exploratory analysis of the viability of general tax, user fees, out-of-pocket expenditure and insurance financed health system in Nigeria. The rest of the paper is divided into five sections. Section two is pre-occupied with the review of the literature on health care financing mechanism and the changing world of health care financing while section three contains health financing means and its growth in the MDGs period in Nigeria. Section four contains an exploratory analysis of viability of different health financing means in Nigeria; section five contains conclusion and policy recommendation.

Health care financing mechanism and the changing world of health care financing¹

The five-basic health care financing system include general and earmarked taxes, social insurance, private insurance, community financing and out-of-pocket payments (Irvine and Ferguson, 2002 and WHO, 2002). The strategy chosen has implications for the health status and financial risk protection of various income and age groups. Countries need to consider fiscal capacity, equity, efficiency in raising funds and the economic effects of raising funds in their selection of health care financing methods (WHO, 2002). Therefore, when nations search for financing strategies to improve the performance of their health systems, they have to know the relative strengths and weaknesses of the five financing methods. The financing arrangements of health care systems of many nations are under reforms because countries

¹This section benefited mostly from Donalson, Cam and Karen Gerrad (1993) *Economics of Health Care Financing: The Invisible Hand* and Olayiwola S. O. (2007) *Financing Health Care Services in Nigeria: A willingness and Ability-to-Pay Analysis*.

(the richest ones inclusive) are finding it increasingly difficult to cover the rising health care costs, and more so the economic downturn is adding more pressure to health spending. The fundamentals of evaluating these reforms is whether they make things easy for the population at large within the context of the national economy, the distribution of national resources and the living standard of the population. More importantly how a health system is financed determines how much money is available, who bears the financial burden and controls the funds and whether health expenditure inflation can be managed (CMH, 2002). These outcomes determine the health status of the population, who has access to health care, and who is protected against catastrophic medical expenses. The UK Health Policy Consensus Group, (2003), identified eight key features by which healthcare financing systems can be assessed. These include: price consciousness, social solidarity, consumer empowerment and patient satisfaction, quality of care, clinical autonomy, conflicts of interest with the third-party payer, responsiveness and fiscal viability.

Taxes are used to withdraw resources from the private sector for public use. Since the burden of government goods and services must be borne by the people who enjoyed those goods and services, taxes must be viewed as representing charges paid by the citizen to government to cover the cost of goods and services. Health financing can be provided by raising taxation either in the form of general taxation (i.e. earmarked taxes specifically for health services) or a general public tax system (i.e. covering more benefits than only health care and with contributions that are not experience-rated) (Donaldson and Gerard, 1993). However, a nation's ability to raise tax revenue for healthcare depends on its aggregate economic capacity, on the number of rich and poor households and on the government's ability to collect taxes. The use of tax revenue to finance healthcare services is most common in industrial western countries and is most closely associated with the comprehensive national insurance systems in Canada, the general taxation in the United Kingdom and local taxation combined with provider management by local councils in Denmark (The UK Health Policy Consensus Group, 2003). Donaldson and Gerard, (1993) further submitted that direct tax payment has been one of the basic funding arrangements for health in Western Europe (such as in Denmark, Norway, Sweden and the UK), Eastern Europe and in many less-developed countries (LDCs). This implies that general tax revenue is prevalent in countries that can afford to develop, sustain, and administer a government bureaucracy to collect and manage tax revenue. This arrangement reflects both economic

considerations, cultural differences and the history of health care financing in the countries involved. Sanders (2002) observed that the use of tax revenue system is least likely to be effective in poorer countries, where personal income is low and other public goods (e.g. roads, education, military) must compete for scarce government resources. This means that a tax-financed health system may not be feasible, efficient and sustainable in low-income countries like Nigeria.

Social insurance is a social security system model under which insurance funds may be independent from government (the UK Health Policy Consensus Group, 2003). Social insurance systems have four common features: universality (compulsory insurance with subsidization of the sick by the healthy), price regulation (to ensure risk solidarity usually combined with some form of risk compensation for insurers with relatively many high risks insured), open enrolment, and a defined and regulated benefits package. The capacity of social insurance to raise funds depends largely on the scheme's ability to collect the contributions from the employer and workers who are covered by it. Worldwide experience shows that for low and middle-income countries, social insurance can be effectively implemented only for workers employed by larger companies in the formal sector. Another form of health insurance is private health insurance. The distinctive feature of private insurance is that the buyers voluntarily purchase insurance from independent, competitive sellers (either for-profit or non-profit organizations) who charge premiums that reflect the buyer's risk rather than his or her ability to pay (WHO, 2002). Many countries have shown increased interest in various forms of private insurance to finance the health sector (Arhin-Tenkorang, 1994; Brown and Churchill, 2000). This interest appears to be driven by several arguments. The first is that private insurance will raise additional resources. Since non-payers are not covered, the problem of tax evasion is avoided. Advocates of private insurance also argue that when people can choose a plan and an insurer they will feel more empowered and be more willing to pay for health care. It is however noted that, private insurance has the capacity to raise funds from those who have the capacity to pay, wish to be insured, and are unreachable by other financing methods. People in the upper-income bracket, may be much more willing to pay for private insurance that covers expanded or higher-quality services.

Community financing is any financing scheme that has community members paying into the scheme and/or participating in its management.

A clearer but narrower concept of community financing involves tapping into the social cohesion and spirit of mutual assistance that can exist in a small community. These social forces may make it possible to organize prepayment schemes to fund and spend money locally, at the village and township level. Under most community-financing schemes, the financing and delivery of primary care are integrated. Where community financing is both prepaid and compulsory, it does offer some pooling of risk and a certain amount of risk protection (Arhin-Tenkorang, 1994). Studies have revealed that community-financing arrangements make a positive contribution of the financing of health care at low-income levels. These arrangements improve people's access to drugs, to primary care, and to more advanced hospital care (Dave, 1991). Researchers have also consistently found that community-based health financing has been effective in reaching more low-income populations who would otherwise have had no financial protection against the cost of illness (Litvack and Bodart, 1992).

An out-of-pocket payment occurs when patients pay providers directly out of their own pockets for the goods and services they have received (WHO, 2002). These payments are not reimbursable by third parties-such as an insurance plan. User-fees are a sub-category. These are out-of-pocket payments for services provided by public facilities. The government uses these to finance a portion of their operating expenses. Out-of-pocket payments by patients are a common feature of the health sector in low and middle-income countries, including Nigeria. Berman (1998) suggested that there may be substantial willingness and ability to spend on outpatient care, even among relatively poor people in low-income countries-especially when we include "informal" payments. Studies have found that among non-socialist low-income countries, 40 to 50 per cent of the national health expenditure comes from out-of-pocket payments. Poor and low-income households bear a large share of these payments (Berman, 1998). For example, close to 60 per cent of the Indian national health expenditure is funded by out-of-pocket payments, mostly from lower-income households (Berman, 1998) and more than 70 per cent of Nigerian health expenditure is funded by out-of-pocket spending (Soyibo et.al., 2009; Olayiwola, 2015). Studies have consistently found that the amounts spent on out-of-pocket by households in low- and middle-income countries, have not purchased the most cost-effective services (Liu, 1998).

The basic funding arrangements of health care systems in Western Europe as earlier stated are direct tax revenues and funding from social insurance contributions. However, some countries used the mixture of the two (e.g. Spain, Italy). But the recent trends have been towards tax financing. Also, other systems like the Dutch system relies on both social and private insurance for routine care for those over a certain level of income. The countries in Western Europe however, have considered changing their financing arrangements and whether these will make things better or worse for the people remains to be seen. Some of the changes are at system level which involves changing the whole of the basic funding arrangements while others are at micro-level which involve considering different ways of raising funds or changing arrangements. On the basic-system changes both Italy and Spain have moved from systems funded mainly from taxation. Other major reforms involving the basic systems of raising finances include attempts to inject more competitive elements into health care financing in the Netherlands and the UK. In these countries, competition will be in health care provision rather than in financing. The micro-level changes that have occurred in countries in Western Europe are in the areas of patient charges for health care which are in varying degrees. For example, patient charges are more pronounced in Italy than Spain, charges for visits to general practitioners (GPs) in Norway and a hospital day charge in France. In general, more innovations have included more competition between providers to attract funds (e.g. Netherlands and the UK) and the introduction of patient-based reimbursement in Germany.

The health care system of Eastern Europe was based on the principle of “tree” access, financed by monies from general revenues of governments before 1989. These general revenues were decentralized to local levels. In Hungary, local taxation was introduced to complement funds from general revenues. However, restructuring and openness shows that Eastern European health care faces many problems which include perverse incentives (such as hospital funding being based on bed days), shortages of supplies and equipment, and duplication of services between primary care clinics and hospital. In Poland, health financing reforms included provision of a limited health package by the state with a system of voluntary health insurance for services beyond the basic package. But coverage of the disadvantages was unclear in this system (Idulski et al, 1989). The greatest innovation in the former USSR was the experiment in primary care clinics (or polyclinics) and hospital funding that took place in Leningrad, Kushiben (Volga) and kemerono (Siberia) (Hakansson et al.,

1988). Hospital budgets were initially going from the ministry of health to the hospitals and polyclinics separately. However, polyclinics build the budgets in the experiment; the hospitals were paid by the polyclinic for services carried out on the polyclinic's patient. The polyclinics received a fee for each patient registered, and have an incentive to attract patients. Polyclinics and hospital retained surpluses. The purpose was to achieve greater efficiency in health care by reducing length of stay which has been on the increase. Reforms were structural in Hungary while financial aspects include social insurance system made up of employers' contribution, experiment with diagnosis-related groups (DRGs) in the hospital sector, more emphasis on patient charges (particularly for drugs), and people being allowed to insure privately on top of state contributions (Angelus, 1990 in Donaldson and Gerard, 1993).

The Canadian health care system was based on public insurance and has been relatively stable since the introduction of public health care insurance. The common debates were about the introduction or extension of patient charges (Barer et. al., 1979 in Donaldson and Gerard, 1993). The switch in Canada from US type of system to public insurance provides some useful comparisons at the global level with extremely large sample sizes (22 million people in the Canada group at about 250 million in the US). However, the USA and Turkey are the only countries in the OECD which do not have universal coverage of their populations, whether through tax-funded schemes or through private health care insurance. The public health care system in the USA is Medicaid for low-income persons and financed from federal and state general taxation revenues and Medicare for those aged over 65years, those on renal dialysis and those who are permanently disabled (financed by a combination of payroll taxes on earning up to a ceiling, premiums paid by elderly people and general revenues) (Ginsburg, 1988 in Donaldson and Gerard, 1993). Within the US Medicare system, a prospective pricing system for hospital episodes was introduced in 1983. Diagnosis-related groups (DRGs) were used to fix prices paid by Medicare for hospitalization, price being determined by the patient's diagnosis. The US private sector is dominated by private health care insurance, and many policies require substantial out-of-pocket payments from enrollees. Other development includes HMOs and Preferred Provider Organization (PPOs). This affects both hospital financing and doctor reimbursement. Payment of doctors, however, remains dominated by fee for service (FFS). Despite many developments aimed at cost containment, one in six of the US population remains

uninsured or underinsured (publicly or privately), which has led to calls for a system of universal health care insurance.

Latin America was dominated by social insurance systems (Akin, 1988 in Donaldson and Gerard, 1993). Workers usually pay a fixed percentage of wages to the system and most are self-financing. Sixteen Latin America countries use such systems, with varying degrees of success regarding coverage: as many as 80 percent in the population are covered in Argentina and as few as 7 percent in Honduras. The proportion of the population covered is rising in most countries. Two-tier system exists in all countries, with more wealthy members of society receiving access to better facilities through private health insurance, several countries claim to have had problems with 'over consumption' of services and therefore, introduced different methods of financing. Argentina's social insurance funds (Private, not-for-profit entities) have varying levels of patient charges attached to them. Brazil has also introduced a DRG system for funding hospital care while Uruguay has been at the forefront of experimentation with prepaid health care plans, such as HMOs.

The stability of the Australian and New Zealand health care systems over the past decades was significantly contrasted. The New Zealand health care system, the first to establish a National Health Services remained very stable until recently. The Australian health care system, on the other hand, is a constant source of political debate and has been subjected to many fundamental changes since 1945. In 1984, a universal public health insurance system (Medicare) was reintroduced in Australia. A previous version (Medibank) operated for 12 months in 1975-76, before it was dismantled under the Liberal administration until the return of the labour government in 1983. Private insurance was widespread in the system prior to Medicare. Elderly people and some poor people were covered by the public sector, but many people remained uninsured (Deeble, 1982; Palmer and Shaort, 1989 in Donaldson and Gerard, 1993). The Liberal Party in opposition advocated for the return to the previous system in 1983 with assurances that it will not be costlier and that universal coverage will be maintained. Later, budget proposals include the introduction of charge for general-practitioner consultations and general-practice grants to replace FFS payments. In New Zealand, a change of government resulted in two great changes to the health care system. The first is the introduction of provider competition, as in the UK and the Netherlands. Four new regional health authorities (RHA) were created which purchased care on behalf of the people from public, private and voluntary sectors. The basic source of

health financing in LDCs is the central revenue of government insurance schemes which can be organized easily for large numbers of civil servant, private finance through user charges and out-of-pocket spending. Two other main sources of enhanced funding (community financing and increased use of patients' charges) were later advocated or implemented. Community financing is often more organizational than financial; self-help on a mutual basis (Abel-Smith and Dua, 1988; Myers, 1988; Asia Development Bank, 1988 in Donaldson and Gerard, 1993). People who live together in some local communities come together to undertake collective action to achieve common goals. Recently, there are more trends towards moving to social health insurance financing in LDCs. It is therefore, obvious that in various regions of the world, health care financing is changing and some of these changes are fundamental.

Growth of health financing means in the MDGs' period

The 2015 Government Spending Watch (GSW) reports show that only about 40% of all countries in the world were able to meet World Health Organization (WHO) per capita spending targets and no African country is among these countries. The GSW data shows that no Sub-Saharan African country met the 15% Abuja target. Table I below shows health financing of selected countries by income group. The table shows health spending as percentage of GDP, pooled health spending as percentage of total health spending, tax-based health spending as percentage of public spending and gross domestic per person for high-income countries, middle-income countries with universal health coverage and middle-income countries making rapid progress towards universal health coverage. For the high-income countries with universal coverage; health spending as percentage of GDP was between 9% and 11%, less than 10% for both the middle-income countries with universal coverage and middle-income countries making rapid progress toward universal health coverage. Pooled health spending as percentage of total health spending was above 85% for the high-income countries with universal coverage, between 60% and 65% for the middle-income countries with universal coverage and between 52% and 84% for the middle-income countries making rapid progress toward universal health coverage. The tax-based health spending as percentage of total public spending for the high-income countries with universal health coverage was 100% for the UK and Sweden and about 52% for Germany, between 87% and 99% for the middle-income countries with universal coverage and 100% for Brazil, 92% for Thailand and 65% for Mexico among

the middle-income countries making rapid progress toward universal health coverage. This is an indication that both pooled spending and tax-based health spending can be used to achieve universal health coverage taking into consideration the level of economic development and efficiency and accountability of the government sector in the country concern.

Table I: Health financing for selected countries by income group

	Health spending (% GDP)	Pooled health Spending (% of THS)	Tax-based health spending (% of total public spending)	Gross domestic product per person (US\$)
High-income countries with universal health coverage				
Germany	11%	89%	52%	40275
UK	9%	90%	100%	35163
Sweden	10%	85%	100%	43472
Middle-income countries with universal health coverage				
Chile	8%	66%	87%	9487
South Korea	7%	65%	56%	17 110
Malaysia	5%	60%	99%	8373
Middle-income countries making rapid progress toward universal health coverage				
Brazil	9%	69%	100%	82251
Mexico	7%	52%	65%	7852
Thailand	4%	84%	92%	4608

Source: Savedoff et.al; 2012 (Pg 930)

Table II and Table III below shows the number of years it takes some high-income and middle-income countries to reach universal health coverage and the increasing share of pooled health financing. Table II shows that it took at least 20 years for these countries to achieve universal health coverage. The least year was 20 years for Costa Rica and the highest was 127 years for Austria. This is a signal of the need to do more for the present low-income countries in particular Sub-Saharan African countries to achieve universal health coverage in a short period of time.

Table II: Timeline for reaching universal coverage social health insurance system

Belgium	1851 -1969	118
Germany	1854 - 1988	127
Austria	1888 - 1967	79
Luxembourg	1901 - 1973	72
Israel	1911 - 1995	84
Japan	1922 - 1958	36
Costa Rica	1941 - 1961	20
South Korea	1963 - 1989	26

Source: Savedoff et.al; 2012 (Pg 927)

From Table III, the increasing share of pooled health financing was at a higher rate in some countries with rapid growth towards universal health coverage relative to some countries that are still struggling with covering large proportion of their people. From the table, pooled share health financing grows by 13.1% in Brazil and 47.4% in Thailand between 1995 and 2009. The growth was about 90.1% for Democratic Republic of Congo, 18.5% for Indonesia and 8.9% for the Gambia. Enrolment in pooled health financing (social health insurance) grows by 24.9% between 2007 and 2013 in Nigeria (Olayiwola, 2015).

Table III: Increasing share of pooled health care financing

Country	1995	2009
Brazil	61%	69%
Democratic Republic of Congo	22%	42%
Gambia	61%	67%
India	34%	49%
Indonesia	54%	64%
Thailand	57%	84%

Source: Source: Savedoff et.al; 2012 (Pg 929)

In relation to total health expenditure per capita in Sub-Saharan African countries, Table IV shows that about 24 countries spend less than US\$20 per capita, 10 countries spend between US\$20 to US\$44 and only 10 countries spent more than US\$44 in 2001. In 2005, about 14 countries spend less than US\$20 per capita, 18 countries spend between US\$20 to US\$44 and only 12 countries spent more than US\$44 in and in 2010 about 6 countries spend less than US\$20 per capita, 16 countries spend between US\$20 to US\$44 and 23 countries spent more than US\$44. This picture shows increasing health expenditure per capita in the presence of dwindling resources and poor commitment to universal health coverage. However, Nigeria moved from total health expenditure less than US\$20 per capita in 2001 to total health expenditure more than US\$44 in 2010.

Table IV: Trends in total health expenditure in Sub-Saharan Africa per capita in current US\$

Year	
2001	Benin, Burkina Faso, Burundi, Angola, Cameroon, Botswana, Cape Verde, Central Africa Republic, Chad, Congo, Cote d'Ivoire, Equatorial Guinea, Gabon, Comoros, DRC, Eritrea, Ethiopia, Guinea, Mauritius, Namibia, Sao Tome and Principe, Seychelles, South Gambia, Ghana, Guinea Bissau, Lesotho, Mauritania, and Principe, Seychelles, South Kenya, Liberia, Madagascar, Senegal, Sierra Leone, Africa, Swaziland (10 countries) Malawi, Mali, Mozambique, Zambia Niger, Nigeria, Rwanda, Togo, (10 countries) Uganda, Tanzania (24 countries)
2005	Burundi, Central African Republic, DRC, Eritrea, Ethiopia, Gambia, Guinea, Liberia, Madagascar, Malawi, Mozambique, Niger, Rwanda, Tanzania (14 countries) Angola, Benin, Burkina Faso, Botswana, Cameroon, Cape Verde, Comoros, Equatorial Guinea, Congo, Coted'Ivoire, Gabon, Mauritius, Namibia, Ghana, Guinea-Bissau, Nigeria, Sao Tome and Principe, Kenya, Lesotho, Mali, Seychelles, South Africa, Mauritania, Senegal, Sierra Leone, Swaziland Togo, (12 countries) Uganda, Zambia (18 countries)
2010	Central African Republic, DRC, Benin, Burkina Faso, Angola, Botswana, Cameroon, Eritrea, Ethiopia, Madagascar, Burundi, Chad, Comoros, Cape Verde, Congo, Cote d'Ivoire, Niger Gambia, Guinea, Kenya, Equatorial Guinea, Gabon, Ghana, Liberia, Malawi, Mali, Guinea-Bissau, Lesotho, Mauritania, Mozambique, Mauritius, Namibia, Nigeria, Sierra Leone, Togo, Rwanda, Sao Tome and Principe, Tanzania (16 countries) Senegal, Seychelles, South Africa, Swaziland, Uganda, Zambia (23 countries)

Source: WHO, 2013.

Another important issue is the level of out-of-pocket expenditure (OOP) in the Sub-Saharan African countries. This is shown in comparison with the per capita total health expenditure in Table V as at 2010. Table V shows that about 15 African countries which spent more than US\$44 per capita on health expenditure still have OOP above 20% (Nigeria inclusive). And about 19 countries which spent less than US\$44 per capita on health still have OOP above 20%. This means about 34 countries still have incidence of catastrophic health spending amidst slow growth to universal health coverage. These trends are very worrying, given the major shortfalls in meeting the health MDGs.

Table V: Total health expenditure and level of out-of-pocket payment in Sub-Saharan Africa (2010)

	Out-of-pocket payments less than 20%	Out-of-pocket payments more than 20%
Total health expenditure per capita more than US\$ 44	Angola, Botswana, Lesotho, Namibia, Seychelles, South Africa, Swaziland (7 countries)	Cameroon, Cape Verde, Congo, Cote d'Ivoire, Equatorial Guinea, Gabon, Ghana, Guinea-Bissau, Mauritius, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Uganda, Zambia (15 countries)
Total health expenditure per capita less than US\$ 44	Malawi, Mozambique, Tanzania (3 countries)	Benin, Burkina Faso, Burundi, Central African Republic, Chad, Comoros, DRC, Eritrea, Ethiopia, Gambia, Guinea, Kenya, Liberia, Madagascar, Mali, Mauritania, Niger, Sierra Leone, Togo (19 countries)

Source:WHO, 2013

Government, private sector (including households and donors) and private sources of which household contributes the most are the three principal main sources of health care financing in Nigeria (Olaniyan and Lawanson, 2010). The public source of financing health expenditure is either part of the general public tax revenues or from the health insurance in the form of contributions to the social health insurance. The private source of health expenditure funding is divided into three parts: private health insurance, out-of-pocket payments and all other private means. Table VI shows the structure of health financing in Nigeria from 1998 to 2005. It shows the structure of health care financing in Nigeria being made up public-private mix. The public source of financing health care in Nigeria comprises public expenditures on the health sector by federal government (FG), state governments (SG) and local governments (LG) while private financing comprises households and firms' out-of-pocket expenditures on health, private health insurance, donor agencies or development partners' expenditures and health expenditures by departments of private firms. The table shows households as the major source of health care financing in Nigeria contributing about 60% to 74% from 1998 to 2014 while government health expenditure was between 17% and 27%. Donor agencies and development partners financing were around 4% and 16% while financing of other departments of private firms stay around 1% for the whole period. Health insurance is mainly from private health insurance and constitutes about 2.4% of total health care financing from 1998 to 2005 which falls in the first six years of the MDGs. This trend prevails throughout the remaining MDGs period. Social health insurance fully came into being in 2006 about

six years after the take-off of MDGs. Although, there were private health insurance and work-based health insurance in operation but this was available to less than 1% of the Nigerian population. However, Table VI shows that private health insurance constitutes about 2.4% of total health funding in the early years of the MDGs. Data on the proportion of social health insurance in health care funding in Nigeria is still unavailable. However, the increasing enrolment in social health insurance and emergence of micro-health insurance schemes in Nigeria indicates a promising future for the contribution of health insurance to health care financing in Nigeria. At least countries like Benin, Ghana, and Zimbabwe have shown that such efforts are possible and can support increases in expenditures in the health sector.

Table VI: Structure of health care financing in Nigeria: 1998-2005 (N'mn)

Years	Government Health Expenditure	Out-of-Pocket Payments				Health Insurance			All Means	other	Private	Total			
		Households		Firms		Social	Private		Donor Agencies/Develop ments Partners	Firms					
		%		%		%			%		%	%			
1998	,502.13	14.9	108720.00	69.3	2808.95	1.8	-	-	-	20,551.00	13.1	1,499.09	0.9	157081.10	
1999	,882.85	16.6	118,782.39	66.0	4,283.81	2.4	-	-	-	24,911.96	13.8	2,030.15	1.1	179,891.16	
2000	,391.25	18.8	129,872.07	60.4	7,238.05	3.4	-	-	-	34,899.04	16.2	2,808.72	1.3	215,209.13	
2001	,765.96	27.2	157,601.66	61.5	11,456.66	4.5	-	-	-	14,269.05	5.6	3,190.09	1.3	256,283.42	
2002	,211.87	21.6	183,598.37	65.9	13,836.39	4.9	-	-	-	17,104.00	6.1	3,981.52	1.4	278,732.15	
2003	3,681.78	18.7	489,464.57	74.0	1,504.07	0.2	-	-	15,655.5	2.4	27,872.16	4.2	3,484.03	0.5	561,662.16
2004	8,207.86	26.4	518,070.34	65.7	1,591.97	0.2	-	-	18,788.9	2.4	36,037.98	4.6	6,026.79	0.8	788,723.91
2005	4,174.42	26.0	656,115.84	67.2	2,016.17	0.2	-	-	21,335.4	2.2	36,296.70	3.7	6,749.09	0.7	976,687.60

Source: Soyibo, Olaniyan and Lawanson, 2009

Table VII shows the proportion of various means of financing health care services in government expenditure, total expenditure and gross domestic product (GDP). General government health expenditure (GGHE) as a proportion of general government expenditure (GGE) ranges between 4.5% and 8.8% and between 22.4% and 36.8% of total health expenditure (THE) throughout the MDGs period in Nigeria. Private health expenditure (PHE) constitutes about 66.5% and 77.6% of total health expenditure in which out-of-pocket expenditure (OOP) constitute between 90.4% and 96.2% of this in the whole period of the MDGs. This shows that private health expenditure accounted for a large proportion of THE during the MDGs years and OOP accounted for more than significant proportion. Furthermore, OOP as a proportion of THE was between 60.5% and 74.7%

throughout the MDGs period. The data on insurance contribution shows that private insurance (PI) as percentage of private health expenditure (PHE) was around 3.1% and 6.7%. The picture here shows that private means of financing health services accounted for a substantial percentage of health financing and OOP constituted the highest proportion. Considering the proportion of GDP committed to health financing in the MDGs period; GGHE accounted for just 0.6% and 1.5% of GDP while the constitutes about 2.4% and 4.5% of GDP in the whole MDGs period. Given the small proportion of GDP going into health financing, a re-direction of part of the country's resources is required in order to spend more of GDP on health services.

Table VII: Health expenditure in Nigeria: 1999-2014

Years	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
General	1.5	1.9	1.5	1.7	1.9	1.8	1.3	1.6	9.2	7.6	7.4	1.7	7.4	7.4	6.5	8.2
Government																
Health Expenditure																
(GGHE) as % of																
General																
Government																
Expenditure																
General	29.1	33.5	31.4	25.6	22.4	12.7	29.2	32.9	32.9	16.8	31.3	26.2	31.2	31.3	13.8	25.1
Government																
Health Expenditure																
(GGHE) as % of																
Total																
Health																
Expenditure																
Private	70.9	66.5	68.6	74.4	77.6	67.3	70.8	67.1	17.1	13.2	18.7	73.8	18.8	68.7	76.2	74.9
Expenditure as %																
of Total Health																
Expenditure																
Out of Pocket	14.8	12.7	91.4	10.4	96.2	95.3	95.8	95.6	15.8	95.7	95.8	95.7	95.7	95.5	95.8	15.7
Expenditure as %																
of Private Health																
Expenditure																
Out of Pocket	17.2	11.7	12.7	17.3	74.7	14.2	17.9	14.1	14.3	10.5	15.8	70.6	65.8	65.6	72.9	71.7
Expenditure as %																
of Total Health																
Expenditure																
Private Insurance	3.4	5.1	6.5	1.7	3.1	3.4	3.1	3.1	3.1	3.1	3.1	3.1	3.1	3.1	3.1	3.1
as % of Private																
Health Expenditure																
General	1.0	0.9	1.0	1.6	0.9	1.4	1.2	1.2	1.5	1.5	1.3	1.9	1.2	1.0	0.9	0.9
Government																
Health Expenditure																
(GGHE) as % GDP																
External Resources	13.8	16.2	5.6	1.1	4.2	4.5	1.7	2.7	3.0	3.8	1.5	7.6	4.7	1.5	5.4	6.7
on Health as % of																
Total																
Health																
Expenditure																
Total	3.4	2.8	3.2	2.4	4.0	1.3	4.1	3.7	4.5	4.0	4.2	3.5	3.7	3.3	3.7	3.7
Expenditure (THE)																
as % of GDP																

Source: WHO world health statistics, various years

Table VIII shows the proportion of recurrent government expenditure spent on health care services against the 15% threshold of Abuja 2001 declaration target. The Table shows that throughout the MDGs period THE as proportion of TGE was between 3.1% and 7.0%. The highest was in 2011 in which about 7.0% of government budget (tax-financed) was allocated to health sector. This picture shows shortfalls of between 8.0% and 11.9% in the whole MDGs period. Placing the achievement of SDGs on GGHE, this means that on average GGHE must increase by about 10.1% every year to meet the SDGs health targets.

Table VIII: Government health expenditure and the 15% budget threshold in the MDGs period in Nigeria

Years	Value of Government Health Expenditure (N'Bilion)	Total Government Expenditure (N'Bilion)	Proportion of Total Government Health Expenditure in Total Government Expenditure (%)*	Shortfall of 15% Budget threshold (%)*
1999	16.64	449.66	3.7	11.3
2000	15.22	461.60	3.3	11.7
2001	24.52	579.30	4.2	10.8
2002	40.62	696.80	5.8	9.2
2003	33.27	984.30	3.4	11.6
2004	34.20	1,110.64	3.1	11.9
2005	55.66	1,321.23	4.2	10.8
2006	62.25	1,390.10	4.5	10.5
2007	81.91	1,589.27	5.2	9.8
2008	98.22	2,117.36	4.6	10.4
2009	90.20	2,127.97	4.2	10.8
2010	99.10	3,109.44	3.2	11.8
2011	231.80	3,314.51	7.0	8.0
2012	197.90	3,325.16	6.0	9.0
2013	179.99	3,214.95	5.6	9.4
2014	195.98	3,426.94	5.7	9.3
2015	257.72	3,831.98	6.7	8.3

Source: Central Bank of Nigeria Statistical Bulletin, 2015

*Authors Computation

Exploratory analysis of the viability of health financing mechanism in Nigeria

Health system in Nigeria is generally funded from federation account to the states and local government areas (LGAs). Since the proportion of the informal sector employment is more than 70% and due to the political undesirability of raising taxes from an already poor population, tax collection is difficult in Nigeria. Therefore, the low-tax and non-tax resource base and the slow growth rates in Nigeria coupled with the present

economic reality imply that any increase in health expenditures derived from domestic tax financing will be slow unless drastic changes take place in government revenue generation capacity. Furthermore, available information shows that Nigeria is heavily dependent on oil revenues, oil and gas comprises over 90 percent of Nigeria's exports and more than 70% of consolidated budgetary revenue (World Bank, 2015). Non-oil GDP growth was registered at 4% for the first three quarters of 2015, down from the 7.3% growth pace in 2014. The pace of job creation which reduced by 45% in the second quarter of 2015 provides more evidence of a significant economic slowdown (World Bank, 2015). Falling oil revenues have weakened domestic demand and a major fuel shortage in the second quarter of 2015 related to fuel subsidy payments disrupted economic activity. After years of double-digit growth, manufacturing contracted by 2.1%, year-on-year, in the first three quarters of 2015, the oil and gas sector also declined in the first half of 2015. The Nigerian economy contracted in the first quarter of year 2016 as it recorded a negative Gross Domestic Product (GDP) during the quarter. The National Bureau of Statistics reported that the nation's GDP in the first quarter contracted by 0.36% which is the first negative growth in several years. This may be a critical challenge for the economy since recovering from recession sometimes takes longer than expected. A shrinking resource prompted the Federal Government to introduce significant cuts and adjustments to the 2014 and 2015 budgets with a particular focus on capital expenditures. Federal revenues in 2014 were 15% below the level anticipated in the approved budget, with oil revenues falling 6% below expectations. The Federal Government responded by significantly reducing capital expenditures in 2014. While Nigeria's capital-budget execution rate was low, in 2014 actual spending amounted to just 39% of budgeted spending, down from 60% in 2013. This was a deliberate move by the Federal Government to curb expenditures. The approved 2015 budget which was about 2.5% of GDP was 4% lower in nominal terms than the 2014 budget and about 3.9% of GDP. Resource allocations to priority social sectors such as education and health were protected in the 2015 budget. The total share of health spending accounted for 5.7% up from 5.0% in 2014 (World Bank, 2015). The general government budget deficit was projected at 3.1% of GDP in 2015 up from 9.1% in 2014 (World Bank, 2015). Figure I below show the macroeconomic situation in Nigeria. The figure shows that unemployment was constant around 40% from 2005 to 2013. These show the reality of economic situation in Nigeria which may make tax-financed health system

infeasible and non-sustainable in the near future unless drastic changes take place in domestic revenue generation capacity.

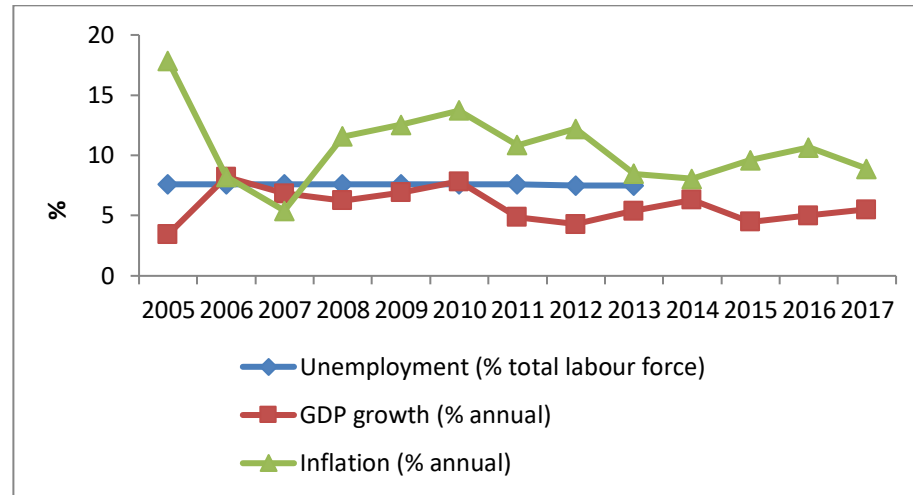


Figure I: Macroeconomic situation in Nigeria

Source: World development indicators, 2013.

Tables IX and X show information about specific types of insurance coverage for women and men by background characteristics as at 2013 in Nigeria. The tables show that individuals in Nigeria are covered by employer-based health insurance, mutual health organisation/community-based health insurance or privately purchased commercial insurance. Employer-based health insurance system ties medical coverage directly to the place of employment. In the system of work-based risk pools, healthy members subsidize the health costs of participants more likely to become ill, while employers appear to pay the bulk of expenses. Mutual health organisation or community-based health insurance ties coverage to mutual organisation or community, individuals with common interest or in the community pay an agreed sum on a monthly basis to subsidize the health care costs of ill members of the association or community. Individuals purchase health insurance and pay premium based on the health needs or health status under the privately purchased commercial insurance. The tables show that majority of women and men have no health insurance coverage, about 98.2% and 97.0%, respectively. Among all categories of insurance, employer-based is used most commonly, only about 2.4% of men and 1.4% of women are covered by this type of insurance. About 2.7% of

women and 4.1% of men in urban areas were covered and those in the highest wealth quintile are 4.6% and 7.1% are the most likely to have health insurance coverage. About 96.7% of women and 95.0% of men have no health insurance in urban areas while 99.3% of women and 98.5% of men have no health insurance in rural areas and mutual or community health insurance accounts for less than 2% for men and women of different age-groups.

Table IX: Health insurance coverage in Nigeria: women

Percentage Distribution of Women Age 15-49 by type of Health Insurance Coverage, according to Background Characteristics, Nigeria 2013						
Background Characteristics	Employer-based Insurance	Mutual health organization /Community-based insurance	Privately purchased commercial insurance	Other No health insurance	Number of women	
Age						
15-19	0.7	0.1	0.0	0.0	99.1	7,820
20-24	1.1	0.4	0.3	0.0	98.3	6,757
25-29	1.2	0.2	0.3	0.0	98.3	7,145
30-34	2.1	0.2	0.2	0.0	97.5	5,467
35-39	2.1	0.3	0.2	0.1	97.4	4,718
40-44	2.0	0.3	0.2	0.1	97.5	3,620
45-49	1.3	0.2	0.1	0.0	98.4	3,422
Residence						
Urban	2.7	0.3	0.4	0.0	96.7	16,414
Rural	0.5	0.2	0.1	0.0	99.3	22,534
Zone						
North	1.8	0.6	0.2	0.0	97.4	5,572
Central	1.5	0.1	0.2	0.0	98.3	5,766
North East	0.5	0.1	0.0	0.0	99.4	11,877
North West	1.3	0.3	0.5	0.0	97.9	4,476
South East	2.5	0.4	0.5	0.1	96.6	4,942
South South	1.8	0.1	0.2	0.1	97.8	6,314
South West						
Education						
No education	0.1	0.1	0.0	0.0	99.8	14,729
Primary	0.5	0.1	0.1	0.0	99.4	6,734
Secondary	1.4	0.3	0.3	0.0	98.1	13,927
More than secondary	8.6	0.9	0.9	0.2	89.4	3,558
Wealth quintile						
Lowest	0.0	0.0	0.0	0.0	100.0	7,132
Second	0.0	0.0	0.0	0.0	99.9	7,428
Middle	0.4	0.1	0.1	0.0	99.3	7,486
Middle	1.2	0.2	0.2	0.0	98.3	7,992
Fourth	4.6	0.7	0.5	0.1	94.1	8,910
Highest						
Total	1.4	0.2	0.2	0.0	98.2	38,948

Source: NPC and ICF Macro, 2014

Table X: Health insurance coverage in Nigeria: men

Percent Distribution of Men Age 15-49 by type of Health Insurance Coverage, according to Background Characteristics, Nigeria 2013						
Background Characteristic	Employer-based insurance	Mutual health organisation/community-based insurance	Privately purchased commercial insurance	Other insurance	No health insurance	Number of women
Age						
15-19	0.6	0.1	0.1	0.2	99.1	3,619
20-24	1.0	0.3	0.2	0.3	98.1	2,892
25-29	1.8	0.3	0.1	0.1	97.7	2,757
30-34	3.5	0.6	0.0	0.1	95.9	2,414
35-39	3.5	0.4	0.3	0.1	95.8	2,175
40-44	4.4	0.4	0.4	0.0	94.8	1,777
45-49	4.5	0.4	0.2	0.0	94.9	1,724
Residence						
Urban	4.1	0.5	0.3	0.1	95.0	7,611
Rural	1.1	0.2	0.1	0.1	98.5	9,748
Zone						
North Central	3.4	1.0	0.1	0.4	95.2	2,685
North East	1.6	0.3	0.1	0.5	97.6	2,515
North West	1.0	0.2	0.1	0.0	98.7	5,185
South East	2.1	0.1	0.1	0.0	97.6	1,686
South South	3.5	0.3	0.2	0.0	96.0	2,445
South West	4.1	0.1	0.3	0.0	95.4	2,843
Education						
No education	0.0	0.0	0.0	0.0	100.0	3,685
Primary	0.5	0.2	0.0	0.0	99.3	2,907
Secondary	1.8	0.2	0.1	0.1	97.8	8,218
More than secondary	10.1	1.5	0.9	1.7	86.8	2,486
Wealth quintile						
Lowest	0.0	0.0	0.0	0.0	100.0	2,862
Second	0.1	0.1	0.0	0.0	99.7	2,992
Middle	1.0	0.1	0.1	0.1	98.6	3,338
Fourth	1.8	0.4	0.1	0.1	97.6	3,835
Highest	7.1	0.8	0.5	0.3	91.3	4,332
1	2.4	0.3	0.2	0.1	97.0	17,359

Source: NPC and ICF Macro, 2014

Social and private insurances are the two major types of insurance programmes used to finance health care services in Nigeria. Social health insurance is usually compulsory for all eligible groups and entitles such groups to the specific benefits, while private health insurance is voluntary. Social health insurance is premised on the fact that people cannot always meet the financial requirement of the consequences of risks of falling ill and their resources are pooled among a large population. The number of participants in the National Health Insurance Scheme (NHIS) has increased from less than 20 at the inception in 2006 to more than two million participants as at June, 2013 in Nigeria. A total of 272, 068 civil servants (principal and dependants) were registered under the scheme in 2007. The total number of enrollees from 2005 to 2007 was around 1, 881,426 (NHIS,

2007). As at June 2013, the total number of enrollees has increased to 2,349,363 given a growth rate of 24.9% from 2007 to 2013. Using, 2006 census figures, this is just about 1.68% of the total population in Nigeria (Olayiwola, 2015). In theory, social health insurance revenue is well protected from political interference, since budgetary and spending decisions are devolved to independent bodies and can also be used to raise funds from higher-income workers employed by large firms. However, social insurance may limit the access of the non-employed population, elderly, unemployed people and dependants to health services. Nigeria government has introduced voluntary contributor health insurance scheme (VCHIS) to cater for these sets of people. Private health insurance is distinguished according to how premiums are calculated, how benefits are determined and the status of the insurance providers but it undermines the redistributive effect of funding arrangements. Given the limitation of insurance financing health system; revenue generation capacity of insurance, protection from political interference and loose dependency of social health insurance and community health insurance on earning with positive risk pooling capacity of all forms of health insurance makes insurance financing health system more reliable for sustainable health financing in Nigeria and other developing countries. More so, increase in the number of the enrollees in the enrolment for social health insurance may be an indication of people's confidence in health insurance in Nigeria and this may provide a reliable and sustainable financing means of financing health care services in Nigeria (Olayiwola, 2015).

About 70% of healthcare payments in Nigeria are made out-of-pocket. In 2007, out-of-pocket spending (OOPS) increased from 92.7% to 95.9% of private expenditures. 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. At least OOPS is above 20% for an average household in Nigeria (WHO, 2013). As a result, many households in Nigeria experience catastrophic spending and thus push some into poverty and worsen the poverty of others. Although user fees have been removed by the federal government and not all health services are charged but OOPS has remained the dominant way of financing healthcare in Nigeria. This can lead to poor health seeking behaviours and inequity. At the threshold level of 40% of non-food expenditure, the poorest quintiles often experienced catastrophic spending. This is an indication that households are the most important financing agents through which health expenditure sources channel funds

to providers of health services. In 2003, fund channeled through OOPS was 74% of THE, decreasing to 66% in 2004 but increasing to 68% in 2005 (Soyibo *et.al*, 2009). Out-of-pocket expenditure as % of private expenditure on health in 2011 was around 95.6%. OOPS is and still remains the major source of health care spending in Nigeria. Figure II below further shows OOPS being above all other sources of health financing in Nigeria. Given the level of poverty in Nigeria, OOPS cannot constitute an adequate and sustainable means of health financing in Nigeria. Indeed many people are priced out of certain health services due to poverty and inability to afford payment for health services. Hence, high OOPS was a major factor for inaccessibility of certain health services to some households in Nigeria. As a result, OOPS does not constitute a sustainable way of financing health services in Nigeria like other Sub-Saharan African countries.

Donor agencies and development partners financing in Nigeria were between 4% and 16% between 1998 and 2003 (Soyibo *et.al*, 2009). Since this is assistance; domestic health financing cannot be too attached to this due to internal security and external shocks as a result of economic condition of another country. Another major challenge is that of an effective coordination of the funds and tracking donor resource flow. Therefore, donor funding cannot as well constitute an adequate and sustainable financing mechanism for health services in Nigeria.

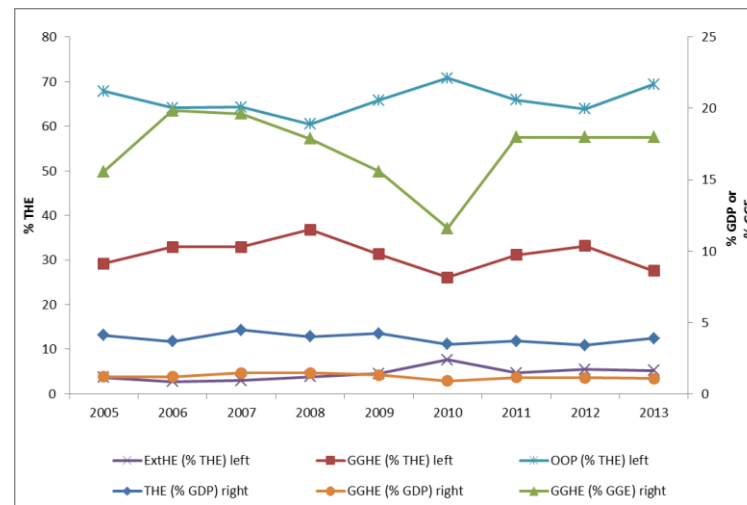


Figure II: Health expenditure in Nigeria

Source: Global health expenditure database, world health organization (2005-2013)

Conclusion and policy recommendation

Adequate and sustainable health financing is important to the attainment of SDGs health goals. The study shows that social health insurance and community based health financing is the most feasible, efficient, adequate and sustainable health financing means for Nigeria. This is as a result of their revenue generation capacity and willingness of people to join. More so, tax health financing is not presently sustainable in Nigeria due to low income and economic downturn. Therefore, a move towards domestic funding through health insurance, community financing and more budgetary allocation to health care is indispensable to the attainment of universal health coverage and the achievement of sustainable development health goals in Nigeria. Consequently, government should vigorously pursue expansion of health insurance in Nigeria and display a strong political will to increase budgetary allocation to health to meet at least the 2001 Abuja declaration with improved economic performance.

References

- Abel-Smith, B. and A. Dua (1988). "Community-Financing in Developing Countries: The Potential for the Health Sector". *Health Policy and Planning*, 3;2; 95-108.
- Akin, J. S. (1988). "Health Insurance in Developing Countries: Experience and Prospects". In *Health Care Financing: Regional Seminar in Health Care Financing*, 27 July-3rd August, 1987, Manila Philippines. Asian Development Bank, Manila; Economic Development Institute of the World Bank, Washington; East-West Center, Honolulu.
- Angelus, T. (1990). "Personal Communication with Berman, P".
- Arhin-Tenkorang, D.C. (1994). "The Health Care Insurance Scheme in Burundi: A Social Asset or a Non-Viable Venture?" *International Journal of Social Science and Medicine*, 39(6): 861 – 870, Pergamon.
- Asian Development Bank (1988) *Health Care Financing: Regional Seminar in Health Care Financing*, 27 July-3 August, 1987, Manila, Philippines. Asian Development Bank, Manila; Economic Development Institute of the World Bank, Washington; East-West Center, Honolulu.
- Barer, M., R.G. Evans and Stoddart, G. L. (1979). "Controlling Health Care Costs by Direct Charges to Patient: Snare or Delusion?" Ontario

- Economic Council Occasional Paper No. 10. Toronto, Ontario Economic Council.
- Berman, P. (1998). "Comparative Analysis of the Result of the Latin American and Caribbean National Health Accounts Network." Washington DC, USAID, Partnerships for Health Reform.
- Brown, W. and Churchill, C. (2000). "Insurance Provision in Low-Income Communities". Part 11 Initial Lessons from Micro -Insurance Experiments for the Poor, Micro Enterprise Best Practices, Bethesda MD, Development Alternatives Inc.
- Central Bank of Nigeria (2015). "Central Bank of Nigeria Statistical Bulletin."
- Commission on Health and Macroeconomics (2002). "Report of Working Group 3 of the Commission on Macroeconomics and Health." WHO. August; 2002.
- Dave, P. (1991). "Community and Self-Financing in Voluntary Health Programmes in India". Health Policy and Planning, 6(1): 20 – 31.
- Deeble J.S. (1982). "Unscrambling the Omelet: Public and Private Health Financing in Australia." In The Public/Private Mix for Health Financing: The Relevance and Effects of Change, London. Nuffield Provincial Hospitals Trust.
- Donaldson Cam and Karen Gerard (1993). Economics of Health Care Financing: The Visible Hand. Macmillan Press Ltd. London.
- Development Finance International (DFI) and Oxfam (2015). "Financing the Sustainable Development GOALS: Lessons from Government Spending on the MDGs." Government Spending Watch 2015 Report.
- Ginsburg P.B. (1988). "Public Insurance Programme: Medicare and Medicaid. In Health Care in America: The Political Economy of Hospital and Health Insurance. Pacific Research Institute for Public Policy, San Francisco.
- Hankansson, S., B. d' Intignano Majnoni, J. Roberts and H. Zollner (1988). "The Leningrad Experiment in Health Care Management 1988." Report SSR/MPN 501.
- Hsiao, W.C. (1995). "The Chinese Health Care System: Lessons for Other Nations". International Journal of Social Science and Medicine, 41(8): 1047 – 1055, Pergamon.
- Indulski, J.A., M.M. Smolen and C. Wlodarczyz (1989). "Some economic aspects of the Polish NHS Reform Project." Paper presented to the first European conference on Health Economics, Barcelona, Sept, 1989.

- Irvine B. and S. Ferguson, (2002). "Background Briefing: The Canadian Health Care System".
- Litvack, J.I. and C.I. Bodart (1992). "User Fees plus Quality Equals Improved Access to Health Care: Results of a Field Experiment in Cameroon". *International Journal of Social Science and Medicine*, 37(3): 369-383, Pergamon.
- Liu, Y. (1998). The Study of Health Care Financing in China's Poor Rural Areas, Beijing. In *Inefficiency in China's Rural Health Care: A Stochastic Frontier Approach in the China Network of Training and Research in Health Economics and Finance*. The People's Publishing House.
- Myers, C. N. (1988). "Thailand's Community Finance Experience: Experience and Prospects". In *Health Care Financing: Regional Seminar in Health Care Financing*, 27 July-3 August, 1987, Manila, Philippines. Asian Development Bank, Manila; Economic Development Institute of the World Bank, Washington; East-West Center, Honolulu.
- National Bureau of Statistics and Federal Government of Nigeria (2015). "Goals Performance Tracking Survey 2015 Report".
- National Health Insurance Scheme (2007). *Annual Reports*. Abuja, Nigeria.
- National Population Commission (NPC, Nigeria) and ICF Macro (2009). "Nigeria Demographic and Health Survey, 2008". Abuja, Nigeria.
- Olaniyan O. A. and Lawanson A.O. (2010). "Health expenditure and health status in Northern and Southern Nigeria: A comparative analysis using NHA framework" 2010 CSAE conference. University of Oxford, UK.
- Olayiwola, Saheed O. (2015). *Adverse Selection, Moral Hazard and the Welfare Effects of Health Insurance in Nigeria*. An unpublished Ph.D. thesis submitted to the Department of Economics, University of Ibadan. November, 2015.
- Olayiwola, Saheed O. (2007). "Financing Health Care Services: A willingness and Ability-to-Pay Analysis". An unpublished MSc dissertation submitted to the department of Economics, University of Ibadan. October, 2007.
- Osungbade, K.O., Olanrewaju Olaniyan and Saheed Olayiwola (2014). "The Distribution of Household Health Expenditure in Nigeria: Implications for Health Care Reform". *Nigeria Economic Society 2013 Conference Proceedings*.
- Palmer, G. and S.D. Short (1989). "Health Care and Public Policy: An Australian Analysis". Melbourne, Macmillan.

- Savedoff, William D. and Amy L. Smith (2012). "Achieving Universal Health Coverage: Learning from Chile, Japan, Malaysia and Sweden." Working Paper: Washington, DC: Results for Development Institute.
- Savedoff, William D., David de Ferranti, Amy L. Smith and Victoria Y. Fan (2012). "Political and Economic Aspects of the Transition to Universal Health Coverage." *The Lancet*. Sept. 8.
- Sanders, J. (2002). "Financing and Organization of National Health Systems". In *Current Issues Facing Global Health Systems*. Retrieved from WHO Website: www.who.org.
- Soyibo, A., Olaniyan, O.A. and Lawanson A.O. (2009). "National Health Accounts of Nigeria, 2003 – 2005 Incorporating Sub-National Health Accounts of States. VOL.1. Federal Ministry of Health, Abuja.
- Sustainable Development Network Solution (2014). "Health in the Framework of Sustainable Development: Technical Report for the Post-2015 Development Agenda". Prepared by the Thematic Group on Health for All of the Sustainable Development Solutions Network.
- The UK Health Policy Consensus Group (2003). "Options for Healthcare Funding." Paper Based on Research Carried Out by Benedict Irvine Of Civitas and Sponsored by Reform. Retrieved from the Website: <http://ben2/myfiles/myfiles/hpcgsystemsrevised.wpd>.
- Uzochukwu, B. S. C., M.D Ughasoro, E. Etiaba, C. Okwuosa, E. Envuladu, O.E Onwujekwe (2015). Health Care Financing in Nigeria: Implications for achieving Universal Health Coverage". *Nigerian Journal of Clinical Practice*. Vol. 18 Issue: 4; Page: 437-444.
- World Bank (2015). *Nigeria Economic Report*. No. 3, November, 2015.
- World Bank (2013). *World Development Indicators*, 2013.
- World Health Organization (2002). "Primary Healthcare Review Project: Region Specific Report". World Health Organization Regional Office for the Western Pacific, Manila.
- World Health Organization *World Health Statistics*, Various Years.
- World Health Organization (2014). "Global Health Expenditure Database."
- World Health Organization (2005 – 2013).