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Health Care Financing and Budgetary Allocation in Ondo State

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Authors' contributions

This work was carried out in collaboration between both authors. Author UJ designed the study, wrote the protocol and wrote the first draft of the manuscript. Author UJ managed the literature searches, analyses of the study performed the spectroscopy analysis and author BW managed the experimental process and author BW identified the species of plant. Both authors read and approved the final manuscript.

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ABSTRACT

Funding of the health care sector in Nigeria is faced with enormous challenges that must be overcome if quality and effective health care service is to be made available to the people. While health care research has focused largely on the provision, access, and quality of the facilities, this study investigated the mechanism of public health care financing in Ondo State, Nigeria. The data used for the study were from both primary and secondary sources. A multi-stage sampling technique was adopted to select and elicit information from the respondents. The 18 local government areas (LGAs) in Ondo state were segregated into three senatorial districts; three LGAs were randomly selected from each senatorial district. With the aid of an interview guide, in-depth interview were held with the chairmen of the three LGAs. Information sought included the various sources of finance and health care financial challenges. Descriptive statistics as well as trend analysis were used for data analysis. The major challenges of health care financing were inadequate funding by government, high out-of pocket-payment, inadequate implementation of health care financing policy and corruption. This study concluded that health care financing was inadequate in the study area and recommended an increase in government budgetary allocation

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and prompt release of funds for public health care, adequate implementation of health care policies as well as proper monitoring and evaluation of fund utilization to discourage corruption and mismanagement.

Keywords: Budgetary allocation; challenges; public health care; financing; Ondo State.

1. INTRODUCTION

Public health care in Nigeria is provided at three levels. The primary, secondary and tertiary managed by local, state and federal governments, respectively. Primary health centres are the first point of contact for patients, providing preventive, curative, health promoting and rehabilitative services. At the secondary care level, patients are referred for specialized services from the primary health care level, through out-patient and in-patient services of hospitals for general medical, surgical, paediatric, obstetric, gynaecological and community health services [1]. The tertiary level is the apex health care system in Nigeria, consisting of teaching hospitals, federal medical centres and other specialist hospitals which provide care for specific disease conditions or specific groups of patients. In Nigeria, many secondary and tertiary health facilities are crowded with patients that have simple ailments that can be managed at the primary health centres [2]. However, there are some services that should be provided at all levels of care, such as immunization, antenatal care and family planning. Although the local governments have the main responsibility of managing the primary health care (PHC), all the three tiers of government and various agencies participate in the management of the PHC. This, at times, results in duplication, overlap, and confusion of roles and responsibilities [3].

The provision of effective health care services to citizens in Nigeria is one of the basic functions of government, especially as it relates to the provision of quality care. This is predicated on the belief that, it is only when the people are healthy that any reasonable development can take place. In the performance of this health care provision service, governments are handicapped by lack of funds for equipment, personnel, building infrastructure and logistics. Funding of the health care sector in Nigeria is faced with enormous challenges that must be overcome if quality and effective health care service is to be made available to the people. National Primary Health Care Development Agency, notes that Nigeria's health care financing is the underpinning of health care delivery system and that a carefully thought out, formulated and implemented financing mechanisms is necessary for the success of the health care system [4].

According to the Federal Ministry of Health, in the past, the health care budget was a paper exercise and no one paid any attention to it owing to the fact that the real cost of health services was unknown because there was no system for national health accounts [5]. There were no reliable data or information on the combined federal, state and LGA expenditures, nor on expenditures of private and donor sources. There was no broad-based health care sector financing strategy, even with the planned commencement of a National Health Insurance Scheme (NHIS). In view of the foregoing, this study focused on the health care financing in Ondo State, Nigeria. In the state, the financing options for effective services included fund raising and donations from philanthropists, industries, community groups, and cooperative societies (micro-credit facilities provision).

1.1 Statement of the Problems and Literature Review

Globally, more than 100 million people each year fall into poverty because of the cost of medical treatment exacerbating and perpetuating poverty in the poorest countries. The past decade has witnessed growing evidence that households are likely to be confronted with catastrophic expenses when they are forced to pay out-of-pocket for health care. The Nigerian health system in general is believed to be characterized by not only low public sector funding, but also poor staff motivation and inequitable access to health. Financing health care in Nigeria has continued to present formidable challenges to government, academics and policy experts [6]. The models of financing healthcare in many developed countries are rarely applicable in Nigeria because of limited institutional capacity, paucity of data on health status and service utilization, corruption, unstable economic and political climates and consumers' low level of awareness of health development issues.

There are two main approaches to health care financing; the public and private approaches [7]. The public approach includes general tax revenue (direct and indirect tax), loan-deficit financing, grants and insurance; while the private approaches include user fees (that is, fees-for-service), employer-financed scheme, insurance (employee or individual paid), and community financing options [8]. Patients currently share in the financing of government health care services through the payment of consultation charges and the purchase of drugs and other renewable items because the health institutions have inadequate government provision.

It is unfortunate that the host nation for HEALTH FOR ALL conference, in which African countries resolved to spend at least 15% of their budget on health, still spend paltry 3.5% a decade after. No wonder Nigerians' life expectancy remains unacceptably low at 56 years in 2016. With a vicious circle of ignorance, poverty and disease, it is obvious that public funding and market-based funding (without safety nets) cannot ensure health for all Nigerians. In addition, despite the health financing options so identified in Nigeria, there still exist disproportions in health system financing. For instance, there are severe budgetary constraints and uneven distribution of resources among the urban and rural areas with the rural areas mostly affected by inequitable budgetary health expenditure allocations [9]. Ichoku and Fonta (2009) had also found a catastrophic health care financing in Nigeria, which has led to further impoverishment of the poor.

This situation is further explained by Adinma and Adinman in their evaluation of healthcare funding in Nigeria with respect to health budget and health expenditure [8]. They note that the federal government's budget on health was ₦ 4,835 million- ₦17, 581.9 million from 1996 to 2000. This amount represented only 2.7%-5.0% of the total federal government budget. In Nigeria, while the Total Health Expenditure (THE) as a percentage of gross domestic products (GDP) was low, ranging between 4.3%-5.5% from 1996-2005, the General Government Health Expenditure (GGHE) as percentage of THE is also low ranging from 21.8% to 33.5%. However, the private sector expenditure on health as percentage of the was high 66.5%-78.2% in 1996-2005, with private households out-of-pocket accounting for 90.4%-95.0% over the period. Social security fund had no contribution to the general government expenditure over the 10-year period. The National Health Insurance Scheme (NHIS) currently covers only the formal sector of 4.5 million people (3.2%) of the population. The situation has not in any way improved especially in Ondo State, Nigeria.

A number of scholars have worked on some aspects of health care financing: the trends and challenges of public health care financing system in Nigeria [1]; the Nigerian health care funding system and how it compares to that of South Africa, Europe and America [10], and the fiscal space for health financing in Nigeria [11]. However, none of these studies brought focus on health care finance in Ondo State. This study, therefore, investigated the various sources of health care finance and their associated problems with a view to promoting the quality health care required in the study area.

1.2 The Study Area

Ondo State of Nigeria was one of the seven states created on 3rd February, 1976 by the Federal Military Government of Nigeria. It was carved out of the old Western State. The state covers the total area of the former Ondo Province, created in 1915, with Akure as the provincial headquarters. Ondo State took off formally in April, 1976, with nine administrative divisions of the former Western State [12]. However, on 1st October, 1996, Ekiti State, comprising Ekiti Central, Ekiti South and Ekiti West Divisions, was carved out of Ondo State. Hence, the present Ondo State is made up of Akoko, Akure, Okiti-Pupa, Ondo and Owo Divisions. Akure remains the state capital.

Ondo State lies between latitude 5°45^{1} and 7°52^{1}N and longitudes 4°20^{1} and 6°5^{1}E. Its land area is about 15,500 square kilometres. Ondo State is bounded by Edo and Delta States on the east, Ogun and Osun States, on the west, Ekiti and Kogi State on the north; and the Bight of Benin and the Atlantic Ocean, on the south (Fig. 1).

Ondo State has a maternal mortality rate of 371/100,000 live births and an infant mortality rate of 68/1000 live births and was pronounced by the World Bank in June 2009 as having the worst health indices in the south west zone of the country [13]. In 2009, the per capita health expenditure was $4, as against the standard of $34 recommended by the Macroeconomic Commission on health for the attainment of health - related MDGs. However, there was a

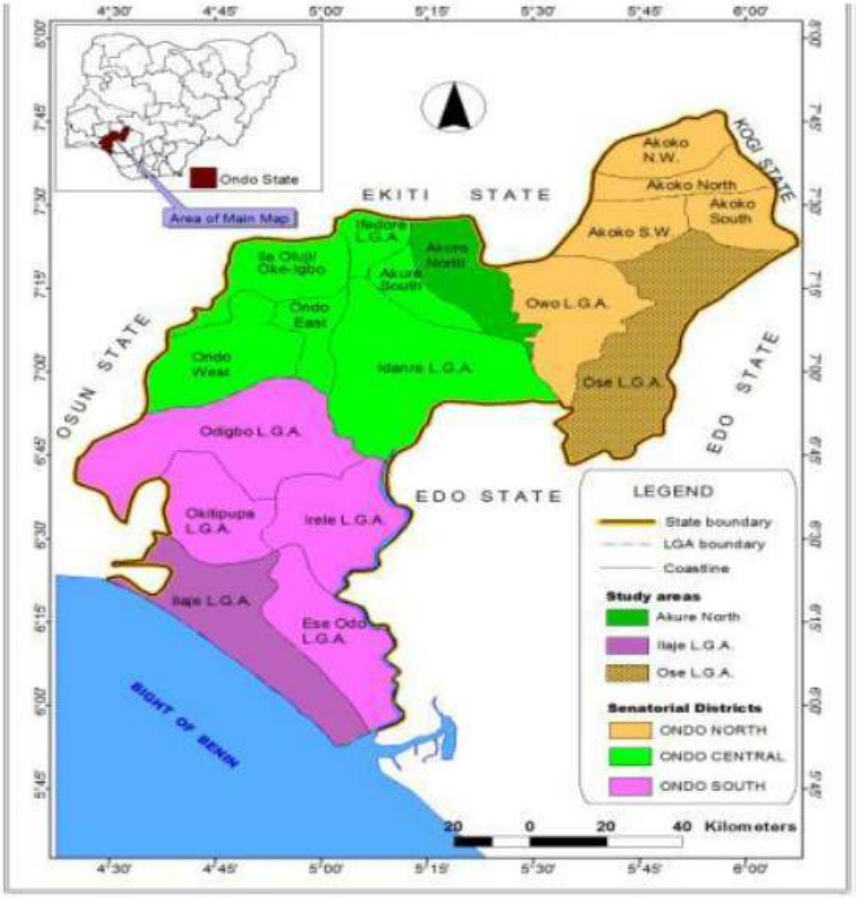

Fig. 1. Ondo state in the context of Nigeria
Source: Ondo State Ministry of Lands and Survey

scale up in health investment by the state in 2010 budget with per capita health expenditure of $12. The doctor/patient ratio in the state in 2016 was 1:14,000, as against 1:5,000 recommended by the World Health Organization (WHO)/global standard for the health sector. The total number of antenatal attendance recorded in the 18 general and state specialist hospitals was 115,299 in 2008, while the total Caesarean Section amounted to 3,875. The low maternal mortality rate and infant mortality rate was as a result of the awareness created among the women. A handset was given to each of them in case of emergency. The pregnant women got quick response before delivery became complicated. In addition, doctors are being discouraged from travelling abroad through provision of incentives and attractive remuneration.

In order to provide dedicated care for mother and child and to considerably reduce the delay in care provided at the health care service centres, which are identified in the state as being one of the contributing factors to maternal mortality, specialized health facilities are being constructed to reduce the perennial delay. These specialized health facilities are tagged “Mother and Child” Hospitals and are to be adequately equipped and appropriately staffed [14].

2. METHODOLOGY

The data collected for the study were from both primary and secondary sources. A multi-stage sampling technique was adopted to elicit information from the respondents. The 18 local government areas in Ondo State were segregated into three senatorial districts out of which three LGAs were randomly selected from each of the senatorial districts. With the aid of an interview guide, in-depth interviews were held with the chairmen of the three LGAs. Secondary data were also sourced from the Department of

Statistics, Ondo State Ministry of Finance and Budgeting. All data were analysed using descriptive statistics and trend analysis, while the qualitative data were content analysed.

3. RESULTS AND DISCUSSION

3.1 Sources of Health Care Funding

The source of health care finance in the three LGAs is shown in Table 1. Statutory fund allocation from the federation account and user charges were the main common sources of finance to Ose, Akure North and Ilaje LGAs for health care services, followed by voluntary organisations' health insurance and loans. It is clear from Table 1 that the sources of finance for health care were predominantly through government allocation and user's charge (these applied to all the LGAs). Ose and Akure North LGAs also sourced funds through donor contributions outside government allocation, Ose LGA also received donations from voluntary organisations and accessed micro-finance credit. While Ose LGA had the highest sources (5) of funding, Ilaje LGA had the least (2).

While Ose LGA utilized other funding channels, Akure North and Ilaje LGAs had a total reliance on the fund disbursement from the federation account. The implication of this is that, when the fund from the federation account is shared to all the sectors, the percentage share to the health sector is always inadequate, thus crippling the performance of the service providers. The poor health sector financing accounted for why there were complaints about shortage in the modern health care equipment by the users. The chairman of Ose LGA submitted that "in spite of other available funding sources, the target of effective health care delivery in terms of financing has not been met". The effect was a gradual transfer of the financial responsibility of the LGA to individuals and households, as indirect and major sources of health care financing [4].

The user charge policy has been introduced in all the LGAs and could be used as an alternative for health care financing. The user charge policy varied in amount and implementation across the study area with Ose LG being the most active in user charge implementation (Table 2). However, in spite of the policy, the government budgetary allocation seemed to be the major source of health care financing because even the user charges, in the LGAs were quite minimally low to depend on for effective service delivery. Again, the minimal user charge has inimical implication for the quality of care that will be required by the people. Table 2 captures the schedule of fees across the LGAs.

Policy for exemption has a significant effect on the accessibility of health care by the patients. This is owing to the status of utilisation of health care facilities. When the fund available to health care facilities increases, it brings a positive effect; but the effect is negative when poor patients are deterred from using services [15]. The results revealed that there existed a mechanism for exemption of certain groups from payment for medical services in Ondo State and the payment implementation varied from one LGA to another. In Akure North and Ilaje LGAs, children under five years and pregnant women were exempted from the payment for health care services. The exemption was practised differently in Ose LGA; it was for the extremely poor orphans. As found from the Accounting Department of Ilaje and Akure LGAs, the payment approach was discretional and funded through the internally generated revenue. By implication, the payment exemptions of the aforementioned groups would help in augmenting inadequate facility budget in the two LGAs. However, providing exemptions or discounts for the poor users could result in budget shortages, if there is no system for reimbursing those exempted or discounted costs [16].

The children exemption policy had a major impact on reinforcing the labour force and sustenance of community. It has been estimated that over 10 million children under five years of age died annually as a result of preventable diseases, while many sick children brought to see a health provider did not receive adequate assessment or treatment [17]. Increasing the groups access to health care service has a great implication for quality health care delivery, quality living and human development.

3.2 Problems of Health Care Funding in the Study Area

The study presents the result on budgetary allocation for the health care sector in the last fifteen years in the study area (Table 3). The table shows the amount of money allocated to health care delivery in the area, and what was eventually released yearly from 2005 to 2015. The budgetary allocations were quite low, in comparison to the ones in other developing

countries. There were yearly fluctuations in the amount of money released. While there was an increase from - ₦630,390,000 in 2005 to ₦798, 480, 000 in 2006, it plunged to ₦163, 470, 000 in 2009 (the lowest figure for the ten-year period). However, it rose sharply in 2012 to 3,272,500,000 (representing 2.18% of the total budget and the highest for the ten-year period) and fell again 600,000,000 in the year 2015.

With the level of funding by the state (as presented in Table 3), it was expected that the community should have a feel of improved health care delivery. However, it was observed that the allocations did not yield much impact on health care delivery in the state (see Table 3 and Fig. 2). Also, much of this money was spent on recurrent capital projects that had no direct impact on quality and effective health care delivery and sustainability.

The FGD result supported the fact that the programme of the health care delivery in Ondo state has not impacted on the general wellbeing of the people. This has affected the patronage of government health care facilities, because poor attention is given to them by the medical personnel. In 2006, it was estimated that the total cost of the strategies enumerated for improving access to quality health services would be 5 billion naira [18]. It was envisaged that funding for this component of the health programme would derive from government budgets and development partners' contributions. The total amount disbursed was far low compared with the average national standard. For instance, fifteen years of accumulated disbursement in Ondo state was 2.091 billion naira in 2009.

Furthermore, corruption could also be identified as a reason why the disbursed fund could not transform into meaningful health impact for the people. This was noted in the lack of transparency, as the sampled LGAs found it difficult to specifically state the amount committed to health care delivery in their respective LGAs. In a campaign for good urban governance in the LGAs, the problems identified were the influence of vested interests and cronies, whose financial dealings with local governments often went unreported [18]. In addition, the silence of the community on the issue, which reinforced the problem, and lack of transparency on the part of the state and federal governments set bad precedents for LGAs and had corrupting influence on vested groups.

Table 1. Sources of health care financing in three LGAs of Ondo state

L.G.A	*Govt. allocation*	*Users charges*	*Donor contributions*	*Voluntary organization*	*Health insurance*	*Loans*
Ose	1	1	1	1		1
Akure	1	1	1	2	2	2
Ilaje	1	1	2	2	2	2

Source: Authors' Fieldwork, 2010

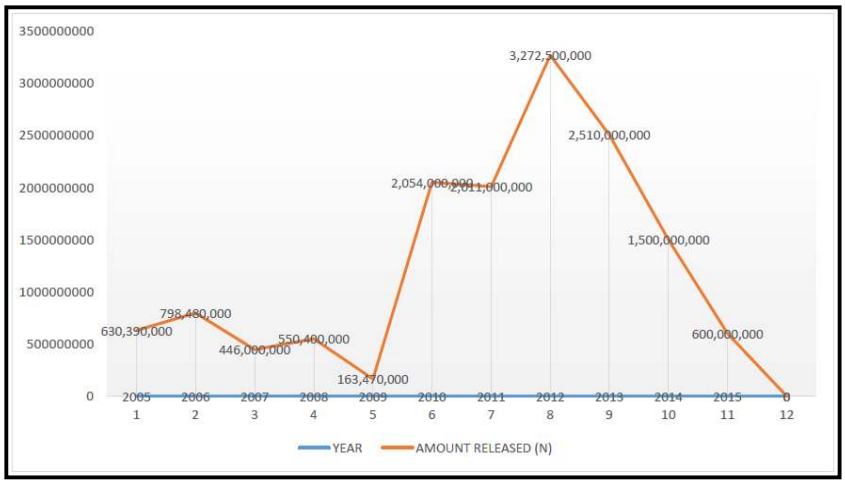

Fig. 2. Trend analysis of the budget estimate for health care finance in Ondo state 2005-2015
Source: Authors' Fieldwork, 2016

Table 2. User charge in Naira for health care services in the study area

LGA	*Card*	*Consultation*	*Investigation*	*Inpatient care*	*Drugs*	*Antenatal care*	*Family planning*	*Immunization*	*Outpatient care*
Ose	20–50	100	200-1000	500	Depends	100–150	100	Free	200
Akure	200	Depends	Depends	Depends	Not free	Free	Free	Free	
Ilaje	100	No response	Variable	No response	No response	300	No response	No response	Variable

Source: Authors' Fieldwork, 2010

Table 3. Budgetary allocation to health in Ondo state in 2005-2015

S/no	Year	Total budget (N)	Approved estimate on health (N)	Amount released (N)	% on total budget
1	2005	28,815,000,000	775,490,000	630,390,000	2.19
2	2006	38,299,000,000	891,007,000	798,480,000	2.08
3	2007	50,748,000,000	582,058,000	446,000,000	0.89
4	2008	80,771,000,000	980,120,000	550,400,000	0.68
5	2009	84,974,235,770	164,965,054	163,470,000	0.19
6	2010	124,371,513,000	4,818,000,000	2,054,000,000	1.65
7	2011	143,500,000,000	4,511,000,000	2,011,000,000	1.4
8	2012	150,000,000,000	8,272,000,000	3,272,500,000	2.18
9	2013	152,500,000,000	6,932,000,000	2,510,000,000	1.65
10	2014	168,000,000,000	4,400,000,000	1,500,000,000	0.89
11	2015	131,000,000,000	1,700,000,000	600,000,000	0.46

Source: Computation from the Ministry of Economic Planning and Budgeting, Ondo State, 2016

4. CONCLUSION AND RECOMMENDATION

The sources of health care financing in the three LGAs of Ondo State are government allocation, user charges, donor contributions, health insurance, voluntary organizations and loans. The funds available from the sources were inadequate, resulting in poor health care delivery. The major challenges of health care financing include, poor funding by government, high out-of-pocket payment, inadequate implementation of health care financing policy and corruption. The study revealed that the annual budgetary allocations and actual release were low, unstable and even dwindling. User charges were not effective. Based on the findings, the study recommended that there should be an increase in government funding of public health care, adequate implementation of health care policies, proper monitoring and evaluation of utilization of funds, to prevent corruption and mismanagement of limited funds. The state and local government need to discontinue government sponsorship of medical treatment of their personnel abroad and channel such funds towards local production of drugs and provision of medical equipment.

CONSENT

It is not applicable.

ETHICAL APPROVAL

It is not applicable.

COMPETING INTERESTS

Authors have declared that no competing interests exist.

REFERENCES

1. Yunusa U, Irinoye O, Suberu A, Garba A, M, Timothy G, Dalhatu A, Ahmed S. Trends and challenges of public health care financing system in Nigeria: The way forward. IOSR Journal of Economics and Finance. 2014;4(3):28-34.
2. The Nigerian Academy of Science Lagos; 2009.
3. World Bank. World Bank Development Report. Geneva: World Bank; 2010.
4. National Primary Healthcare Development Agency. The status of primary healthcare in Nigeria. Reports of the needs assessment survey. Abuja; 2001.
5. Federal Ministry of Health. Health sector reform programme: Strategic thrusts with a logical framework and a plan of action, 2004-2007. Abuja: Federal Ministry of Health Report; 2004.
6. UNICEF/FGN. Children's and Women's right in Nigeria: A wake-up call. Situation assessment and analysis, financing of health services. 2001;94-98.
7. Ibukun-Oluwa O. Health insurance: A viable approach to financing health care in Nigeria? Private initiatives for primary healthcare project. Nigeria Medical Journal; 1996.
8. Adinma ED, Adinma BDJ. Community based healthcare financing: An untapped option to a more effective healthcare funding in Nigeria. Niger Med J. 2010;51:95-100.
   Available:http://www.nigeriamedj.com/text.asp?2010/51/3/95/71010
   (Cited 2015 Sep 12)
9. Olaniyan O, Lawanson A. Health expenditure and health status in Northern and Southern Nigeria: A comparative analysis using NHA framework. Paper presented at the 2010 CSAE Conference held at St Catherine College, University of Oxford, Oxford, UK.
   Available:www.csae.ox.ac.uk/conferences/2010-EDiA/.../451-Lawanson
10. Onotai-Lucky O, Nwankwo NC. A review of the Nigerian health care funding system and how it compares to that of South Africa, Europe and America. J Med and Med Sci. 2012;3(4):226-231.
    Available:http://www.interesjournals.org/JMMS
11. Hyacinth E, Ichoku, Chijioke IO. Fiscal space for health financing in Nigeria. African Journal of Health Economics.
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12. Ondo state Ministry of Information and Culture; 1979.
13. World Bank. Annual Report; 2009.
14. Ondo State Government. Strategic health development plan 2010-2015. Akure: Ondo state bureau of statistics; 2010.
15. Kibaru. Facility level infrasturucture and resources and systems in Kenya service provision Assessment survey maternal and

child health family planning. ORC Matro Chalveton, Maryland USA; 2004.
16. KSPA, Kenya service provision assessment survey. Maternal and child health, family planning and sti Kenya national coordinating agency for population and development. Nairobi, Kenya; 2004.
17. WHO, world health organization on collaborations and partnership with commercial enterprise. Geneva; 1999.
18. Federal Ministry of Health Evaluation of health expenditures. A paper presented at the Health Budget Preparation and Expenditure and Revenue Monitoring Roundtable, Abuja; 2006.

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