Health Care Financing in Nigeria: National Health Accounts Perspective

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ABSTRACT— ***The paper investigated the funding pattern of healthcare in Nigeria based on the National Health Accounts framework. Two rounds of National Health Accounts estimation covering the eight-year period, 1998-2005 were analyzed in this paper. The first round covering 1998-2002 was funded by donors and characterized by limited access to data, which accounted for its seeming underestimation. The second round funded by Federal Ministry of Health enjoyed access to wider data set, and allowed for state level sub- National Health Accounts estimates covering 17 out of 36 states of the federation. The estimates generally revealed that the households constitute the main source of financing healthcare in the Nigeria, accounting for over 66% of Total Health Expenditure, while government contributes average of 29%. Though resource pooling through health insurance appreciably grew over the years, it is still at its infancy, contributing minimally to Total Health Expenditure. While the private facilities dominates in the provision of healthcare service in the first round, the second round estimates shows that more than half of health care services were provided in the public facilities. Despite preventive care through Primary Health Care being the pillar of the National Health Policy strategy, curative care continued to dominate Total Health Expenditure in the country. The process of second round estimation accorded the issue of institutionalization a priority place, which resulted in the identification and training of state focal persons for possible integration of regular National Health Accounts data collection into public service practices. The absence of continuity in funding by government is threatening the ownership of the process. While the Nigeria Total Health Expenditure is highest in Africa, her per capita Total Health Expenditure and as percentage of GDP is well below figure for some African countries.***

Keywords--- Total Health Expenditure, Financing Sources, Financing Agents, Out-of-Pocket Expenditure

1. INTRODUCTION

The need for health data and statistics about and for the health system of developing countries has continued to grow. However, accessing information on the financing structure of health in developing countries has over the years been challenging. While financing data on health is readily available in developed countries, collection of the same remains a herculean task to most developing countries. Over the years, information on the funding of health care has been limited to government contribution, which is often inferred from the annual budget estimates, in the absence of data on actual expenditure. In April 2001, heads of state of African Union countries met in Abuja and pledged to set a target of allocating at least 15% of the annual budget to improve the health sector. While over a decade after, majority of African countries have not been able to at any year met this target, there are indications that actual Africa government spending on health is even far less than proportion indicated by the budget. Thus tracking spending by government on health care has been a difficult task no to talk of capturing information on spending of other stakeholders. The absence of data has generally made health planning and programme implementation ineffective, as well as difficult to assess impact of health policies.

The last two decades has however, witnessed an increasing adoption of the concept of National Health Accounts (NHA) by many African countries, including Nigeria to track the flows and contribution of funds to health care system of these countries by different stakeholders. The adoption and acceptance of NHA is global, as over one hundred countries have developed NHA estimates at least once (Garg, 2010). NHA estimates are useful in tracking the contributions by different stakeholders in the health sector to the funding of health care of the population. It provides information on both public and private funding as well as external contribution. While quite a number of countries in Africa are yet to have NHA estimate for any year, in the majority of the countries where it has been carried out it is limited to few years. Most of these estimates have been supported by external assistance, as well as reliance on foreign technical expertise. Only in few of the countries has domestic expertise been relied upon, of which Nigeria is one.

Nigeria has fully conducted two rounds of NHA estimates. The first round of NHA estimates for Nigeria was conducted for the years 1998-2002, courtesy of financial assistance from international organizations such as Carnegie Corporation of New York, USA, which provided the initial fund for the project, and World Health Organisation (WHO), that provided the funds for completing the estimation. The figures from the estimates were widely used for presentations by the then Minster of Health, Professor Eyitayo Lambo at many international fora, including United Nations, and WHO assemblies, placing Nigeria on the global scene. The second round was conducted for the years 2003-2005, funded by the Federal Ministry of Health, Nigeria, with support from PATH II. These two rounds of estimates were conducted by group of experts from the Health Policy Training and Research Programme of the Department of Economics, University of Ibadan, Ibadan, Nigeria. This study therefore provides a review of the NHA estimation process and the distribution of burden of financing health care in Nigeria among the different stakeholders, as well as across various health care functions and providers, and to situate the Nigerian health care financing within the context of some selected African countries for which data is available.

The remaining part of this paper is organised into seven sections. The next section provides brief literature review of the definition, concept and methodology of NHA, while the NHA history and methodology framework applied for Nigeria in this study is presented in section three. While the results and discussion are presented in section four, we conclude in section five with some emerging policy issues germane to the country's health sector funding and development.

2. REVIEW OF NHA DEFINITION, CONCEPT AND METHODOLOGY

The term NHA has been defined in several ways, with one message running through all. While many have defined it from the perspective of its ability to track flow of funds in the health sector, the focus of others have been in terms of being a monitoring instrument of flow of resources in a country's health system. The WHO has been in the forefront of promoting the adoption and estimation of NHA, especially among developing countries, therefore many definitions are found in the WHO publications. The NHA is simply an international established method of tracking the sources and uses of funds in the health sector of a country (Soyibo et al., 2007), over a period of time usually a year. It provides a systematic, comprehensive and consistent monitoring of resource flows in a country's health system (Poullieral et al., 2002), using standardized tools of measurement to trace all resource flows within the health system over time (Sein, 2002). It is a standardized tool to track where and how much money flows into the health system, and what it is used for (Garg, 2010). It has also been defined as an integrated set of cross-classifications purporting to measure health related activities and economic flows: inputs, output and resource use, contributing to the enhancement of health status (Poullier and Hernández, 2002). Health expenditure relates to any spending designed to restore, improve and maintain the health of individual or the nation (WHO, 2003; OECD, 2000).

Bhawalkar and Hsi (2004) describes NHA as an internationally recognized tool for summarizing, describing, and analyzing the sources and uses of financing in national health systems – essential to better use of health financing information to improve national health system performance. NHA examines total health spending in a country – including public, private, and donor expenditures. It tracks the flow of funds from one health care actor to another. It is a methodology designed to capture costs and allocation pattern information that can inform policy making and evaluation. It is a diagnostic tool designed to estimate past expenditures and track the flow of funds through the entire health sector.

Baseline information is collected and policy implications drawn from results. NHA helps estimate key indicators such as: total health expenditure (THE) as a proportion of GDP, THE per capita, proportion of THE borne by donors, public sector, and households, proportion of expenditures spent on preventive and curative care or outpatient and inpatient care. It traces for any given year all the resources that flow through the health system from sources to uses over time and across countries. While *sources* relates to the primary origin of the funds, the *uses* are the categories of providers or types of health services on which the fund is expended. It is designed to capture the full range of information contained in the resource flows and reflect the main functions of health care financing: resources mobilization and allocation, pooling and insurance, purchasing of care, and distribution of benefits (Soyibo, et al., 2007). NHA captures the contributions of different stakeholders in the funding of the health care system. In doing this, NHA estimates are traditionally presented in matrix form, reflecting the *sources* and *uses* of funds, for disaggregated analysis of expenditure, and an understanding of the flow of funds within the health sector. Situated and playing an intermediary role between the sources and uses are the financing agents involved in the disbursement of fund from sources to specific uses. They receive funds from sources and pay them to providers. Financing sources, which are broken down into public and private refer to entities through which resources enter initially into the health system for health goods and services. Financing agents are the institutions receiving and managing funds from financing sources to pay for or purchase health goods and services. The *uses* are the health activities or categories of persons receiving health care benefits, which are usually disaggregated by functions, providers, geographical location, and often by gender. While the leading NHA matrix presents the flow from sources to financing agents, the remaining matrices trace the resource flows from financing agents

to these disaggregated categories. NHA is designed to be estimated regularly, with the objective of tracking health expenditure trends, which is an essential element in health care monitoring and evaluation.

NHA estimates are useful in quite a number of ways. For instance, it allows for monitoring of trends and making projections within the health sector, diagnosing health financing problems, monitoring of reforms and budgetary allocations, assessing geographical disparities in health care and spending for specific needs/programs, as well as international comparisons. By providing information on financing sources and uses, NHA could serve as basis for resource allocation, and provide basis for quick comparisons between countries. NHA measures the "financial pulse" of the health system and answers the questions: Who pays for health care (financing sources)? How much do they spend (financing agents)? Through what mechanisms or intermediaries? (providers) On what type of services? (functions) (Bhawalkar and Hsi, 2004). It also provides answers to a number of policy questions, such as: Who pays and how much is paid for health? Who are the important actors in health care financing and delivery and how significant are they in THE? How are health funds distributed across the different services, interventions, and activities that the health system produces? Who benefits from health expenditure? (Soyibo, 2005). NHA estimates are designed to facilitate the successful implementation of health system stewardship goals of providing an optimal package of goods and services to sustain and promote the health of individuals and populations, be responsive to their legitimate expectations and protect them from an unfair financial burden. As developing countries governments face the challenges of strengthening stewardship and managing health system reforms, the implementation of NHA provides an opportunity to considerably expand the monitoring of these systems. As a tool, NHA is specifically designed to inform the health policy process, including policy design and implementation, policy dialogue and the monitoring and evaluation of health care interventions. According to Schwartz, et al. (2000), NHA allows for analysis of the changes in the level and source of all public and private health care expenditures at the aggregate national level, as well as changes in public expenditures that affect allocative efficiency by the central and aggregated local levels of government.

NHA focuses on capturing all actual expenditures in monetary terms, on rendered health services and products, whose primary purpose is to restore, improve, and maintain health of individuals and the country over a defined period. Expenditures are also distinct from disbursements not accompanied by spending by recipient.

3. MATERIALS AND METHODS[1]

3.1. History of NHA in Nigeria

For several years, information on the flow of resources in the health sector was limited to public spending on health, usually proxy by the budget allocation to health. Prior to the conduct of the first round of NHA estimates for Nigeria, data available on health expenditure in the country was limited to administrative data along budget line from budgetary allocations to the Federal Ministry of Health (FMoH). Thus sustainability of financing of health care has been debated from the premise of government contributions. Activities of development partners in the health sector in the country were not coordinated, with much duplication of efforts, and difficulty of ascertaining the financial contribution of each to the health sector. Information about private spending on health, especially the household, and the development partners operating in the country was generally lacking. The idea of carrying out a NHA study was first conceived by the Health Policy Training and Research Programme (HPTRP) of the Department of Economics, University of Ibadan, whose establishment was funded by Carnegie Corporation of New York, and administered by the International Health Policy Programme (IHPP) and activity of the Pew Charitable Trust, the World Bank, and WHO. With this process which began in 1996/97, the HPTRP adopted a consultative and collaborative approach to develop concepts, clarify issues and develop instruments for the exercise. The funding which was the third round of funding to the HPTRP was only able to cover a part of the project. It took the support of WHO to complete the project.

Collaborative relationship was developed with the then Federal Office of Statistics (FOS), now the National Bureau of Statistics (NBS) and the FMoH to organize training workshops to develop the capacity of staff on the concepts and methodology of NHA estimation. However, due to limited funding, this effort did not go beyond conduct of pilot survey across the country. The funding of household health expenditure estimate using the NHA framework in Benue state by United Kingdom Department for International Development (DFID) plus the General Household Survey (GHS) conducted by the FOS in 2002 provided the basis that was adapted for the entire country and study period to estimate NHA for the country. Eventually the WHO in 2002, gave the HPTRP a grant to complete the estimation of the NHA of Nigeria for the years 1998 to 2002, in which three matrices of Sources x Financing Agents, Financing Agents x Providers and Financing Agents x Functions for each of the years were estimated.

Another study to estimate NHA matrices for the entire country, and Sub-National Health Accounts (SNHA) at state levels for 17 states (the first of its kind in Africa; and perhaps in the world) for which data were available, covering the period 2003 to 2005 was conducted in 2008/2009. The estimates also benefited from the rich household health expenditure data set of the National Living Standard Survey (NLSS), 2004; conducted by the NBS.

[1] The discussion from this part borrows substantially from Lawanson et al. (2010)

3.2 Methodology of NHA in Nigeria

The methodology application in the estimation of NHA in Nigeria has been evolutionary. In the light of richer data set and better coordination of the process, the methodology applied in the second round of estimation represents a significant improvement over the one in the first round. While estimates at the federal level in the first round was lumped up under federal ministries, the availability of enriched data in the second round allowed for additional information from other federal ministries. Similarly, at the state level it was possible in the second round of estimates to separate purchase of the state ministry from that of the Hospital Management Board (HMB), which are separate entities. We hereby separately espouse the methodology applied in each of the two rounds:

3.2.1. First Round Methodology: 1998 to 2002

Data for the Nigeria's first NHA estimation experience were derived from a number of surveys using a representative sample of the socio-cultural groups of Nigeria along the geo-political zones. Lagos and Abuja in addition to a state per the six geopolitical zones were selected. The states include: three states with former regional headquarters as capitals (i.e. Enugu (South East), Kaduna (North West), Oyo (South West)), and Akwa-Ibom (South-South), Bauchi (North-East), and Benue (North-Central).

Administrative data were collected from Federal, State and Local Government Ministries and establishments. A survey of enterprises involving government parastatals and private sector companies and insurance companies was also conducted to determine the amount expended on health. Data were also collected from donor agencies and development partners as well as non-governmental organizations (NGOs) to determine their expenditure on health in Nigeria.

The household health expenditure data was derived from the General Household Survey (GHS) conducted by the FOS in 2002. Since the GHS did not include any information on provider choice, the study adapted the provider distribution of household health expenditure from the Benue State household expenditure survey of 2001 (Soyibo and Ladejobi, 2002) for the entire country and period of study, which is a great limitation of the study. The data collected on the health expenditure of the Federal Government and its agencies were highly aggregative and could hardly be broken down into budget line items, functions and providers. The NHA matrices of the first estimation experience were estimated using the NHA Version 2 Software (Berman and Cooper, 2000).

3.2.2. Second Round Methodology: 2003 to 2005

The methodological approach adopted in the second estimation experience of the NHA of Nigeria, which took off with a National Workshop on Health Accounts was consultative and collaborative in nature; and it also had an institution-building focus. Several meetings and training workshops were held under the auspices of a NHA Technical Committee setup for the estimation. The committee working closely with HPTRP came up with possibility of estimation of the private sector component of the SNHA at state level. While the resource persons were trained to support the zones in building capacity for SNHA, training of the focal persons for the states were organised for the Northern and Southern zones in Kaduna and Benin, respectively. HPTRP conducted capacity building on health accounts estimation on zonal basis for focal persons at the FMoH and State Ministry of Health (SMOH), to include the use of STATA software for survey data analysis, and the finalization of data collection instruments for the public sector (federal, state and local), development partners and enterprises.

The NHA estimation experience utilised a plethora of primary and secondary data in estimating the NHA for the three years. Public sector, the data on government expenditure data were collected at the federal, states and local government levels, with the assistance of FMoH focal person, and desk officers in all the SMOHs in the country. The data at the federal level was triangulated with separate expenditure data collected from individual tertiary hospitals, agencies and other sources by the research team. For the collection of data from relevant MDAs that spend significantly on health three different questionnaires were used, each for federal MDAs, state and local government MDAs, and for development partners.

For the public sector health expenditure data, two situations emerged from this NHA estimation experience. The first situation occurred when there was total coverage of the appropriate agencies or entities, in which case, the total health expenditure was derived through addition. The second situation is when there was no total coverage. In this situation, the appropriate per capita health expenditure was determined from the available estimate. The desired NHA or SHNA estimate was then similarly estimated as before. Household data were obtained from the household health expenditure data collected by the NBS in the NLSS exercise of 2004, by computing the per capita household health expenditure from the survey data together with an indication of where the expenditure took place. Health expenditure data from private sector enterprises were collected through enterprise survey, with different questionnaires for non-insurance private sector enterprises, and insurance companies including health insurance companies. The findings from these surveys was complemented by secondary data from the Annual Abstract of Statistics, 2007 (NBS, 2007) and triangulated using results

from the enterprise survey and NLSS survey. While the household and enterprise survey data were analyzed using STATA software, the administrative data were analyzed using Microsoft Excel.

4. RESULTS AND DISCUSSION OF FINDINGS

This section presents estimates of the THE for the 1998-2005 NHA estimation, to examine the pattern of health financing in Nigeria. The adoption of NHA in the health sector in Nigeria is basically to serve as a tool to provide information on health expenditures and resource flows, as well as to show how these resources are used. The estimates are useful to mobilize additional resources for the health sector and to help guide resource allocation to guarantee access and equity of health services, especially to the poor. The trend of financing is significant, as it highlights government and donor roll-out of health programmes.

4.1. Aggregate NHA Findings for Nigeria

4.1.1. Health Expenditure by sources

Presented in Table 1 are the THE in Nigeria obtained from two round of NHA estimation, indicating financing by source, as well as some main health financing indicators. The first round estimates shows that in 2002, Nigeria spent over ₦278.7 billion (US$2,207million) on health, an increase of more than 77% over 1998 total health expenditures. The argument of possible underestimation appears to be supported, as the second round estimates produced a significant increase in funding of health (see Table 1). THE estimate of ₦661,662.16 million (US$4.94billion) for 2003 more than doubled the preceding year spending. The THE spending of ₦976,687.6 million (US$7.48billion) in 2005 represents about 48% increase within two years. The per capita health expenditure, though steadily increased from ₦1,445.95 (US$17.41) in 1998 to ₦2,565.77 (US$20.32) in 2002, amounted to only less than 17% increase. As would be expected, in the second round estimates, the per capita THE almost doubled, amounting to ₦5,327.78 (US$39.75) in 2003, which further increased to ₦7,454.48 (US$57.08) in 2005 (see Table 1). However, the economy as a whole grew faster than the growth observed in the health sector financing between 1998-2002, as the THE as percentage of GDP, dropped from about 5.5 percent in 1998 to 4.7 percent in 2002. It however picked up in the second round estimates to 7.57 percent in 2003, only to steadily drop to 6.63 percent in 2005.

The financing of health care in Nigeria heavily relied on domestic sources with minimal external support. Both the public and private sources, as well as donor agencies contributed to financing of health care in Nigeria, however more than 85% of the funds flow in the health sector is generally contributed by the duo of public and private sectors within the economy. The combination of the households and the enterprise firms makes up the private sector. Though in the first round of estimates for 1998-2002, government sources on the average accounted for less than 25%, it steadily increased from 15% in 1998 to 27.2% in 2001, which is encouraging, but significantly dropped to 21.6% in 2002.

From the second round estimates for 2003-2005, government contribution to financing of health in Nigeria generally improved, though less than 30%. The proportion of financing sourced from government increased from about 19% in 2003 to over 26% in 2004 and 2005. The general low share of government in financing of health care has implication on the stewardship role of government, as this translates into greater burden on the household. The private sector, which is mainly the household constitute the main source of financing health in Nigeria accounting for between 65% and 72% in the period 1998-2002, which slightly further increased to between 69% and 77% in the second round estimates for 2003-2005. The household alone accounted for between 60% and 69% in the period 1998-2002, and between 66% and 74% in the period 2003-2005, while private enterprise/firms' contributions are relatively insignificant.

The donor agencies also plays an appreciable role in providing fund for health care in Nigeria, as it generally contributed between 6% and 16% over the period 1998-2002. In the second round estimates for 2003-2005, the relative share of the contribution of the donor agents dropped significantly to between 4-5 percent, though the absolute financing sourced from the donors increased significantly from N17.1billion(US$135.5million) in 2002 by more than 53% to N27.87billion (US$207.9million) in 2003, and further increased to 36.3billion (US$278million) in 2005. While there was increase in the fund provision for health in the country by donor agents, the increase in other stakeholders' contributions in the second round estimates appear to outstrip donor sources.

Table 1: Characteristics and Trend Analysis of Health Expenditure by Sources in Nigeria

	First Round					Second Round		
	1998	1999	2000	2001	2002	2003	2004	2005
Total Health Expenditure (THE) ₦" Million	157081.1	179891.16	215209.13	256283.42	278732.15	661,662.16	788,723.91	976,687.60
Total Health Expenditure (THE) US$ Million	1874.32	1948.08	2134.98	2294.37	2207.65	4936.39	5958.46	7478.37
General Govt. Exp	23502.13	29882.85	40391.25	69765.96	60211.87	123681.8	208207.9	254174.4
Federal	15199	16866.03	22781.25	45078.14	34538.73	47,026.82	115,068.86	130,760.24
State	6162.13	6486.68	13552.27	20417.09	20660.43	48,022.77	56,963.53	78,778.28
Local	2141	6530.14	4057.73	4270.73	5012.71	28,632.19	36,175.47	44,635.90
Private Expenditure	113028	125096.4	139918.84	172248.41	201416.28	510,108.30	544,478.08	686,216.48
Firms	4308.04	6313.96	10046.77	14646.75	17817.91	20,323.11	26,068.46	29,670.97
Household	108720	118782.39	129872.07	157601.66	183598.37	489,785.19	518,409.62	656,545.51
Donors	20551	24911.96	34899.04	14269.05	17104	27,872.16	36,037.98	36,296.70
GDP (million ₦)	2882310	3322030	4902800	5702650	5927680	8,742,647	11,673,602	14,735,324
Population ('000)	108635	111681	114746	117823	120911	124191	127560	131020
THE/GDP (%)	5.45	5.42	4.39	4.49	4.70	7.57	6.76	6.63
Govt/THE (%)	14.96	16.61	18.77	27.22	21.60	18.69	26.40	26.02
HHD/THE (%)	69.21	66.03	60.35	61.50	65.87	0.74	0.66	0.67
Per Capital THE (₦)	1445.95	1655.92	1981.03	2359.12	2565.77	5327.78	6183.17	7454.48
Per Capital THE (US$)	17.41	17.93	19.65	21.12	20.32	39.76	44.67	54.61

Sources: Compiled from Soyibo (2005) and Soyibo et al. (2009).

4.1.2. Health Expenditure by Financing Agents

The involvement of financing agents in the management of health resources and purchase of health care good and services combines both public and private entities. The public financing agents cut across the three tiers of government in Nigeria: Federal, state, and local governments. As presented in Table 2, neither the public nor the private financing agents maintained any steady pattern of share of burden, though they both generally increased in absolute values. In the first round of estimates, the volume of resources managed by the entire public financing agents increased from N41.1billion (US$490million) in 1998, representing 26% of THE, to N72billion (US$714milion) in 2000 where the share reached its peak at 33.5% of THE. In subsequent years, the share of public financing agent steadily dropped to N71.3billion (US$564.7billion) in 2002, representing 25.6% of THE. The second round NHA estimates revealed a significant increase in the amount of funds managed by public financing agents, which double to N149.4billion (US$1.1billion) in 2003, but accounted for just 22.6% of THE. The amount channeled through public financing agents, however steadily increased to N287.6billion (US$2.2billion) in 2005, accounting for roughly 30% of THE.

Estimates for private financing agents were limited to household out-of-pocket (OOP) spending, health insurance, and activities of the NGOs in the first round, while the spending of the health departments of firms was captured in the second round. Generally, the burden of purchases of health care heavily rest on the household through OOP payments in which between 62% and 74% of the THE was accounted for. While, the OOP estimates for the period 1998-2002 was between 62% and 70%, the share of burden through OOP generally increased in the second round estimates to between 66% and 74%. In a country where the poverty level has worsen to over 54% in 2004 and further deteriorate to 69% in 2010 (NBS, 2012), the implication of the burden of financing management left to the household appears unsustainable. This calls for not only increased share by government to lighten the burden, but also to initiate alternative financing means that could be considered to be sustainable. This draws the searchlight to health insurance as a possible appropriate alternative of financing health care in Nigeria.

The two estimates revealed that health insurance presently contribute very minute proportion in the purchase of health care in Nigeria. The volume of health care purchased through health insurance was only 2 percent in 1998, which steadily increased to 5 percent in 2002, but dropped back to 2 percent in each of the three years of estimates in the second round. However, the positive picture in the health insurance activities is that the trend in its absolute contribution to THE in Nigeria steadily continued to rise. From a meager N2.8billion (US$33.5million) in 1998, it steadily increased to N13billion (US$109.6million) in 2002, which is about 400% increase, and further increased between 2003 and 2005 by 36% from N15.6billion (US$116.8million) to N21.3billion (US$163.4million). With the takeoff of the National Health Insurance Scheme, there are all indications that the contribution of health insurance to THE in Nigeria would have significantly increased as more Nigerian, especially in the federal civil service are captured under the scheme. Given the benefit and convenience of health insurance, there is need to step up the enrolment process and assist more Nigerians to lessen the burden of health care financing. Currently, apart from pockets of community health insurance schemes being bankrolled by external assistance and few state governments, minimal effort has been made towards steamrolling the informal sector aspect of the health insurance scheme in Nigeria.

Table 2: Characteristics and Trend Analysis of Health Expenditure by Financing Agents in Nigeria

	First Round					Second Round		
Health Expenditure (Millions)	1998	1999	2000	2001	2002	2003	2004	2005
Total Health Expenditure (THE)	15,7081.1	179,891.2	215,209.13	256,283.42	278,732.15	661,662.16	788,723.91	976,687.60
Govt. Financing Agents	41,061.13	52,393.01	72,009.99	80,346.22	71,297.87	149,384.14	241,949.21	287,562.54
Federal Ministries	30,295.00	36,808.59	51,714.49	48,528.14	38,153.73	51,580.80	63,516.70	70,057.30
Other Fed. Agencies						923.64	58,407.89	67,433.95
State Ministries	7,172.00	7,547.54	14,652.64	23,946.42	24,369.64	26,016.94	35,438.71	51,010.89
HMB						27,785.78	29,546.48	35,651.09
LGA Health Depts.	3,594.13	8,036.88	5,642.86	7,871.66	8,774.50	43,076.98	55,039.43	63,409.31
Private Financing Agents	116,020.05	127,498.15	143,199.14	175,937.46	207,434.28	512,278.05	546,774.70	689,125.06
OOP	110,219.10	120,812.54	132,680.79	160,791.75	187,579.89	492,497.40	521,280.39	660,181.24
Firm Health Depts.						3,484.03	6,026.79	6,749.09
Health Insurance.	2,808.95	4,283.81	7,238.05	11,456.66	13,836.39	15,655.54	18,788.97	21,335.38
NGOs	2,992.00	2,401.80	3,280.30	3,689.05	6,018.00	641.08	678.55	859.35
Govt. FAs/THE (%)	26.14	29.12	33.46	31.35	25.58	22.58	30.68	29.44
OOP/THE (%)	70.17	67.16	61.65	62.74	67.30	74.43	66.09	67.59

Sources: Compiled from Soyibo (2005) and Soyibo et al. (2009).

4.1.3. Health Expenditure by Providers

Nigerians seek and spend money to buy health care in both public and private facilities, as well as the traditional health care facilities. The estimates from the NHA for Nigeria revealed that the public effort at providing health is complimented by the private sector healthcare facilities, as well as the missions, NGOs, and traditional care facilities. The first round NHA estimates for the country basically lumped up the public facilities, while the availability of richer data in the second round of estimates made it possible to separate the activities of public health facilities into the three different tiers of government: federal, states, and local governments. The estimates for 1998-2002 portray the private health facilities as been more active in provision of health care than the public facilities. However, a substantial proportion of health provision could not be properly categorized, lumped under "others", which might significantly include activities in the public facilities. This is more so, given the change of tied in the second round of estimates, in which public facilities combined dominates in the provision of health care to Nigerians.

Table 3: Characteristics and Trend Analysis of Health Expenditure by Providers in Nigeria

	First Round					Second Round		
Health Expenditure	1998	1999	2000	2001	2002	2003	2004	2005
Total Health Expenditure (THE)	157081.1	179891.2	215209.1	256283.4	278732.2	661,662.2	788,723.9	976,687.6
Govt. Facilities (%)	15.8	14.8	13.4	13.5	14.3			
Fed. Health Facilities (%)	NA	NA	NA	NA	NA	4.4	10.7	10.3
State Health Facilities (%)	NA	NA	NA	NA	NA	26.6	24.6	18.1
LGAs Health Facilities (%)	NA	NA	NA	NA	NA	19.4	18.2	18.2
Private Facilities (%)	27.0	26.6	25.6	27.1	29.2	33.9	30.6	31.0
Missions/NGO Facilities (%)	9.8	9.4	8.6	8.8	9.4	1.4	1.3	1.3
Chemist/Pharmacy (%)	14.0	13.4	12.3	12.5	13.5	4.1	3.6	3.7
Traditional Health Care (%)	4.2	4.0	3.7	3.6	4.0			
Others (%)	29.1	31.7	36.4	34.4	29.6	10.3	10.9	10.0

Sources: Derived by the author from Soyibo (2005) and Soyibo et al. (2009), NA: Not available.

The public facilities which barely accounted for about 15% of health care provision in the country in the first round of estimates, constituted more than half of healthcare provision in the second round. The private sector facilities significantly expanded over the years in the provision of care. Its share increased from an average of around 27% between 1998 and 2002 to more than 31% in 2003-2005. Other players in the health sector include Missions/NGOs, Chemist/Pharmacy, and traditional health care providers. Following closely after the public and private health care facilities is Nigerian's resort to chemist and pharmacy for health care, which received between 12% and 14% of THE over the period 1998-2002 in Nigeria.

The share generally dropped to less than 4 percent in 2003-2005. Missions and NGOs also plays relatively significant role in provision of health care in Nigeria, as they accounted for around 9 percent over the period 1998-2002, but dropped to less than 2 percent in the period 2003-2005. The traditional health care providers, though least patronized also contributed to provision of care in Nigeria as they accounted for about 4 percent of THE.

4.1.4. Health Expenditure by Functions

Following the Alma Alta Declaration of 1978, the cure of the Nigeria's National Health policy (NHP) is built on the adoption of a health system based on primary health care (PHC), which is fundamentally preventive in nature as the means to achieve the NHP goal. The Alma-Ata Declaration of 1978 emerged as a major milestone of the twentieth century in the field of public health, and it identified primary health care as the key to the attainment of the goal of Health for All. The success of the health policy significantly depends on the level of success recorded in PHC or in preventive health care. Given the preventive care at the cure of NHP, it would be expected that more resources will be channeled to fund PHC. However, the share of preventive care has remained significantly low, being dominated by resource flow to curative care. Over the period 1998-2005, curative care generally accounts for over 70% of THE, leaving preventive care at distant second position, accounting for less than 15% of THE. In fact, the estimate for 1998-2002 in the first round allocate extremely insignificant share to preventive care.

Apart from 1999, when preventive care was 4.8 percent of THE, other years' estimates were roughly 1 percent and below. Other health functions to which resources are devoted in Nigeria include rehabilitation care, educational training

of health labour force, research and development, and capital formation. All these put together accounts for less than 2 percent of THE.

Table 4: Characteristics and Trend Analysis of Health Expenditure by Functions in Nigeria

	First Round					Second Round		
Health Expenditure	1998	1999	2000	2001	2002	2003	2004	2005
Total Health Expenditure (₦' million)	157,081.1	179,891.2	215,209.1	256,283.4	278,732.2	661,662.2	788,723.9	976,687.6
Curative (%)	72.33	70.52	66.24	68.49	73.57	74.03	74.81	73.95
Rehabilitative Care (%)	0.22	0.20	0.31	0.18	0.20	0.22	2.96	0.06
Preventive Care (%)	0.50	4.82	1.04	0.87	1.02	14.39	9.99	13.87
Capital Formation for Provider Institutions (%)	0.30	0.34	0.04	0.31	0.32			
Education Training (%)	0.18	0.16	0.79	0.11	0.13	0.30	0.52	0.44
Res. & Devt. in Health (%)	0.02	0.09	0.11	0.10	0.15			
Others (%)	26.45	23.87	31.48	29.93	24.62	11.05	11.73	11.68

Sources: Derived by the author from Soyibo (2005) and Soyibo et al. (2009)

4.2. State Sub-NHA Estimates

Nigeria is divided into six geopolitical zones with component of six states each, except for North West and South East that have seven states and five states, respectively. The Sub-NHA for states in the country was estimated for 17 states cutting across five of the six geopolitical zones. These are the states for which data were available to estimates Sub-NHA at state level. Apart from South East zone, every other zone has at least one state represented in the estimation. While all the states in the South West were covered, four out of the six states in the North East zone were included in the estimate. Both North West and South South zones have three states covered, while the North Central zone was represented by only one state. Presented in Table 5 are the 2003-2005 average estimates for each zone with respect to sources, financing agents, providers and functions. The average STHE ranged between the least value of ₦11.97billion for North East to the highest of ₦28.72billion in South West. However, the per capita health expenditure is highest in South South, amounting to ₦7,699.54 (US$58.19) and least of N3,853 (US$29.12) in North West.

Similar to the THE for the country, the households constitute the main source of financing health across the states in the zones, though differs in proportion across the zones. The household burden of financing health is highest in North Central accounting for as much as over 83% of STHE, while it is least in South West and North West accounting for 71% of STHE. Public source of financing health ranged between 15.6% in North Central to 28.4% in North West. The relative involvement of the three tiers of government in each of the zone appears to differ. While the federal government commits more resources to financing health than the states and local governments (LG) in North West, South South, and South West, the states and LGs shoulder more financial burden than the federal government in North Central and North East. The roles of the firms and donor agents appear to be significantly minimal across the zones.

The only exception to this is the contribution of firms in the South West zone where they contribute 5.5 percent. This share in the South West is attributable to the activities of firms in Lagos State, the main commercial nerve center of the country. When financing pattern is viewed along the financing agents' "health care purchasing" activities, the estimates from each of the zone indicates that the household OOP spending remains the heaviest carrier of health care financing. Between 71% and 83% of STHE in South west and North Central, respectively is funded through OOP spending. Activities of private enterprise health departments, health insurance, and NGOs are extremely minimal contributing less than 1 percent of STHE. The public channels which include agencies at the three levels of government accounts for around one-quarter of STHE. The share of public financing agents in the STHE ranges from 16.7% in North Central to 27.1% in North West. However, the relative share of the agencies of the three tiers of government differs across the zones. Federal presence and involvement in health care financing as financing agents is not evenly spread across the zones of the country. The federal presence is more pronounced in North West, South South, and South West, while the states and local governments are prominent in North Central and North East.

The involvement of public, private, missions/NGOs and traditional health care providers is common to all the five zones covered in 2003-2005 STHE estimates. However the distribution of the shares of different types of providers is not same across the zones. For instance in the two Southern zones, the private providers dominates, accounting for 39.5% and 47.4% in South South, and South West, respectively, whereas in the three Northern zones, the states bear the highest burden in providing health care services. Between 31.5% of STHE in North East and 40.4% of STHE in North West are provided in State Health Facilities. Another proportion of between 1.7% of STHE in North West and 5.7% of STHE in South West is provided by chemists and traditional care facilities.

Table 5: States Average Share of Total Health Expenditure by Zone (2003-2005 Annual Average) ₦' Millions

	North Central	North East	North West	South South	South West
Proportion of states covered	**1/6**	**4/6**	**3/7**	**3/6**	**6/6**
STHE	**16,092.6**	**11,970.0**	**22,719.1**	**24,791.9**	**28,715.6**
Per capita (₦)	**5,185.95**	**4,986.64**	**3,853.05**	**7,699.54**	**6,599.63**
Per capita (US$)	**39.19**	**37.69**	**29.12**	**58.19**	**49.88**
BY SOURCES					
Federal Government	390.1(**2.4**)	538.5(**4.5**)	2,302.5(**10.1**)	2,971.4(**12.0**)	3,448.1(**12.0**)
State Governments	1,018.7(**6.3**)	1,035.0(**8.6**)	2,123.3(**9.3**)	2,450.1(**9.9**)	2,074.9(**7.2**)
Local Governments	1,105.9(**6.9**)	795.6(**6.6**)	2,034.3(**9.0**)	1,087.3(**4.4**)	976.7(**3.4**)
Households	13,384.3(**83.2**)	9,548.7(**79.8**)	16,165.8(**71.2**)	18,192.5(**73.4**)	20,377.7(**71.0**)
Firms	16.2(**0.1**)	6.4(**0.1**)	44.5(**0.2**)	73.0(**0.3**)	1,587.1(**5.5**)
Donor/Development Partners	177.4(**1.1**)	46.0(**0.4**)	48.7(**0.2**)	17.5(**0.1**)	251.0(**0.9**)
BY FINANCING AGENTS					
Fed. Government Agencies	390.1 (**2.4**)	535.6(**4.5**)	2,128.0(**9.4**)	2,962.2(**11.9**)	3,421.2(**11.9**)
SMOH	1,196.1(**7.4**)	818.3(**6.8**)	1,549.6(**6.8**)	1,614.0(**6.5**)	1,150.1(**4.0**)
HMB	-	238.3(**2.0**)	490.1(**2.2**)	829.4(**3.3**)	678.6(**2.4**)
Other State Agencies	-	17.7(**0.1**)	13.4(**0.1**)	-	145.9(**0.5**)
LGA Health Departments	1,105.9(**6.9**)	794.4(**6.6**)	1,964.5(**8.6**)	1,084.7(**4.4**)	1,102.7(**3.8**)
Out-of-Pocket	13,399.1(**83.3**)	9,559.4(**79.9**)	16,540.7(**72.8**)	18,248.3(**73.6**)	20,458.2(**71.2**)
Firm Health Departments	1.5(**0.01**)	1.2(**0.01**)	2.4(**0.01**)	35.2(**0.1**)	1,363.5(**4.7**)
Health Insurance	-	0.3(**0.003**)	16.3(**0.1**)	0.6(**0.003**)	197.1(**0.7**)
NGOs	-	5.0(**0.04**)	14.2(**0.1**)	17.5(**0.1**)	198.4(**0.7**)
BY PROVIDERS					
Federal Health Facilities	1,078.8(**6.7**)	1,011.4(**8.4**)	3,104.1(**13.7**)	3,540.5(**14.3**)	4,012.9(**14.0**)
State Health Facilities	5,567.0(**34.6**)	3,772.9(**31.5**)	9,182.4(**40.4**)	6,388.0(**25.8**)	5,758.9(**20.1**)
LGA Health Facilities	5,977.8(**37.1**)	3,772.9(**31.5**)	4,175.9(**18.4**)	2,710.7(**10.9**)	2,836.3(**9.9**)
Mission/NGO Facilities	53.6(**0.3**)	312.6(**2.6**)	238.8(**1.1**)	85.1(**0.3**)	452.5(**1.6**)
Private Facilities	3,232.0(**20.1**)	2,462.6(**20.6**)	5,030.9(**22.1**)	9,792.1(**39.5**)	13,617.2(**47.4**)
Chemist/Tradition Care	-	481.3(**4.0**)	387.6(**1.7**)	1,010.8(**4.1**)	1,627.9(**5.7**)
Others	183.4(**1.1**)	156.3(**1.3**)	599.4(**2.6**)	1,264.8(**5.1**)	410.0(**1.4**)
BY FUNCTIONS					
Public Health Preventive	3,611.7(**22.4**)	2,636.5(**22.0**)	3,009.3(**13.2**)	3,262.8(**13.2**)	4,245.0(**14.8**)
Curative Care	12,135.8(**75.4**)	9,099.5(**76.0**)	18,406.0(**81.0**)	18,929.1(**76.4**)	21,801.2(**75.9**)
Rehabilitative Care	44.9(**0.3**)	-	-	313.1(**1.3**)	1.8(**0.01**)
Training & Research	130.9(**0.8**)	81.3(**0.7**)	57.6(**0.3**)	1,712.8(**6.9**)	1,018.4(**3.5**)
Others	169.3(**1.1**)	153.4(**1.3**)	1,246.3(**5.5**)	574.1(**2.3**)	1,649.3(**5.7**)

Sources: Derived by the author from Soyibo (2005) and Soyibo et al. (2009)

As reflected in the country estimates, more than three-quarters of STHE across the states of the five zones are channeled to provide curative care. The preventive care is pushed to the background, accounting for between 13.2% and 22.4% of STHE. The estimates revealed that the southern zones' states commit relatively substantial proportion of their STHE to training and research development, in which 3.5% of STHE and 6.9% of STHE is committed in South West and South South, respectively. For the states in the northern zones, less than 1% of STHE is devoted to training and research development.

4.3. Institutionalization of the NHA Process

Though there has been an appreciable adoption and estimation of NHA in many African countries, its occupation of priority place is yet to be seen. In order to take advantage of regular NHA estimation, there is a growing demand for the institutionalization of NHA process by developing countries. According to Garg (2010), NHA institutionalization is simply routine government-mandated production and utilization of a minimum set of health expenditure data using a standard NHA framework. Institutionalization of NHA has the advantage of allowing for country ownership and engagement, capacity building, long-term cost effectiveness considerations, and better policy use of data. While most developing countries have not taken ownership of the NHA process it has remained purely donor driven exercise. Not only do most developing countries failed to appreciate the worth of doing NHAs, there generally exist poor policy linkages to data.

Measures for NHA institutionalization are primarily based on the number of years of NHA data produced and/or the number of times that the NHA exercise/project has been conducted. Measuring institutionalization of NHA centers on four basic criteria.

- Consistency in the use of NHA data.
- Adequacy of financial, human, and institutional capacity to routinely produce and use health accounts
- Consistency in the production of NHA data, and
- Extent of the use of health accounts methodology

Presently in the public domain, there are two rounds of NHA estimates for the country, covering 8-year period: 1998-2005. However there is a minimal use of the data itself by policy makers, and even in the academic circle. There appears to be minimal or no appreciation of NHA data has useful tool for redirecting affairs in the health sector. Second, it should be noted that the second round of NHA estimates for Nigeria was funded by the Federal Ministry of Health, which is an indication of commitment and belief in the NHA estimation project. However, sustainability of this financial commitment is lacking, as subsequent officials at the helms of the nation's health affairs are not forthcoming in supporting the project financially. This gap has however been taken up by donor assistance to finance NHA estimation. This situation stands to threaten the sustainability of the process as well as possible compromise of true estimates.

When the first NHA was carried out, it was conceived and packaged as a single, self-standing exercise, product of financial support from Carnegie Corporation of New York and WHO. The exercise did seek to transfer the responsibility and ownership to the government, which was adequately demonstrated by the then Minister of Health's approval and provision of funds, covering data collection, analysis and dissemination for the second round of NHA estimates for the country. To guarantee future sustainability of the estimation process the desirability of institutionalizing NHA was agreed upon, while the potential to inform policy was recognized. However, the long term financing sustainability of the NHA process was not explicitly factored in. Thus the third round estimation has substantially been taken over by PATH II, a foreign donor agency, in the absence of government action to initiate the follow-up rounds of estimation.

While the FMoH demonstrated her welcome of the NHA initiative through the wide use of the first round results by the former Minister of Health, Professor Eyitayo Lambo in presentations at many international fora and health policy decisions, and the funding of the second round of NHA estimations, there was no apparent effort to create the necessary environment to make it sustainable. The Department of Statistics, Planning and Research of the Ministry of Health was tasked with following up on the NHA and its institutionalization. Though the unit has the human resource capacity to engage, manage and oversee the conduct of NHA estimation, the unit was grossly incapacitated as it did not receive additional resources for estimating and institutionalizing subsequent rounds of NHA. Due to a seemingly lack of appreciation of NHA by the succeeding minsters, and lukewarm attitude of top carrier officers in the ministry, it has remained a herculean task bringing NHA estimation on board the annual budget of the ministry. The consciousness and political will to promote institutionalization of NHA in the country is yet to be demonstrated. At present, no real efforts have been made to advocate the concept more broadly in the government circle, which has made the role of NHA to guide policymaking or to serve as input into the budgetary allocation process to be undermined.

4.3.1 Key Elements of NHA Institutionalization

4.3.1.1 Institutional / Governance Structure Capacity and Resources

While the potential for institutionalizing NHA is better enhanced by the enactment of the information bill, the obstacle to collection of data in the country is still very much entrenched. There is still great deal of resistance, especially by public office holders to release information on their expenditure as the effect of the information bill has not materialized. The Department responsible functionally for the NHA institutionalization within the FMoH is ill-equipped to do this in terms of financial resources, while the human resource capacity requires some building-up. Interestingly, the technical capacity does exist in the country (notably at the HPRTP). As a result, the first and second NHA exercises have been entirely conducted by domestic technical experts, within a pre-established framework of institutionalization, though funding availability and ability to mobilize technical expertise for subsequent rounds is lacking, which has implication for consistency.

4.3.1.2. Consistency and Methodology

While, the second round of NHA estimates designed and widely disseminated the framework to extract the relevant public sector data from its financial reporting and monitoring system, tracking of financial flows outside of the public sector was not provided for. Though there was consistency in the methodology for the first two-rounds, the change of guards in the third round may have resulted in some methodological deviations.

4.3.1.3. Information and Dissemination

Results from the first two-rounds of NHA study have been made widely available on the WHO's National Health Accounts website for Nigeria (at: http://www.who.int/nha/country/nga/en) and have been used and quoted widely, but no effort has been made to proactively disseminate it through workshops.

4.3.1.4. Policy Impact

The extent to which results from the first and second NHA study have been used to influence health policy and budget planning in the country is very minimal. While regular update of NHA is important for the proper budgeting and planning process within the FMoH, the utilization of the existing result is yet to be seen. It need be stated that the NHA is useful in determining the distribution of health financing burden among the different stakeholders, especially the households, and to inform policy action to ameliorate the burden on the vulnerable member of the society.

4.4. Comparison of NHA Estimates for Nigeria and Some African Countries

Presented in Table 6a is comparative NHA estimates from the latest available estimates for thirteen selected African countries including Nigeria. The selection of these countries is subject to easy access to countries' NHA estimates, and limited to the ones posted on the web. The reported NHA estimates for the countries are for different years as indicated in the third row of Table 6a. Given the variation in the size and population of the selected countries, the NHA estimates for the countries varies from the least estimate of US$25.9million for Seychelles to US$7.48billion for Nigeria. Though the Nigeria total health expenditure is highest among these countries, with consideration of ratio of THE/GDP, and per capita THE, the country performs poorly relative to some countries. While Nigeria THE constitute 6.6% of her GDP, it lies below the proportion for countries like Sierra Leone, Gambia, Malawi, Rwanda, and Namibia with 22.9%, 14.9%, 12.8%, 11%, and 8.3%, respectively. The per capita THE for Nigeria in 2005 of US$57.08, is less than what obtains in Namibia, Seychelles, and Zambia. In fact the per capita THE in Namibia and Seychelles is around four-fold the Nigerian value. However, in general, expenditure on health in Nigeria is significantly better than many of the selected African countries.

Sources of financing health care in African countries are generally similar, involving entities such as the government, the household, and donor agencies, while for few countries, including Nigeria, the firm is also identified as feasible financing source. However, the distribution of the burden of financing health in Nigeria is significantly different from the pattern associated with other African countries. According to Lawanson (2013), the financing structure among stakeholders in Sub-Sahara Africa (SSA) revealed the resting of the main burden on the households, with minimal contribution by government.

While the burden of financing health rest mainly on the household in Nigeria, accounting for two-third of THE, most other countries depend more on donors to fund their healthcare. The lesser burden on the household in many of African countries is courtesy of the financial commitment of the donors. More than 40% of THE is provided by the donors in seven of the of countries analyzed in this review.

The stewardship role of government in majority of African countries is lacking as generally less than 30% of THE is sourced from the public sector. With the exception of Namibia, Ghana, and Seychelles, barely one-quarter of THE is funded by government. This basically raises the issue of sustainability of health care financing in African countries. In a continent where poverty level is high, with generally more than half of the population being poor, the ability of the household to continue to shoulder the burden of health care financing may sooner or later crumble. For countries, where donor funding is the saving grace, continued flow of such fund may not be guaranteed for long, or at least not forever. This calls for increased role by government of these countries, as well as exploring other financing alternatives, such as social health insurance mechanism. The firms as a source of financing health care play a less significant role. Estimates for this entity are only available for five countries including Nigeria, accounting for between 2 percent and 8.9 percent of THE in Ethiopia and Namibia, respectively. The significant financing agents that characterized the countries include public agencies, household OOP, and NGOs. For Nigeria and Sierra Leone, the OOP remains the dominant financing agent, accounting for 67% and 70%, respectively.

Table 6a: Comparative NHA Estimates for Selected African Countries by Financing Source and Financing Agents

	Nigeria	Ethiopia	Namibia	Zambia	Uganda	Gambia	Ghana	Rwanda	Seychelles	Sierra Leone	Kenya	Malawi	Tanzania
Year	2005	2007/08	2006/07	2006	2004/05	2004	2002	2006	2009	2006	2009/10	1997/98	2005/06
General NHA Estimates Indicators													
THE (US$'M)	7478.4	1200	3,890	49.8	269	56.0	278.4	307.3	25.9	327.0	1,620	240.6	918.8
THE/GDP	6.63	6.2	8.3	6.3	4.7	14.9	4.8	11.0	3.3	22.9	5.4	12.8	5.0
Per capita THE (US$)	57.08	16.09	276.00	58.0	12.28	40.1	13.6	33.93	297.0	65.66	42.2	20.00	24.50
Pop. ('000)	131,020	73,919	1,986	11,800	21,900	1,398	18,412	9,058	87	4,980	38,610	11,938	37,500
Financing Source													
Govt. (%)	26	21	44	24.4	20	18	39.8	19	87	19	28.80	25.4	28.1
Firms (%)	3	2	8.9	5.4	3								
HH (%)	67.3	37	24.7	27.3	34	12	38.8	28	7	70	36.7	14.6	25
Donors (%)	3.7	40	22.4	41.5	43	70	21.4	53	6	11	34.5	60	44
Financing Agents													
Govt. (%)	29.4	42	42.2	38	38	22	54	49	93.4	19	36.6	64.6	
OOP (%)	68.3	43	4	31	33.8	11	45	23	5.4	67.13	33.9	24.5	
NGOs (%)	0.01	14	16.3	29	25	67	1	28	1.2	10.97	29.5	10.9	
Insurance (%)	2.2	1	37.5										

Sources: World Health Organization National Health Account database (www.who.int/nha/en) supplemented by country data.

The significant share of public agencies as financing agents in other countries is indicative of the fact that donors' activities in these countries are channeled through public agencies/ministry. Exception to this is case of Gambia and Kenya, where the NGOs appears to be the focus of donors in channeling health care financing. In the case of Gambia about 67% of THE is channeled through the NGOs, whereas NGOs appears to be infeasible in Nigeria, as they handle only 0.01 percent of THE. While health insurance may not be said to be non-existing in most African countries, most NHA estimates failed to account for it as a financing agent. Only in two other countries (Ethiopia and Namibia), apart from Nigeria is health insurance recorded an estimate against. While health insurance as of 2005 plays a relatively little role in channeling health are finance in Nigeria, and even worse in Ethiopia, the estimate of 37.5% of THE for health insurance in Namibia is suggestive of the existence of a well-established health insurance mechanism in Namibia. Other African countries, including Nigeria should borrow a leave from the success story of health insurance as veritable alternative financing mechanism in Namibia.

In Table 6b we presents NHA estimates by providers and functions for five and six African countries, respectively. Generally, in all the countries, the public ahead of private constitute the dominant facilities in the provision of health care services to the people. In Nigeria, 46.6% of THE takes place in the public facilities, with 34.8% of THE delivered at the private facilities. The share of public health facilities in Nigeria is higher than what obtains in Kenya and Namibia, but it is lower than public facilities' role in Ethiopia and Gambia, where it respectively accounts for 61% and 66% of THE. However, the share of private health facilities which exclude missions and NGOs health facilities is highest in Nigeria relative to the other four African countries included in the analysis.

Table 6b: Comparative NHA Estimates for Selected African Countries by Providers and Functions

	Nigeria	Kenya	Namibia	Ethiopia	Gambia	Malawi	Uganda
Types of Providers							
Private	34.8	33.9	22.1	16.0	24.0	NA	NA
Public	46.6	36.6	40.0	61.0	66.0	NA	NA
Types of Functions							
Curative	73.9	61.0	70.2	42.0		48.3	24.0
Preventive	13.9	22.8	14.5	25.0		31.4	14.0

Sources: World Health Organization National Health Account database (www.who.int/nha/en) supplemented by country data.

Virtually all African countries subscribed to the Alma Alter Declaration, which places priority on primary healthcare as the strategy for delivering effective health care to the people of developing countries. As a follow up to this declaration, most African countries health policy was redesigned to put PHC as the strategy for achieving health for all their people. Ironically the PHC level of health care which focuses on preventive health care appears to have been accorded least priority in funding. In those African countries for which their NHA estimates provided a clear figure for curative and preventive health care, the curative health care service was generally accorded top priority in allocation of funds. While the share of preventive health care in THE is generally lower than 30% in the countries covered, the curative care attracts as high as over 73% in Nigeria, 70% in Namibia, 61% in Kenya, and 48.3% and 42% in Malawi and Ethiopia, respectively. The least is in Gambia, where curative care accounts for only 24%, though higher than the share of preventive care. The preventive care share of THE is as low as less than 15% in three of the six countries, and does not exceed 25% in five of the six countries. This poor allocation of resources to the PHC may be responsible for the persistent poor health status that characterized the developing countries, especially the African countries.

5. POLICY ISSUES AND RECOMMENDATIONS

Institutionalizing the NHA estimation process must be seen from non-negotiable perspective. The first round of estimates was made possible through the financial assistance of donor agencies, while the second round of estimates was driven by the financial and technical commitment of the Nigerian government spearheaded by the Ministry of Health. The decision by the technical committee mandated to conduct the second round of NHA estimates with the FMoH to institutionalize the process appears to be getting eroded. The estimation process as reflected in the third round of estimates, yet to be finalized has gone back to the confines and dictates of the donor agencies. The country cannot hope to take ownership of the process and institutionalize the process appropriately when the Nigerian government is hesitant to commit resources to the process. The NHA estimation issue should cease to be subjected to the personal opinions, values, and conviction of those at the helms of affairs at the FMoH. If the issue of institutionalization is perfectly resolved and accorded its rightful place in the scheme of things, the rest of the process and frequency of it will cease to be a problem. Then the country can take ownership of the process and it can then be integrated into the country's official routine statistical data collection, which is the case in the OECD countries.

The current household health care financing burden may not be sustainable in the light of high level poverty in the country. It has been empirically shown that health and poverty are viciously linked to one another. While poor state of health limit the ability to escape poverty trap, the existence of poverty hinders access to good health. A country where more than half of the people are poor and the citizens are left to carry a dominant share of the financing of health portends significant decline in general welfare. There is need for a conscious effort on the part of government to increase her stewardship role to lighten the unsustainable burden on the household. The weak access to health is easily attributable to the financial constraint at the point of demand. Many Nigerian are unable to access health care because they could not afford it. There is need to intensify programmes that specifically focus on the vulnerable, especially the poor, rural dwellers, and mother and children. Alternative means of financing health care, especially health insurance should be fully explore with the required vigor.

Exploring health insurance as a veritable alternative to financing health in Nigeria is key to sustainable health financing. As of the last NHA estimates for 2005, the contribution of health insurance to total health expenditure is very minute. However, two issue points to the possible potential of relying on health insurance within the Nigerian setting. First, the high share of household in total health expenditure is indicative of the readiness and willingness to pay for health by the household. This attribute can better be annexed by creating room for pooling of risk towards financing health care, and thereby lightening the burden on the household. Second, the observed appreciable growth of health insurance, both in magnitude and share of THE is pointer to the fact that if the needed framework and enabling environment is created, it has a good change to thrive in Nigeria.

Reconciliation of the health care financing distribution by functions with the country's health policy pillar is important to achieve country' health policy objectives. The health policy strategy of Nigeria is founded on the PHC which addresses health care more aggressively from the preventive perspective. The situation where curative care dominates in the share of THE at the expense of preventive care is counterintuitive. PHC is not only closer to the rural populace but also easy and cheaper to establish and manage. There is need to promote preventive health care, as it has been adjudged more effective and cheaper to deliver. If the goal of health for all that was mapped out to have been achieved since year 2000, is still to be delivered, PHC facilities and preventive care must be accorded top priority in both resources allocation and utilization.

6. CONCLUSIONS

This paper reviews the NHA estimation process and the findings from the exercise, with comparison with selected African countries. The NHA framework is used to track the flow of funds in the Nigerian health system. The process of the estimate has been substantially benefitted from domestic expertise while funding of the exercises came from both government and development partners. Attempt was made to institutionalize the process by developing capacity in focal persons at the state and federal level through specialized training programme in NHA estimation. Result estimates revealed that the burden of financing health care in Nigeria rest most on the households accounting for about two-third of the money flows into the sector. Public providers of health care services accounts for the largest share of resources that goes into the sector, while curative care dominates in the use of resources, despite the fact that primary health care constitute the national health policy strategy base for the country. Nigeria, compares relatively well with other African countries on the average, as her per capita total health expenditure is roughly higher than most of the African countries included in the analysis. The paper recommends that the policy issue of institutionalizing the process be taken serious, in order to domesticate the process and guarantee ownership. Policy measures are required to relieve the households of the burden of financing health care through the promotion of pooling mechanism of health insurance, while government wake up to her stewardship role. There is also the need to reconcile the health care financing distribution by functions to reflect country' health policy objectives, by influencing the utilization of higher proportion of total funding at the primary health care level.

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