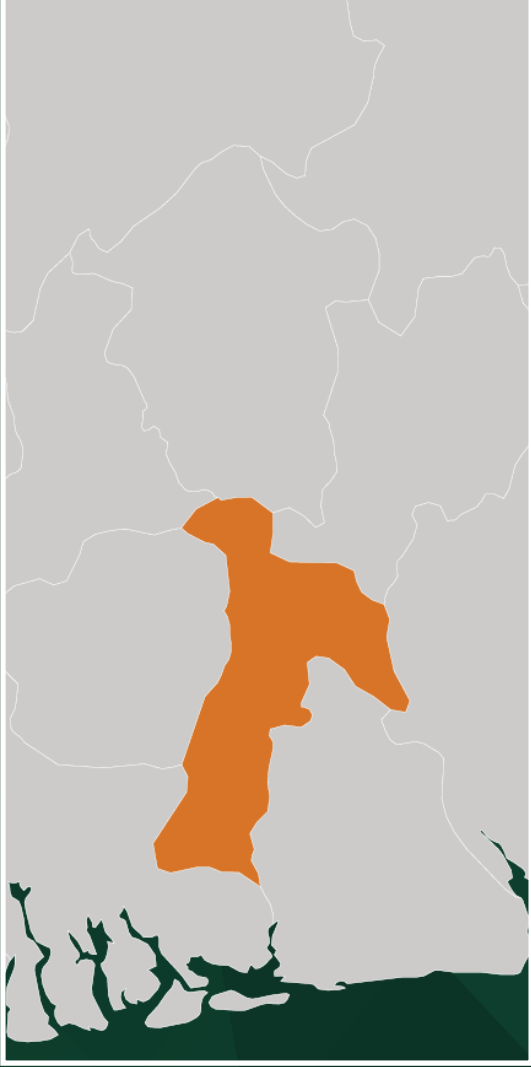


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HEALTH FINANCING LANDSCAPE: ABIA STATE, NIGERIA



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Abbreviations

AIDS	acquired immune deficiency syndrome
BHCPF	Basic Health Care Provision Fund
HIV	human immunodeficiency virus
HMB	Hospital Management Board
HP+	Health Policy Plus
LGA	local government area
LMIC	lower-middle-income country
NGN	Nigerian naira
ODA	official development assistance
SMOH	State Ministry of Health
USAID	U.S. Agency for International Development
WHO	World Health Organization

Introduction

Nigeria is challenged by a high burden of disease and an under-financed, under-performing health care system. The country's poor results on key health indicators are driven by underinvestment as well as inefficient management of limited available resources. Limited public investment in healthcare and insufficient financial protection from rising healthcare costs have made Nigerian households highly vulnerable to catastrophic and impoverishing health spending. Adequate, predictable, and sustainable healthcare financing is key to an effective, efficient, and equitable health system.

To improve health outcomes in Abia State, the state government has committed itself to progress toward achieving universal health coverage. It has embraced the health financing policy reforms introduced at the national level as a means to increase availability of resources needed to finance that progress toward universal health coverage.

It is globally recognized that along with increased government funding, improved efficiency of public spending on health, supplementing government health expenditures with private sector contributions to health, and reducing direct out-of-pocket health expenditures are important for achieving universal health coverage. This is true in Nigeria, particularly as state governments face challenges in increasing the budgetary space for health.

Improving health financing requires an understanding of the current landscape, a vision for the future landscape, and a strategy to evolve from one to the other. This report describes the health financing landscape in Abia State in 2019. It provides the basis for dialogue among health sector leaders and other state stakeholders as they establish a vision for the future landscape and develop strategies to bring about that vision.

Overview of Abia State Health System and Current Context

Abia State is in the southeastern region of Nigeria and consists of 17 local government areas (LGAs) and 292 political wards, with a population of 4.5 million people in 2019 (Abia State SBS, 2019). The Abia State Ministry of Health is responsible for healthcare policy and administration in the state. Through the local government health authorities, the Abia State Health Care Development Agency is responsible for issuing and implementing policies and guidelines for primary healthcare service delivery across the 17 LGAs. The Hospital Management Board oversees secondary healthcare provision. Other major public health entities in the state include the Abia State Health Insurance Agency and 11 health training institutions.

In Abia State, healthcare services are provided and accessed at primary, secondary, and tertiary health facilities. There are 1,496 healthcare facilities (1,245 public, 236 private, and 15 faith-based). Among these are 687 public primary health facilities, 236 private health facilities, and 33 hospitals. Healthcare-seeking behaviour in the state is influenced by a range of factors, including the severity of the illness, illness type, health literacy, educational status, income, and gender.

The *Nigeria National Health Accounts 2010-16* estimated that direct out-of-pocket payments by households make up 75 percent of total national health spending, while only 13 percent comes from federal, state, and local government (FMOH, 2017). Before this assessment of the Abia State health financing landscape, it was assumed but not documented

that the Abia State government and LGA governments within the state spend little on health relative to households.

Health indicators in Abia are quite poor relative to estimates from lower-middle-income countries (LMICs) in sub-Saharan Africa (Table 1).¹ The under-five mortality rate in Abia is estimated at 86 deaths per 1,000 live births, according to the *Nigeria Demographic and Health Survey 2018*, significantly worse than the sub-Saharan Africa LMIC average of 62 deaths per 1,000 live births. The proportion of reproductive-age women using modern contraceptive methods in Abia falls well below the sub-Saharan Africa LMIC average as well, at 13 and 37 percent, respectively.

Table 1. Abia State Service Delivery Quality Indicators

Indicators	Abia*	Sub-Saharan LMICs**
Under-five mortality rate, deaths per 1,000 live births	86	62
Modern contraceptive prevalence rate among women aged 15–49	13	37

*Source: NPC and ICF, 2019

**Source: WHO, 2020

In 2014, the National Health Act introduced the Basic Health Care Provision Fund (BHCPF). The Federal Consolidated Revenue Fund contributes 1 percent of its revenues to the BHCPF, which is then transferred to eligible states according to a formula, to support their respective primary healthcare development agency and state health insurance agencies. To receive installments from the BHCPF, benefitting states must set up primary healthcare development agencies and state health insurance agencies, contribute Nigerian naira (NGN) 100 million from the state government’s revenues, and fulfill other requirements as laid out in the *BHCPF Operations Manual*. The Abia State government has made progress toward BHCPF accreditation, including the establishment of the Abia State Health Insurance Agency and the training of ward development committee members and health facility staff on beneficiary enrollment, claims and financial management, and other operational capacity areas. As of this writing, the State Primary Health Care Development Agency has received NGN 512 million from the BHCPF.

Methodology

Health financing in Abia State is derived primarily from spending by government agencies, household spending, and spending by private entities. This section describes the methodologies used to identify and describe 2019 financing for the health system and services in the state by state government, LGA government, and out-of-pocket household expenditures. Resources did not permit the study team to collect data on other sources of health spending, including private sector contributions to health, off-budget official

¹ The sub-Saharan LMIC estimates were calculated by averaging national indicators from each of the 13 sub-Saharan LMICs classified as such by the World Bank (Angola, Cabo Verde, Cameroon, Democratic Republic of the Congo, Côte d’Ivoire, Eswatini, Ghana, Kenya, Lesotho, Mauritania, Nigeria, São Tome and Príncipe, and Zambia) as provided in the online World Health Organization Maternal, Newborn, and Child and Adolescent Health data portal.

development assistance (ODA) provided directly to the state, and federal and donor spending on medical goods procured centrally that are then transferred to the state.

State Public Expenditures: Refers to spending on health incurred by the state government. The components of state health spending are recurrent expenditures, which includes both personnel and overhead spending, and capital expenditures. Public expenditure on health is funded through the following sources:

- Federal-source revenue, or revenues transferred from the federal government to the state government and LGAs.
- State-source revenue, which includes internally generated revenue—income raised through taxes, fines, fees, and other sources—and loans from commercial banks.
- On-budget ODA. These are funds received from external donors but managed and spent by the state government.

LGA Public Expenditures: Refers to spending on health incurred by LGA governments within the state. LGA revenues derive from federal transfers and LGA-source revenue.

Out-of-Pocket Household Expenditures: Refers to spending on health incurred by individuals at the point of service, excluding contributions to pre-payment schemes.

To collect data on these sources the study team used the following methods:

- *Public Expenditure Review:* To estimate spending by government ministries, departments, and agencies.
- *Household Health Expenditure Survey:* To estimate out-of-pocket spending by households for health services and products. The Household Health Expenditure Survey collected data on household spending on preventive/promotive, outpatient, and inpatient care; care for chronic illness; and injuries.

Public Expenditure Review

The public expenditure review took a retrospective view of state government expenditures over a five-year period (2013–2017) with an emphasis on the health sector. The exercise involved collecting data on state population, state internally generated revenue, federal allocations, state budgets for health and other sectors, state budget performance, health service delivery indicators, and the level of on-budget ODA flowing to the state. The study team collected most of the public expenditure review data from Accountant General reports. A desk review of secondary documentation was conducted using open-source websites. Additional information and secondary materials were obtained from state health sector actors.

Key informant interviews were then conducted with a public expenditure core team consisting of state officials; the data acquired filled gaps in the secondary document review. Data were collated, cleaned, and entered into an Excel template for analysis. The core team then met in a workshop to validate findings.

Household Survey

The methodology adopted for the household survey was a population-based cross-sectional study of 630 households selected through a multistage cluster sampling approach. Data were

collected using a structured questionnaire administered by trained data collectors; heads of households were respondents.

The questionnaire was reviewed and approved by the Ethics Institutional Review Board of the state Ministry of Health. It elicited information on the household's assets and characteristics, out-of-pocket spending on healthcare goods and services, and willingness to pay for social health insurance. Using STATA 16, the team estimated household out-of-pocket expenditures on health and willingness to pay for health insurance for the state population. Weights were applied to out-of-pocket expenditures and willingness-to-pay values based on household sampling probability. To inform recommendations for improving Abia's health financing landscape, the team explored the distribution of out-of-pocket spending and willingness to pay for health insurance by household characteristics such as socioeconomic status and rural-urban classification.

Results from the Public Expenditure Review

The public expenditure review aims to describe the volume, sources, prioritization, and use of public resources for health. Through the public expenditure review, HP+ addressed the following questions:

- What is the total volume of state revenue in Abia State and what share of revenue comes from federal, state, and donor sources?
- What is the total volume of LGA revenue in the state and what share of revenue comes from federal and LGA sources?
- To what degree is the health budget prioritized in the state, as measured by the health budget as a share of the total budget?
- To what degree are health releases prioritized in the state, as measured by health releases as a share of total releases?
- How well is the health budget executed in the state, as measured by health releases as a share of the health budget?
- Which state health ministries, departments, and agencies does the state prioritize over others in the state health sector, as measured by spending on a given health ministry, department, or agency relative to spending on others?
- To what degree is health prioritized at the LGA level in the state, as measured by total LGA health expenditure as a share of total LGA revenue?

State Revenue

As seen in Figure 1, state revenue from the federal level (federal-source) and from the state level (state-source) varied over the 2013–2017 period. Because state revenue from the federal level (federal-source) makes up the majority of total state revenue, total revenue to the state are largely dependent on the national macroeconomic environment. Federal-source revenue declined in 2015 in response to the national recession, from NGN 64 billion to NGN 49 billion during 2014–2015. However, revenue from the federal government recovered quickly following the recession, as federal-source revenue in 2017 climbed to NGN 71 billion, NGN 7 billion higher than 2014 levels (NGN 64 billion).

Curiously, total state revenue actually increased from NGN 87 billion to NGN 105 billion over 2014–2015—the year prior to the national recession and the recession’s first year. This is because state-source revenue rose from NGN 23 billion to NGN 56 billion during this time, as Abia State qualified for a salary bailout loan provided by the federal government to states in 2015 to offset the decline in traditional federal-source financial support in the first year of the recession. The size of this bailout loan was considerable, as total loans to the state government in 2015 was NGN 43 billion as compared to the pre-recession amounts of NGN 6 to 8 billion.

Following the national recession in 2015–2016, state-source revenue doubled those in the pre-recession period, where state-source revenue was NGN 42 billion in 2017 and NGN 18 to 23 billion over 2013–2014. However, internal loans as a share of state-source revenue were much higher following the recession than during the pre-recession years of 2013-14, as shown in Figure 2. Internal loans nearly tripled in absolute terms between 2013-14 and 2017 (NGN 6 to 8 billion in 2013-14 versus NGN 18 billion in 2017) and rose from 31–34 percent to 44 percent of state-source revenue between the two periods as well. The implication is that nearly half of the revenue the state generates from its own sources is in the form of loans, which must eventually be repaid (Abia State AG, 2013-17).

Figure 1. State Revenue by Source (NGN Billions)

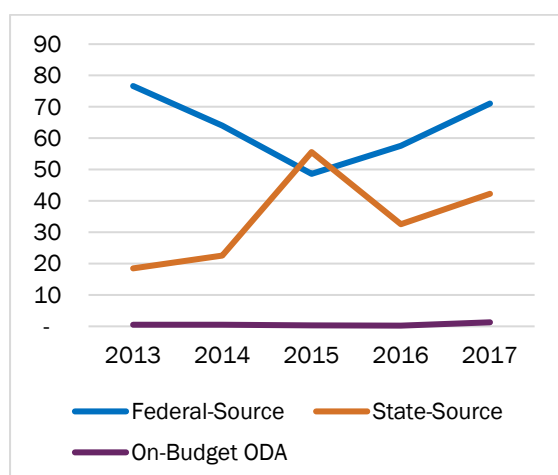
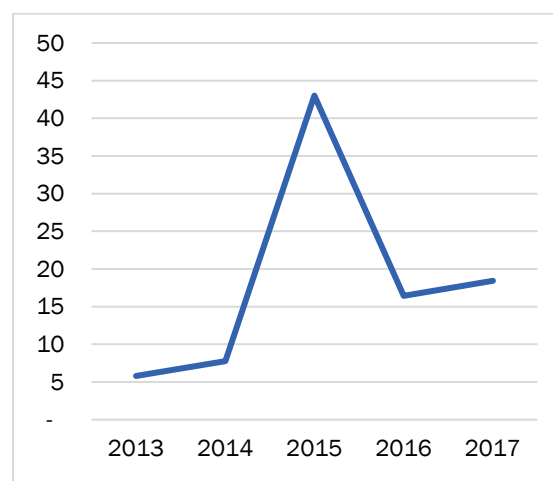


Figure 2. Internal Loans (NGN Billions)



State Budget Allocation and Expenditure

Abia State performs quite poorly against global health financing targets, as demonstrated in Table 2. The first global measure considered is general government health expenditure per capita, which in 2017 was NGN 1,397 (US\$5), just 5 percent of the globally recommended benchmark in 2017 of US\$89 (Abia State AG, 2013-17; Stenberg et al., 2017).² Second, global health financing experts recommend that to protect citizens from catastrophic health expenditures, general government health expenditure as a share of gross domestic product exceed 5 percent (McIntyre and Meheus, 2014). However, in 2017, Abia State government health spending as a proportion of state gross domestic product was only 0.3 percent. Finally, state government health spending as a share of total state government spending was just 5 percent in 2017, as compared to the Abuja Declaration target of 15 percent (WHO,

² The 2017 World Bank exchange rate of 305.79 was used to convert naira into U.S. dollars.

2001).³ Health prioritization in the state budget (the health budget as a share of the total budget) averaged 7 percent over the 2013–2014 period (Abia State AG, 2013-17).

Table 2. Abia State Performance on Global Health Financing Targets

Indicator	Abia State (2017)	Global Target
General Government Health Expenditure per Capita	NGN 1,397 (US\$5)	US\$89 (NGN 27,215) (Stenberg et al., 2017)
General Government Health Expenditure as a Percentage of Gross Domestic Product	0.3 percent	5 percent (McIntyre and Meheus, 2014)
State Government Health Spending as a Percentage of Total State Government Spending	5 percent	15 percent (Abuja Declaration [WHO, 2001])

The total state budget declined from NGN 115–137 billion in the pre-recession years of 2013–2014 to NGN 101–106 billion during the 2015–2016 recession. As depicted in Figure 3, the health budget decreased sharply in both absolute terms and as a share of the total state budget between 2014 and 2015, from 9 percent to 4 percent. Following the recession, the health budget increased by 70 percent over 2016–2017. This significant rise is largely driven by the massive increase in the state’s allocation to the State Primary Health Care Board of NGN 3.9 billion in 2017, as compared to previous levels (NGN 0.2 million or less).

Health prioritization in state expenditures remained fairly constant over 2013 and 2015–2017 (state health spending values could not be located for 2014), as shown in Figure 4. Despite the increased allocation for State Primary Health Care Board in 2017, there were no expenditures from this institution that year.

Figure 3. State Health Budget as a Share of Total State Budget

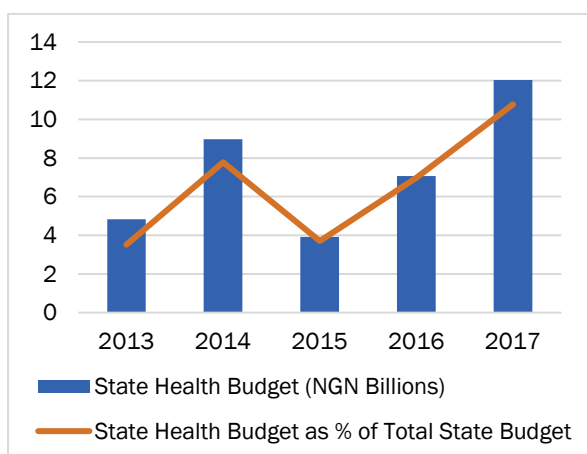
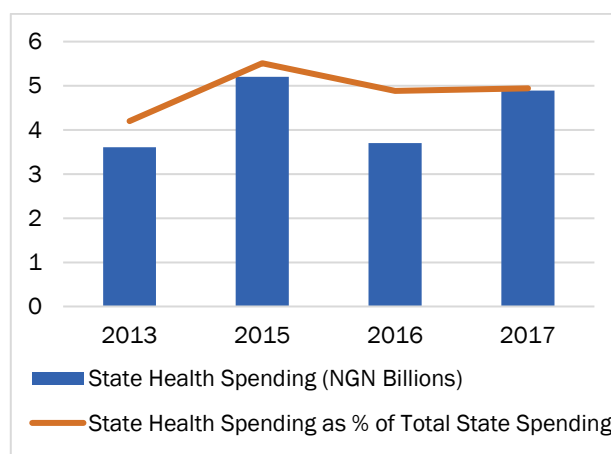


Figure 4. State Health Spending as a Share of Total State Spending



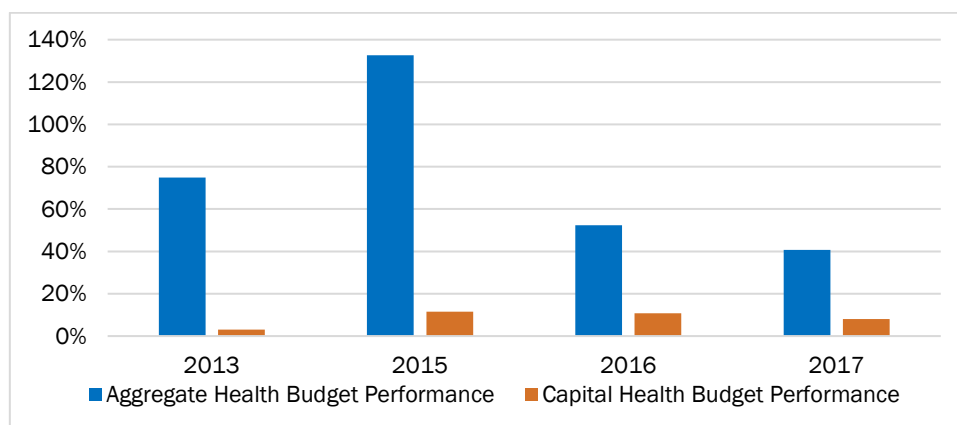
As can be seen in Figure 5, state health spending as a share of the state health budget (health budget performance) is quite poor. It was 75 percent in 2013 but fell to 52 percent in 2016 and further to 41 percent in 2017. The 2015 health budget performance of 133 percent was

³ The Abuja Declaration is a document signed by heads of state of African Union countries by which signatory countries committed to allocating at least 15 percent of their annual government budgets to health purposes.

largely influenced by the Abia State Teaching Hospital spending NGN 2.6 billion while having been allocated just NGN 0.3 billion in the state budget.

Capital health budget performance (capital expenditures on health as a share of the capital health budget) is particularly weak; it was below 12 percent over the period. There are a couple reasons for weak aggregate and capital health budget performance in the state. First, actual state revenue averaged 87 percent of the total state budget in these years, creating a bottleneck in funding for all state sectors. Second, budget release request memos sent by the state Ministry of Health to the governor’s office (the governor is in charge of approving releases from the state Treasury) lack evidence justifying the release of requested funds.

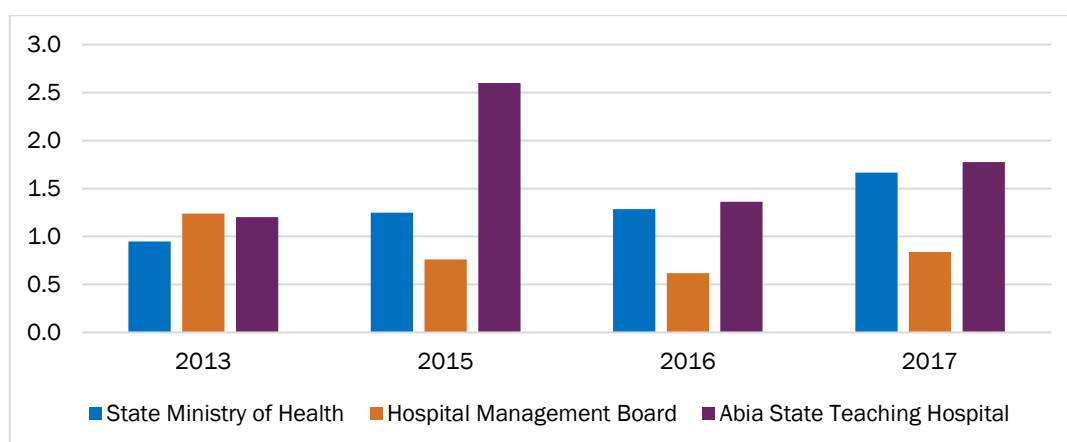
Figure 5. Health Budget Performance



During 2013 and 2015–2017, seven state government ministries, departments, and agencies made expenditures on health. The state Ministry of Health, Hospital Management Board, and Abia State Teaching Hospital were the top spenders over the period, as depicted in Figure 6. In 2013, Hospital Management Board spending was on par with the Ministry’s and Teaching Hospital’s expenditures, though it was deprioritized within state health sector spending in later years. Overall, total state health spending rose between 2016–2017, and all three of the top spending agents saw increases in their individual spending as well over 2016–2017. If this trend is maintained, it would have positive implications on state health spending at all levels of care (Abia State AG, 2013-17).

The other four with health spending—State Primary Health Care Board, the State Agency for the Control of AIDS, Specialist Hospital and Diagnostic Centre, and the Abia State College of Health Sciences and Management Technology—spent less than NGN 400 million on health in any given year. In 2013, Hospital Management Board spending was on par with the Ministry’s and Teaching Hospital’s expenditures, though it was deprioritized within state health sector spending in later years. Overall, total state health spending rose between 2016–2017, and all three of the top spending agents saw increases in their individual spending as well as during 2016–2017. If this trend is maintained, it would have positive implications on state health spending at all levels of care (Abia State AG, 2013-17).

Figure 6. State Government Health Spending by Top Spending Agents (NGN Billions)



Local Government Area Revenue and Health Expenditures

Local government area revenue is almost entirely composed of transfers from the federal level called federal allocations. Federal allocations to LGAs in Abia State amounted to NGN 30–35 billion annually before the recession (2013-14), dropped to NGN 21–22 billion during the recession, and experienced some post-recession recovery in 2017, when federal allocations were NGN 25 billion. The other source of LGA revenue is internally generated revenue, or income generated from entities within a given LGA. Internally generated revenue for the years analyzed are estimated at 3 percent of federal allocations to the LGAs or an average of approximately NGN 833 million (Abia State AG, 2013-17; NBS, 2013-17).

During the years analyzed, estimated annual health expenditures made by all Abia State LGAs averaged, with minimal fluctuation, approximately NGN 0.9 billion (MOLGC, 2019).⁴

Results from the Out-of-Pocket Health Expenditures Survey

At the national level, the most recent estimate shows that out-of-pocket spending by households comprises 75 percent of total health sector spending (FMOH, 2017).⁵ This figure places Nigeria's out-of-pocket health spending, as a proportion of total health spending, among the highest in the world. Government spending, meanwhile, accounts for only 13 percent of current health expenditures in the country according to these estimates. This leaves Nigerian households heavily exposed to the financial risk of unanticipated and catastrophic healthcare costs. Nigerian households spent nearly US\$98 per person in 2016 on health. If these resources were channeled into pre-payments, put into risk pools, and used more efficiently through strategic purchasing, households would be better protected from healthcare costs and simultaneously enjoy greater access to quality services.

⁴ Local government area health expenditure was estimated based on LGA spending nationwide (*National Health Accounts, 2010-16*) and the Abia State population as a share of the national population.

⁵ The figure included in the *National Health Accounts, 2010-16* report was derived by its authors as a projection from the 2009–2010 application of the Harmonized Nigeria Living Standards Survey; see the original *National Health Accounts, 2010-16* report for details on the projection methodology.

To quantify and characterize out-of-pocket spending on healthcare among Abia State residents, the team conducted a household survey. In-person interviews were conducted with heads of a representative sample of 630 households to obtain information needed to answer the following questions:

- What is the total amount of household spending on health in Abia State?
- What amount is spent per capita and per household on healthcare in Abia State?
- What proportion of out-of-pocket spending is spent on outpatient primary healthcare, inpatient hospital services, preventive and promotive services and products, care for chronic diseases, and care for injuries?
- What are the group differences in out-of-pocket spending for the following?
 - Females versus males
 - Different age groups
 - Rural versus urban residents
 - Different socioeconomic quintiles
- How equitable is out-of-pocket spending among the five socioeconomic quintiles?
- What proportion of out-of-pocket spending is spent in the public versus private sector?

Definitions of several terms will aid in understanding the results presented below.

Socioeconomic Status Quintiles. The 630 households interviewed for the Abia State sample were divided into five socioeconomic status quintiles. Quintile 1 is the poorest 20 percent of the households in the sample; Quintile 5 is the wealthiest 20 percent of households in the sample. To create these quintiles, an asset index score was generated for each household from information on household assets collected during the survey. Households were ranked from lowest to highest asset index score and the households with the lowest 20 percent of the scores were categorized as Quintile 1. Households with the next lowest 20 percent of scores were categorized as Quintile 2, and so on.

Average Spending. For the overall sample and for each subgroup defined above, average (mean) spending was calculated by summing reported weighted expenses across the entire state sample and dividing this total expenditure value by the total sample size. Average (mean) spending was calculated at the individual and the household levels.

Typical Spending. Total out-of-pocket spending across all households in the entire sample includes a few individuals with very high expenditures. This results in the average (mean) spending becoming skewed to a higher amount than what a “typical” person or household spends. In this sample, as in many surveys of out-of-pocket expenditures on healthcare, the difference between average (mean) spending and spending more typical of households (excluding the high-spending individuals) is large. To calculate “typical” spending for the sample and for each subgroup, the median of non-zero expenditure values was generated for each of five healthcare expense types (see a description of the five healthcare expense types below). This value was then multiplied by the number of individuals in the sample (or subgroup) with an expense (i.e., excluding those with zero out-of-pocket expense for that category) to generate a sample (or subgroup) total out-of-pocket spending for that healthcare expense type. This sample (or subgroup) total expense was divided by the total sample (or subgroup) size. The resulting value represents the “typical” per capita expense (essentially

correcting for the skewness in the average resulting from the high-spending cases in the sample).

Healthcare Expense Categories. Survey respondents were asked about five categories of healthcare utilization and expenditures:

- Outpatient care: care sought at a healthcare facility that did not require an overnight stay and was not related to a chronic disease (see definition of care for chronic diseases below), excluding care falling under the health promotion and prevention category
- Inpatient care: care that required an overnight stay or longer at a healthcare provider’s facility
- Care for chronic diseases: care for a long-term disease that often does not have a cure but that can be controlled or managed by procedures and/or medication
- Care for injuries: care for physical damage caused by falling, collision, or accidents
- Care for health promotion and prevention: care sought to reduce or eliminate chances that an individual will fall ill and/or to promote health and wellness in an individual

Rural and Urban. Each household was defined as urban or rural according to the rural-urban classification of the enumeration area in which the household is situated. The State Bureau of Statistics provided the list of enumeration areas and their respective rural-urban classifications.

Total Out-of-Pocket Expenditures on Healthcare in Abia State

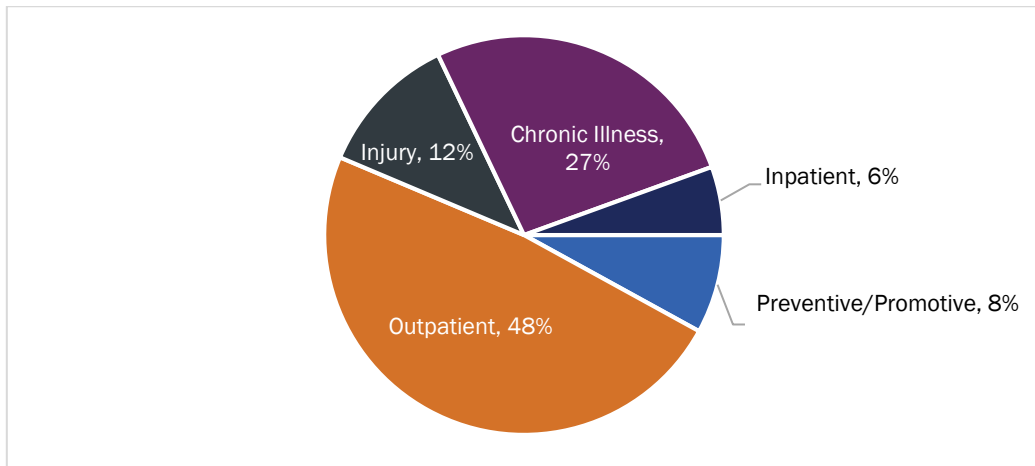
According to the results of the household survey conducted for this analysis, residents of Abia State spent a total of NGN 187.9 billion on healthcare services and products (Table 3). This averaged to NGN 41,877 per person, or NGN 145,839 per household. The NGN 187.9 billion figure is extraordinarily high compared to the NGN 5.7 billion spent on health by state and LGA governments.

Table 3. Sources of Healthcare Funding in Health Financing Landscape Analysis

Source of Healthcare Funds	Amount (NGN)
State Government Spending (2017)	4.9 billion
LGA Government Spending (2017)	0.8 billion
Out-of-Pocket Spending by Households (2019)	187.9 billion
Total Spending per Person by Households	41,877

Figure 7 shows the types of services on which households spent their money. Nearly half of all household spending was on outpatient care. Chronic illness alone accounted for about a quarter of out-of-pocket spending, while care for injuries, preventive/promotive services, and inpatient care together comprised the remaining quarter. Given the rising prevalence of chronic diseases (e.g., hypertension and diabetes) and that 27 percent of out-of-pocket spending is on chronic disease, it is important that state government contains the pace of this rise through preventive and promotive healthcare services and thereby contain out-of-pocket spending on curative care for chronic illness.

Figure 7. Out-of-Pocket Spending by Type of Healthcare Service Purchased in Abia State



Abia State households spent an estimated NGN 15.0 billion on inpatient care in 2019. Of this, 43 percent was spent at private providers. The implication is that households spent 57 percent of their inpatient care expenditures—the most expensive of all categories of care examined—at public providers. As mentioned earlier, the survey also examined the share of preventive/promotive care spending at public versus private providers. Fifty-four and forty-six percent of all preventive/promotive care expenditures were spent at private and public providers, respectively.

Mean and Typical Out-of-Pocket Expenditures on Healthcare and Intergroup Differences

In this section, HP+ examines the equity of out-of-pocket spending according to gender and age, socioeconomic status quintile, and place of residence (rural and urban).

Spending by Gender and Age Groups. Table 4 shows near parity in spending between females and males, either as measured by typical spending (removing the impact of high spenders) or by average spending (including the high spenders). On the measure of typical spending, gender parity was also observed among spending for non-elderly adults, though spending among females was significantly higher than among males on average spending. Among the non-elderly adults, this would be expected given reproductive healthcare needs among women in this age group. Among children, spending on females was higher than males on the typical measure but lower than males on the average measure. This indicates that, although there was high spending on a small group of male children, more was spent on the typical female child than the typical male child in the sample. Spending among adults age 50 and older was significantly higher on both the typical and the average spending measure compared to other age groups. On both typical and average measures, spending rises with age. This was true among females as well as among males.

Table 4. Typical and Average Spending by Gender and Age Group

Demographic Group	Gender	Typical Spending (NGN per Year)	Average Spending (NGN per Year)
Gender, all ages	Females	11,656	41,410
	Males	10,414	42,392
Children, age 0-14	Females	7,358	23,489
	Males	5,919	32,462
Adults age 15-49	Females	12,123	43,472
	Males	11,302	30,947
Adults age 50 and above		18,386	73,644

Spending by Residence. Table 5 compares spending among rural and urban residents. Rural residents spend significantly less than urban residents on the average spending measure, yet more than urban residents on the typical spending measure. Additional analysis would be required to determine why rural spending per capita is higher or lower than urban spending depending on the measure.

Table 5. Typical and Average Spending by Place of Residence

Residence	Typical Spending (NGN Per Year)	Average Spending (NGN Per Year)
Rural residents	11,541	30,780
Urban residents	9,392	56,355

Table 6 compares out-of-pocket spending among Abia State residents by socioeconomic status quintile. By both typical and average spending measures, the expected pattern of higher spending among better-off people is observed. Quintile spending as a share of total state out-of-pocket spending in the wealthiest quintile (Quintile 5) is double that in the poorest quintile (Quintile 1): 26 percent and 13 percent of out-of-pocket spending comes from the wealthiest and poorest quintiles, respectively. The same is true when comparing the second-wealthiest to the poorest quintile.

Table 6. Typical and Average Spending by Socioeconomic Status Quintile

Socioeconomic Status Quintile	Typical Spending per Capita (NGN per Year)	Average Spending per Capita (NGN per Year)	Percent of Total Out-of-Pocket Spending (per Capita)
Quintile 1 (poorest)	8,677	27,245	13%
Quintile 2	10,099	39,109	19%
Quintile 3	8,800	34,024	16%
Quintile 4	15,855	53,056	26%
Quintile 5 (wealthiest)	13,683	52,895	26%

Typical and Average Spending. In all subgroups, there is a large observed difference between typical and average spending. This difference demonstrates the impact of a small group of high spenders on the central tendency of spending. Both typical and average spending values need to be considered in policy discussions on health insurance. This survey was conducted in an environment in which very few (1 percent) of interviewed household heads (and by extension, their dependents) were enrolled in a health insurance risk pool. If the Abia State Health Insurance benefits packages are to be comprehensive (i.e., include all health services reported by this survey’s respondents) and are to be financially sustainable, premium levels would need to take into consideration the average (mean) spending levels shown in Table 6.⁶ Most households that typically spend much lower amounts, however, would not find these premium levels attractive. Moreover, the high premiums would likely be unaffordable for most households. If on the other hand, the premium levels were set based on the “typical” spending shown in the survey data, the health insurance scheme would not be financially self-sufficient, and would need additional resources to cover the gap. The state government could supplement the State Health Insurance Scheme’s resources through subsidies or a reduction in the benefits packages. Additional analysis of services that produced the high spending would need to be conducted and the benefits packages modified to exclude high-cost services in order for the insurance scheme to be financially viable.

Spending on Public versus Private Services and Products. This out-of-pocket health spending survey was designed to obtain information about the type of providers who were the source of reported services and products. However, survey respondents were asked about public versus private source only for services and products sought for inpatient care and for preventive/promotive care. Total spending on preventive/promotive and inpatient care was nearly evenly split between public and private sectors. In terms of episodes of inpatient care sought, there was an exactly even split in care sought from public versus private providers as well. For preventive/promotive care however, only 41 percent of episodes of care were sought at public providers as compared to the 59 percent of episodes sought at private providers, indicating that care from private providers is favored in the sample over care from public providers. However, there is a roughly even split in total preventive/promotive spending between the two provider types, but a slightly lower rate of care sought at public than private providers. This reflects a slightly higher out-of-pocket cost per episode at public providers for preventive/promotive care.

Implications of these out-of-pocket spending findings are examined in the next section, along with recommendations.

Recommendations for Improving the Health Financing Landscape

With the recent launch of the Abia State Health Insurance Agency and NGN 512 million mobilized through the Basic Healthcare Provision Fund to the State Primary Health Care Development Agency (as of December 2019), Abia State is at a turning point in its journey toward universal health coverage. This assessment of the state’s health financing landscape found that the state government spends very little on health relative to household expenditure. The high preponderance of out-of-pocket health expenditure as compared to state government health spending indicates that there is much to improve in the state’s

⁶ Premiums must be set to cover costs of services (as reflected in these survey data), plus an actuarially quantified amount to cover insurance plan administrative and management costs.

policy environment and public financial management systems to expand access to health services while protecting households from impoverishing health expenditures. The study team therefore offers several recommendations below.

Improve health prioritization in the state budget through enhanced evidence generation, better aligned budget proposals, and improved advocacy efforts. In 2013–2017, the Abia State health budget as a share of the total state budget averaged 7 percent, less than one-half of the Abuja Declaration target of 15 percent. One intervention health institutions should employ is to align activities in health budget proposals to mid-term priorities as laid out in the state’s Strategic Health Development Plans. Further, improvements in budget and expenditure tracking by health institutions will generate the evidence needed to strengthen institutions’ budget proposals with data on past financial performance. This evidence can be used to form advocacy arguments for the key decisionmakers in the state budget process. Advocacy efforts would be further amplified through forming an advocacy coordination team that develops a coherent advocacy strategy and that is aware of the political economy of the state, of the timing of critical advocacy windows, and of key influencers to engage.

Increase the proportion of the state capital health budget that is spent through improving the quality of budget release requests, enhancing advocacy efforts, and initiating intersectoral dialogue around broader public financial management reforms. There are two major reasons for the poor budget performance in the state: 1) insufficient reference to approved annual state Ministry of Health activities in the Ministry’s budget release memos to the governor’s office, and 2) annual projected revenue that chronically exceeds actual revenue. To address the first issue, the state should ensure that the release memos reflect approved activities, and ideally, refer to the prior financial performance of these activities. Following up with supplementary advocacy initiatives targeting the governor’s office, led by the advocacy coordination team described in the recommendation above, will also be essential to ensure the prompt and full release of funds to health institutions.

Public financial management reforms can address both issues on a sector-wide scale but developing and reaching a consensus on these reforms will require involvement from all state government sectors and not just health. Still, the state Ministry of Health, the Hospital Management Board, and the Abia State Teaching Hospital—the three highest-spending state government health institutions—can initiate an intersectoral dialog around which public financial management reforms would foster more realistic revenue projections as well as timelier and more complete budget releases for approved activities for all state sectors.

Expand Abia State Health Insurance Scheme informal sector enrollment, in part through developing an informal sector marketing strategy.⁷ The informal sector in Abia State represents roughly 92 percent of the total state population;⁸ for that reason, enrolling informal sector workers and their dependents would result in a significant conversion of direct out-of-pocket payments into pre-payments for risk pooling. Expanding the pool in this manner will lower premiums for all over time. The Abia State Health

⁷ In Abia State, the informal sector is generally viewed as those not employed by formal private sector entities or government institutions, in addition to these employees’ dependents.

⁸ This figure was estimated by subtracting the assumed size of the formal private and civil servant sectors, and their dependents, from the total state population.

Insurance Agency should consider the following measures to expand informal sector enrollment:

- Identifying healthcare needs and the ability to pay of different segments of the informal sector and revising premiums and offering subsidies where appropriate
- Assessing the capacity and interest of foundations and high-net-worth individuals to act as sponsors to expand informal sector enrollment
- Tailoring enrollment mechanisms to be more convenient for informal sector workers
- Ensuring quality services, especially as enrollment rises and utilization among enrollees increases
- Developing an informal sector marketing strategy outlining messaging to attract informal sector workers and measures to engage community mobilizers and health workers to deliver these messages to informal sector clients

Maximize access to services already in the Abia Health Insurance Scheme package that address chronic illness, preventive care, and child health. The out-of-pocket findings suggest that individuals are spending a considerable amount on chronic illness—representing 27 percent of Abia’s total out-of-pocket expenditures—while much less (8 percent) is being spent on preventive/promotive care. Chronic disease rates are expected to increase in Abia State and across Nigeria. By increasing access to preventive/promotive care, the state government can offset future curative spending on preventable diseases, whether from households or state government budgets—including curative spending on chronic illnesses. The potential for future curative spending on preventable diseases to be offset by increasing current access to preventive/promotive care is even greater for children. However, preventive/promotive care spending per capita is lower among children than among adults of reproductive age in Abia. Moreover, average spending on children for all types of healthcare expenses combined is lower than such spending on adults of reproductive age. This disparity in spending per capita suggests that children, whose health needs are greater than those among adults of reproductive age, are not being sufficiently addressed. Given these findings, the Abia State Health Insurance Agency should invest in removing barriers to covered services addressing chronic illness, preventive care, and child health. The Agency may consider ways to ensure purchase arrangements encourage quality, to make it easier to access care at the point of service, or to encourage enrollees to use these services.

Control the cost per episode of preventive/promotive care among public providers through expanding Abia State Health Insurance Scheme accreditation among providers. Earlier, HP+ found that the cost for each preventive/promotive care episode at public providers slightly exceeded that at private providers, which is surprising, as preventive/promotive care providers in the private sector are thought to charge patients more for a given preventive/promotive healthcare service than in the public sector. To drive down out-of-pocket payments for preventive/promotive care at public providers, the health sector should collaborate to increase the amount of facilities accredited for the scheme, as this would restrict these providers to offering preventive/promotive care at compulsory rates per scheme policies.

Regularly update health financing landscape output and adjust interventions accordingly. This landscape analysis only provides a one-year snapshot of health financing trends among the state government and households. It is intended to inform state government’s efforts to sustainably and equitably finance the health sector while making progress toward universal health coverage. Over the next couple of years, the Abia health

financing landscape will shift in response to rapid economic growth and the launch of health reforms mentioned throughout this report. The health sector would therefore benefit from regularly tracking trends in out-of-pocket payments, state health budgets, and other key indicators to ensure it remains on track toward its universal health coverage aims, as laid out in successive Strategic Health Development Plans and other health sector strategy documents.

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