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EFFECTIVENESS AND SUSTAINABILITY OF PUBLIC PRIMARY HEALTH CARE SERVICES FUNDING IN NIGERIA

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Abstract

The study investigated the financing of Primary health care services in Nigeria and compares the effectiveness of public health expenditure and Out-of-pocket health expenditure by individuals in Nigeria. Secondary data from World Bank Indicator on Public Health Expenditure as percent of total health expenditure, private Health Expenditure as percent of total health expenditure, Percentage of the Budget Allocation to Health Sector were used. Data were analysed using descriptive statistics- tables, percentage and charts. Findings show that Nigeria's out-of-pocket health care spending as a percentage of total healthcare expenditure increased from 72.5 in 2008 to 73.1 in 2022, while the consolidated public healthcare spending as a percentage of total health expenditure reduced from 22.5 in 2008 to 5.75 in 2022.With regards to poor funding of health in Nigeria, the study recommends increase in the annual allocation to health sector based on the United Nations benchmark and Abuja declaration 2001 benchmark of 15% of annual health budget.

Keywords: ***Primary Health Care, Out of Pocket, Alma Ata Declaration, Public health financing***

1 Introduction

Primary healthcare (PHC) system in Nigeria by its principle is designed to be the foundation of the country's health system. The PHC system is a product/outcome of World Health Organization conference- the Alma Ata Declaration 1978 and signed by 134 national Government members of the WHO. Following this 1978 health declaration, primary health care was perceived as a basic health services extension into the communities. It was envisaged to operate with the active involvement of community members in planning, delivery and evaluation of health services. This was in line with WHO prioritization of health as a human right based on the principles of equity and community participation. Hence, Primary Health Care was committed and supported by all member states of WHO as 'essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community can afford to maintain at every stage of their development in the spirit of self-reliance and self- determination', (Rifkin, 2018).

Activities to strengthen primary health care capacities and service aim to provide conditions under which people can maintain to be healthy, improve their health and wellbeing, or prevent the deterioration of their health. Many activities are targeted at populations include health campaigns, vaccinations, behavioural counselling, or health advice.

Therefore, primary Health care is a very important aspect of an individual's wellbeing, and since individuals make a nation, hence, primary healthcare could be regarded as one of the necessary conditions to achieving a sustainable long-term economic development. The issue of health is a very important because without good health it is almost impossible to carry out any economic activity and if at all there is any, it will certainly not be efficient, (Cremieux, Ouellette & Pilon 1999).

In the domestication of this WHO Alma Ata Declaration 1978 in Nigeria, the local governments in Nigeria oversee the operations of primary health care facilities within their geographic areas. This includes the provision of basic health services, community health, hygiene and sanitation, and families in the community through their full participation and maintain at every stage of their development in the spirit of self-reliance and self-determination. Its central function is to maintain sustainable good health and development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process. Therefore, Primary Health Care in Nigeria as conceptualized by the Alma Ata declaration of 1978 emphasized grass-root approach towards universal and equitable health care for all. The strategy is meant to address the main health problems in the community providing promotive, preventive, curative and rehabilitative services, (Olise, 2007).

According to Reem (2018), low government health spending over the last two decades has limited the expansion of highly cost-effective interventions, stunted health outcomes of Nigerian rural communities and thereby exposing large shares of the population to catastrophic health expenditures. Nigeria spends less on health than nearly every country in the world. In 2016, government health spending was 0.6 percent as a share of GDP or just $US11 per capita, (IMF, 2017). Funding for primary health care is specially affected as the bulk of spending occurs at the central level and is focused on tertiary and secondary hospitals. Coverage of promotive, preventive, and primary health care interventions is low with the universal health service coverage index, give to be just 39 percent, (Reem, 2018).

As a result of this poor commitment to Abuja Declaration 2001 which is a manifestation and expression of inadequate health spending at primary health care units, Nigeria significantly under performs on key health outcomes when compared with other countries, (Ajikobi, 2018). For instance, Nigeria health sector was ranked 187th among the 191 United Nations member states in 2000, (Reem, 2018). This situation did not improve as the World Health Organization (2007) ranked the Nigerian health system at 197 out of 200 countries surpassing only DRC, Central African Republic (CRA) and Myanmar. Similarly, Nigeria's life expectancy lags in comparison with countries such as Ghana, Ethiopia and Kenya. According to the World Bank data (2012), Nigeria's life expectancy is 52.11years while Ghana, Ethiopia and Kenya are 60.95 and 62.96 and 61.8 years respectively. Maternal mortality at 576 deaths per 100,000 live births is one of the highest in the world (2.6 times the global average). The narrative has not changed. In fact, according to Nwosu and Ataguba, (2019), the country sits with a very high maternal mortality ratio (814 per 100,000 live births with uncertainty interval ranging from 596 to 1180 maternal deaths per 100,000 live births) that is higher than the average for sub-Saharan Africa (765 per 100,000 live births). Hence, Nigeria was ranked seventh among the ten African countries where newborns have the highest risk of dying. Infant deaths in Nigeria account for a quarter of under-five mortality, such that one in eight children dies before reaching their fifth birthday, (Reem, 2018).

Based on the above argument, this study evaluates government health financing on PHC services in Nigeria; to ascertain the effectiveness and sustainability of PHC funding in Nigeria. This is necessary because, Nigeria still stands a chance of reversing the negative health outcomes indices by increasing public expenditure in primary health care system or losing out by not meeting up with the sustainable development goal 3 (SDG Goal 3).

1. Literature Review

This study is anchored on Wagner's theory of government spending expansion and Young Choice-Making Theory. According to Adolph Wagner (1835-1917), there is a long run propensity for the scope of government to increase with higher levels of economic development. Wagner view is invariant with the prevailing view then that the richer a country becomes the tendency of government roles on health, education, among others decline. Wagner predicted the expansion in cultural and welfare expenditures that as income rises, society would demand more education, health and equitable re-distribution of wealth (Wagner, 1890). This is because; public services like provision of good health care, drugs and health facilities through government

increased expenditure were seen as normal goods, (Peters, 2000; Nwanosike, Chukwuma, Nwanya, Ogbu, Reymond & Mbachu, 2022).

Wagner (1893) designed three focal bases for the increased in state expenditure. Firstly, during the industrialization process, public sector activity will replace private sector activity. State functions like administrative and protective functions will increase. Secondly, governments needed to provide cultural and welfare services like education, public health, old age pension or retirement insurance, food subsidy, natural disaster aid, environmental protection programs and other welfare functions. Thirdly, increased industrialization will bring out technological change and large firms that tend to monopolize. Governments will have to offset these effects by providing social and merit goods through budgetary means, (Nwanosike et al., 2015).

However, Choice-Making theory was propounded by Young in 1981 in his ethnographic studies titled '*Medical Choice in a Mexican Village'*. According to Young, an individual will utilize the treatment if they believe the treatment is effective and will not if otherwise. This model incorporates four components that are most essential to the individual's health service choice. They are; perceptions of gravity, the knowledge of a home treatment, the faith in remedy and the accessibility of treatment. Accessibility incorporates the individuals' evaluation of the cost of health services and the availability of those services, (Young, 1981).

In examining Nigeria's PHC system and possible causes of underperformance empirically, Kress, Su and Wang, (2016) used the Primary Health Care Performance Indicators conceptual framework including recent facility level information from the World Bank Service Delivery Indicators Survey. Results show that Nigeria has a relative abundance of PHC centres, reasonable geographic access to PHC, and relatively high health worker density. However, the performance of the PHC system is hindered by segmented supply chains; lack of financial access to PHC; lack of infrastructure, drugs, equipment, and vaccines at the facility level and poor health worker performance. Altogether, these factors reflect two overarching system-level challenges financing and governance that are key root causes of the dysfunctions observed in the PHC system in Nigeria. The study observed that Nigeria ranks low on nearly all PHC performance indicators when compared with peer African countries.

Despite the availability of PHC services as identified, by Kress Su and Wang, (2016), some rural dwellers in Nigeria tend to underuse the services due to perceptions of poor quality and inadequacy of available services (Sule et al., 2008). Various reasons can be adduced for the under use of the services provided: difficulties associated with

transportation and communications; high rates of illiteracy among rural peoples; traditional conservatism and resistance to ideas from outside; deep rooted traditions and customs, including health beliefs and practices, which increase the patronage of the services of traditional healers; lack of understanding of PHC among health professionals and decision-makers resulting in poor quality services; and health worker attitude to work (frequent abstinence from the work place (Adeyemo, 2005).

In trying to ascertain the how health expenditure influences health outcome and economic growth; how health outcomes influence economic growth, Ogunjimi and Adebayo (2019) examined the relationship among health expenditure, health outcomes and economic growth in Nigeria for the period between 1981 and 2017 using Toda-Yamamoto causality framework.

The results of the Toda-Yamamoto causality tests showed a unidirectional causality running from health expenditure to infant mortality while there is no causality between real GDP and infant mortality. The study recommended that the government should make concerted efforts geared towards increasing the health expenditure at least to meet up with the WHO‟s recommendation that all countries should allocate at least 13 per cent of their annual budget to the health sector for effective funding as this would bring desired health outcomes in Nigeria.

Similarly, Nwanosike et al., (2022) investigated Health expenditure and its resultant effect on health outcomes in Nigeria, the study observed that government expenditure on health for Nigeria as for 1990, 2000, 2017, 2018 2020, and 2021 are N658.1million, N202.8million, N304billion, N340billion, N547billion and N427billion respectively. In modelling the effect of health expenditure on health outcome in Nigeria, the study used multiple regression analysis approach to captures the dynamics of annual health expenditure, cash expenditure on health, health insurance and health tax on health outcome (proxy by life expectancy and infant mortality) within the nation, using data set from World Development Indicator (WDI) from 1985 to 2020. The study found that private health expenditure as the major determinants to steady state growth in health outcome in Nigeria. The study revealed that public health expenditure shows a negative relationship with infant mortality and life expectancy in Nigeria due to constrained healthcare financing. Following the finding of the study, therefore, government should endeavour that all the citizens benefit from health insurance irrespective status.

Onwujekwe, Mbachu, Ezenwaka, Arize and Ezumah, (2020) examined how healthcare providers respond to multiple funding flows and the implications of such flows for

achieving equity, efficiency, and quality. The study adopted cross-sectional qualitative data of selected healthcare providers and purchasers in Enugu state, four public hospitals were selected two tertiary and two secondary; because they received funding from more than one healthcare financing mechanism. Key informants were individual healthcare providers and decision-makers in the hospitals, State Ministry of Health, National Health Insurance Scheme and Health Maintenance Organizations. Service users from each hospital were purposively selected for focus group discussions (FGDs). A total of 66 key informant interviews and 8 FGDs were conducted. Findings from the study revealed that Out-of-pocket payment (OOP) and government budget were the only recurring forms of funding to all the public hospitals. The results also showed that multiple fund inflow led to predictability and stability of funding of public hospitals. This finding is similar to Nwanosike, Chukwuma, Ogbu, Nwanya, Mbachu and Reymond, (2022). The study concludes that limited funds flow to public hospitals constrains health care system. However, they could be detrimental to some patients that could be charged more for some services that other patients pay less and may also lead of provision of differential quality of services to different payments depending on the funding flows that are used to purchase services for them.

In summary, most of the study investigated the effect of public health expenditure on health outcomes in Nigeria, without narrowing it down the effect of public health expenditure on primary health care which is the fundamentals of health care system according to World Health Organization, see Onwujekwe, et al, (2020), Nwanosike et al., (2022), Kress Su and Wang, (2016), among others. This study therefore investigated effect of public health expenditure on maternal and infant health with emphasis on the roles of PHC system in Nigeria.

2. Materials and Method

The study adopted ex-port facto research design using secondary data from Central Bank of Nigeria statistical bulletin and World Bank Indicator to analysis the effectiveness of government health financing on Primary Health Care services in Nigeria. The theoretical framework adopted for this study is that of Wagner's theory of government spending expansion, (Wagner, 1890). This is because; public services like provision of good health care, drugs and health facilities through government increased expenditure were seen as normal goods as in line with Wagner's theory. The study collected data on Public Health Expenditure as percent of total health expenditure, private Health Expenditure as percent of total health expenditure, Percentage of the Budget Allocation to Health Sector, medical disposables and vaccines supply in primary health care across the six geopolitical zones between

2008-2022. The study analysed the collected data using descriptive statistics such as tables, graphs and bar charts. This is the best to illustrate the effectiveness of government health financing on PHC services in Nigeria, as against regression analysis previous studies used which could not proxy the effective of government financing on primary health care in Nigeria.

3. Results and Discussion

Health can be sustainably financed by increasing the fiscal space for health and expanding the revenue streams earmarked for health. There's need to discuss effectiveness of primary health care financing in terms of its contribution to growth in GDP (gross domestic product), Public Health Expenditure (% of Total Health Expenditure), Out-Of-Pocket (%of Total Health Expenditure), among others. See table 1 as measure effectiveness of PHC financing using Health care Expenditure trend in Nigeria for details.

Table 1: Measuring effectiveness of PHC financing using Health care Expenditure trend in Nigeria

Variable/Year	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Public HE (% of THE)	22.5	18.4	13.7	14.5	16.4	14.4	13.4	16.5	14.5	3.75	3.09	2.99	3.38	5.43	5.75
Private HE (% of THE)	74.5	77.6	79.9	77.5	75.2	73.1	74.5	73.6	76.7	75.4	72.6	70.5	75.45	73.62	72.54
OOP (% of THE)	72.5	75.6	77.6	75.2	73.6	71.4	72.2	72.2	75.2	77.2	76.6	74.2	73.5	72.8	73.1
HE per Capita (Current US$	81.4	67.9	76.1	83.9	91.6	102	107	97.5	79.3	73	66	70	70	71.2	73.5
OOP Exp. Per Capita (Current US$	59.1	51.4	59	63.1	67.4	72.7	77.5	70.3	59.7	68.6	70.3	75.7	79.8	78.5	78.7
Private HE (% of GDP)	2.5	2.9	2.6	2.5	2.3	2.8	2.8	2.8	2.5	3.6	3.1	3.0	3.4	3.2	3.3
Public HE (% of GDP)	1.5	1.3	0.9	1.2	1.2	0.9	0.9	0.9	0.9	0.7	0.7	0.8	08	0.9	0.8
THE total (% of GDP)	3.7	3.5	3.3	3.3	3.3	3.4	3.3	3.6	3.6	3.75	3.09	2.99	3.38	3.51	3.42

Source: The Researchers compilation (2025)

Table 1, reveals the health care expenditure trend in Nigeria which is used as indices to evaluate the effectiveness of primary health care financing in Nigeria. This table reported that Nigeria's out-of-pocket health care spending as a percentage of total healthcare expenditure (THE) has been fluctuating. It increased from 72.5 in 2008 to 73.1 in 2022, with a maximum value of 77.7 in 2010 and minimum value of 71.4 1n 2013. Similarly, consolidated public healthcare spending as percentage of total health expenditure (THE) reduced from 22.5 in 2008 to 5.75 in 2022. It recorded the highest value (22.5) in 2008 and the lowest value (2.99) in 2019. Furthermore, total health expenditure (THE) as percentage of Gross Domestic Product (GDP) has fluctuated between 2.99 and 3.75, its maximum value (3.75) was recorded in 2017 but as at

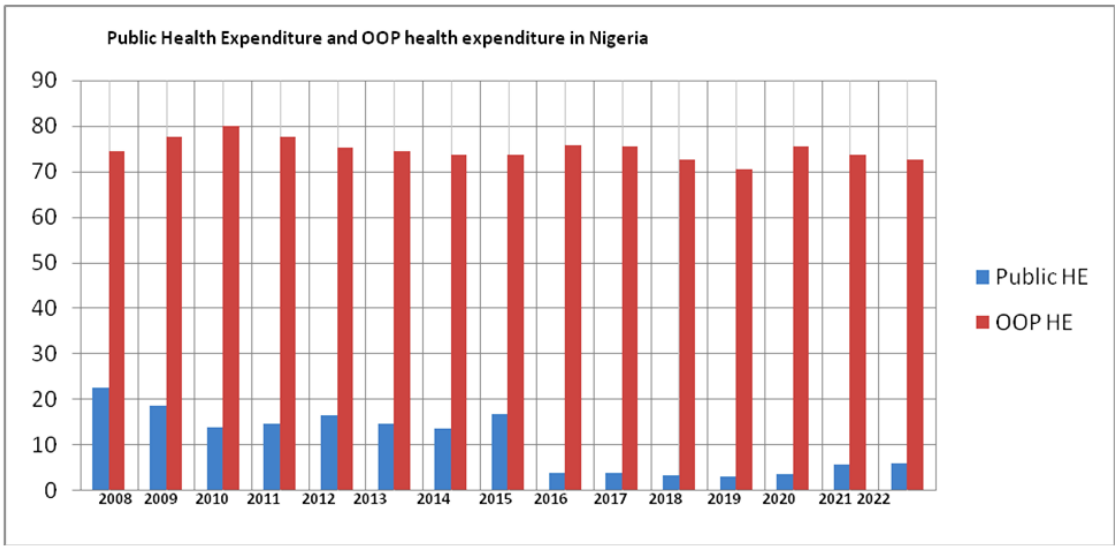
2022, it reduced to 3.42. Private health expenditure (household Out-Of-Pocket plus private expenditure) as percentage of GDP has fluctuated between 2.5 in 2008 and 3.3 in 2022. It recorded maximum level of 3.6 in 2017 and minimum of 2.3 in 2012. Public health expenditure as percentage of GDP was not encouraging, it fluctuated between 1.5 in 2008 and 0.8 in 2022, with a maximum value (1.5) recorded in 2008 and minimum value (0.7) recorded in 2017 and 2018.Though the total healthcare expenditure as a share of GDP has fluctuated substantially in recent years, it tended to decrease through 2008-2022 period ending at 3.42% in 2022.

The analysis above shows that governments at all levels are not making enough investment in the health of the people which is supposed to be a national priority. This result finding is similar to previous findings. For instance, Aregbeshola and Khan (2010), noted that there is high reliance on out-of-pocket (OOP) health payments as a means of financing health system in Nigeria. World Health Organization (2005) observed that the catastrophic OOP continued for many years in spite of a general consensus to move closer to universal health coverage (UHC) and sustain it when achieved. Oyefabi, Aliyu and Idris (2014) also noted that significant number of people in Nigeria footed their health bills based on user-charges. This can be further demonstrated using chart on percentage of the budget allocation to health sector in Nigeria.

This shows that since Nigeria signed the Abuja declaration in 2001, she has not been able to meet up with the target even for one fiscal year. This Inadequate finance of health sector (primary health care) and overdependence of the LGA on federal, state and international agencies for support, because of the meagre internally generated revenue of the LGA posed a problem to a sustainable the healthcare services in Nigeria. The budget allocation on health has been low and inadequate compare to World Health Organizations recommendations and Abuja declaration 2001 requirement. The implication is high maternal and infant mortality rate.

This could be attributed to the fact that budget allocations to the health sector and primary health care to be specific are not based on evidence of demographic considerations or epidemiological factors such as disease burden. As a result of this, government funding for health is grossly inadequate. This is not different when compared with public health expenditure and Out-of-pocket health expenditure in Nigeria. See Fig 2 for details.

Fig 2: Public health expenditure and Out-of-pocket health expenditure in Nigeria.



Source: The researchers' computation 2025

Fig 2 reveals the existence of a very huge gap between public health expenditure and out-of-pocket expenditure in Nigeria. This means that the government is not investing much on health. The over-reliance on user fees as a major source of financing health care in Nigeria is inequitable as majority of those who pay out-of-pocket for health services are taxed to provide health services for the rich who can afford health care. This is evidence in the persistent fall in public health expenditure in Nigeria over the years as against steady increase in out-of-pocket health expenditure. For instance, public health expenditure in 2022 was 5.75 per cent as percentage of total expenditure on health, compared to 72.54 percent from private health expenditure. This implies that most Nigerians are made poor due to the cost of illness which is more than the cost of treatment. This figure 2 really depicts poor and ineffective financing of PHC in Nigeria over time by the government. As such, it is difficult to maintain a sustainable good health condition by individuals without effective financing of primary health care system through public health expenditure.

Following the findings above, it means that the quality of health care financed from government budget was sub-optimal in primary health care system in Nigeria in terms of budget allocation, infrastructure, availability of drugs and medical disposables. The further revealed that there is no clear evidence that financial resources are fairly distributed across PHC facilities in the geographic regions in the country considering their differential variations levels with regards to availability of some medical disposables, drugs and vaccines in primary health care facilities.

There is a need for political actors and policy-makers to design health system financing policies that will provide financial risk protection to households. Government should improve and implement free or subsidized health services and facilities especially on vaccines to improve health outcomes. This will enable the poor to benefit as much as the better-off groups (the political class and the middle-income class), from the public subsidies in health. The prevalence of large-scale health problems (such as high infant mortality rate and low life expectancy) are as a result of the scarce health resources and infrastructure.

4. Summary of Research Findings

This study also reported that Nigeria's out-of-pocket health care spending as a percentage of total healthcare expenditure (THE) increased from 72.5 in 2008 to 75.2 in 2016, while the consolidated public healthcare spending as a percentage of total health expenditure (THE) reduced from 22.5 in 2008 to 13.0 in 2016. This over-reliance on out-of-pocket (OOP) health payments as a means of financing health system in Nigeria posed a problem to sustainability of the healthcare services in Nigeria. Furthermore, it is being revealed that the budget allocation on health has been low and inadequate compare to World Health Organizations recommendations and Abuja declaration 2001 requirement, as such, a big challenge to sustainable primary healthcare services in Nigeria.

5. Conclusion

Based on the findings of the study, it is concluded that public health expenditure in Nigeria is low, poorly managed with wide locational differences. This has impacted in the quality of infrastructure, personnel, services and access. As it were, the larger proportion of the citizens still rely on out-of-pocket expenditure in meeting their health care needs.

6. Recommendations

Government should ensure full health policy formulation and implementation by states and LGAs nationwide. There is need to ensure an effective health management information system and a communication strategy for mobilizing and sustaining the Health System Reform Programme. This is because; proper implementation of primary health care expenditure especially on maternal and infant health is a necessary condition for enhancing health outcomes and reduction of maternal and infant mortality in Nigeria. In other words, quality health outcomes will eventually lead to skilful, efficient and effective labour force.

With regards to effect of out-of-pocket health expenditure on households, the study recommends a shift from out-of-pocket health payments to prepayment mechanism of health insurance or a subsidized healthcare system as this is the key to reducing financial catastrophe. Otherwise, it would be difficult to improve the performance of the Nigerian health system. The NHIS should be expanded to cover more of those in the rural areas and the poor and then subsequently 100% of the Nigerian population in line with WHO (2010) declaration. As such, Community based health insurance should also be strengthened to provide the necessary risk protection to these vulnerable groups. With regards to poor funding of health in Nigeria, the study recommends increase in the annual allocation to health sector based on the United Nations benchmark and Abuja declaration 2001 benchmark.

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