HEALTH FINANCING LANDSCAPE:
EBONYI STATE, NIGERIA
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Health Financing Landscape: Ebonyi State, Nigeria

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# Abbreviations

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<th>Full Form</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>acquired immune deficiency syndrome</td>
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<tr>
<td>BHCPF</td>
<td>Basic Health Care Provision Fund</td>
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<td>EBSPHCDA</td>
<td>Ebonyi State Primary Health Care Development Agency</td>
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<td>EBSHIA</td>
<td>Ebonyi State Health Insurance Agency</td>
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<td>HIV</td>
<td>human immunodeficiency virus</td>
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<td>HP+</td>
<td>Health Policy Plus</td>
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<tr>
<td>LGA</td>
<td>local government area</td>
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<td>LMIC</td>
<td>lower-middle income country</td>
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<td>NGN</td>
<td>Nigerian naira</td>
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<td>NHIS</td>
<td>National Health Insurance Scheme</td>
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<td>ODA</td>
<td>official development assistance</td>
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<td>NPHCDA</td>
<td>National Primary Healthcare Development Agency</td>
</tr>
<tr>
<td>SHIS</td>
<td>State Health Insurance Scheme</td>
</tr>
<tr>
<td>TSA</td>
<td>Treasury Single Account</td>
</tr>
<tr>
<td>USAID</td>
<td>U.S. Agency for International Development</td>
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<td>WHO</td>
<td>World Health Organization</td>
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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 health care financing is key to an effective, efficient and equitable health system.

To improve health outcomes in Ebonyi 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 Ebonyi 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 Ebonyi State Health System and Current Context

Ebonyi State is in the southeastern region of Nigeria and consists of 13 local government areas (LGAs), 171 political wards, and 275 health wards with a population of 3,132,827 in 2019. The federal government is responsible for the management of the Federal Teaching Hospital and the National Obstetrics Fistula Centre in Abakaliki. Ebonyi State government has the responsibility for secondary healthcare in its jurisdiction. It shares responsibility with local government—through the Ebonyi State Primary Health Care Development Agency (EBSPHCDA)—for primary health centers and health posts. The state Ministry of Health is responsible for policy making, planning, and implementation of health programs in accordance with the National Health Policy. The Ministry, through the Hospital Management Board, provides secondary healthcare services.

Health service delivery in Ebonyi State is structured into three tiers, with primary health care at the base, supported by secondary and tertiary healthcare services. There are 604 healthcare facilities (491 public and 113 private). Of these, 548 are primary healthcare facilities, 54 are secondary, and two are tertiary. Reproductive, maternal, newborn, child, and adolescent health services, as well as nutrition and other services are provided by these facilities. A variety of preventive and treatment services for malaria, tuberculosis, and HIV/AIDS is provided at all the primary health facilities in the state, depending on the classification of the health facility. Preventive education services for non-communicable

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diseases such as diabetes and hypertension are generally provided in all health facilities. Mental health services are available in the Ivo LGA.

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 (FMNH, 2017). Before this assessment of the Ebonyi State health financing landscape, it was assumed but not documented that the Ebonyi State government and LGA governments within the state spend little on health relative to households.

Ebonyi’s healthcare system is hampered by low institutional capacity and structural weaknesses. There are inadequate human resources for health, mostly as a result of a subpar salary structure and a continuous embargo on hiring new employees. The health management information system, needed to document and track health data, is weak. Ebonyi’s primary healthcare facilities, often the first point of contact for residents seeking care, are in poor shape and lack basic equipment needed to provide quality services. Inefficiencies in drug distribution to facilities in the state lead to wastage due to expired drugs and sometimes to a lack of essential drugs at facilities.

All of these contribute greatly to poor health indices in the state, as a result of increased financial barriers to accessing care and substandard quality of health care services in health facilities, which then in turn cause underutilization of health services leading to poor health outcomes.

Health indicators in Ebonyi are poor relative to estimates from lower-middle income countries (LMICs) in sub-Saharan Africa (Table 1). The under-five mortality rate in Ebonyi State is estimated at 91 deaths per 1,000 live births, according to the *Nigeria Demographic and Health Survey 2018*, significantly worse than the sub-Saharan Africa lower-middle income country average of 62 deaths per 1,000 live births. The proportion of reproductive-age women using modern contraceptive methods in Ebonyi State falls well below the sub-Saharan Africa lower-middle income country average as well, at 6 and 37 percent, respectively.

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Ebonyi*</th>
<th>SSA LMICs**</th>
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<tbody>
<tr>
<td>Under-five mortality rate, deaths per 1,000 live births</td>
<td>91</td>
<td>62</td>
</tr>
<tr>
<td>Modern contraceptive prevalence rate among women aged 15-49</td>
<td>6</td>
<td>37</td>
</tr>
</tbody>
</table>

*Source: NPC and ICF, 2019
**Source: WHO, 2020

*The sub-Saharan lower-middle income country estimates were calculated by averaging national indicators from each of the 13 sub-Saharan lower-middle income countries classified as such by the World Bank (Angola, Cabo Verde, Cameroon, Republic of Congo, Côte d’Ivoire, Eswatini, Ghana, Kenya, Lesotho, Mauritania, Nigeria, São Tome and Principe, and Zambia) as provided in the online World Health Organization Maternal, Newborn, and Child and Adolescent Health data portal. The data portal indicators are from 2018. The Ebonyi-level indicators are from the Nigeria Demographic and Health Survey 2018 (NPC and ICF, 2019).*
The Ebonyi State government has taken several steps toward mobilizing resources for health by aligning with current national health financing reforms in Nigeria. These include:

- Ebonyi State has made giant strides in establishing the State Health Insurance Scheme (SHIS). The National Council on Health has agreed to decentralize the National Health Insurance Scheme (NHIS) to states to allow autonomy and contextualization to state-specific needs. The scheme calls for mandatory enrollment of the entire state population. The Ebonyi State Health Insurance Agency (EBSHIA) has been established and an executive secretary appointed. Staff have also been deployed to the agency and financial support has been provided by the state government for equipment and office space. Technical support has been provided by donor partners to ensure the state can carry out enrollment and provide services through this mechanism. EBSHIA has distributed enrolment forms and ID cards to accredited facilities, but as of December 2019, enrollment in the Ebonyi Health Insurance Scheme enrolment had not yet begun.

- In 2017, the federal government launched the Primary Health Care Revitalization Scheme to support Basic Healthcare Provision Fund (BHCPF) implementation. The Scheme aims to ensure that at least one facility in each political ward is revamped to meet minimum facility structural standards while the BHCPF aims to provide a free basic minimum package of services (antenatal and postnatal care, malaria services, screening for diabetes, etc.) to all residents. 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. The capacity of health facilities staff and ward development committees have been strengthened to implement the BHCPF and the state government has begun to renovate at least one facility per political ward to ensure the state gains access to the fund. Facilities were supported by the EBSPHCDA with technical guidance from HP+ to develop quality improvement plans and a costed business process manual.

- Ebonyi State has deposited Nigerian naira (NGN) 100 million of its own revenues into the state’s Treasury Single Account (TSA) to provide additional support to EBSHIA and EBSPHCDA. Revenues deposited into the TSA are legally required to then be released to the EBSHIA and EBSCPHDA. As at December 2019, the National Primary Healthcare Development Agency (NPHCDA) and NHIS has transferred NGN 207 million and NGN 230 million respectively to EBSHIA and EBSPHCDA. The final step is a transfer of funds to selected facilities to enable them to begin to provide services.

- The Primary Health Care Under One Roof policy requires that administrative and monitoring functions be put under one agency. This approach is designed to enhance efficiency and ensure proper monitoring and oversight of primary healthcare activities in the state. Ebonyi State had yet to fully embrace this policy, as salaries were still being paid at the LGA level. However, the EBSPHCDA has worked to improve the institutional structure of the agency and advocate for the creation of local government health authorities in each LGA.
Methodology

Health financing in Ebonyi 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 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:** 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 official development assistance. These are funds received from external donors but managed and spent by the state government.

**LGA Public Expenditures:** 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:** 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 official development assistance flowing to the state. The study team collected most of the public expenditure review data from annual budget planning, monitoring, and research reports from the Ebonyi State Ministry of Budget and annual Auditor 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; 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 half-day workshop to validate findings and explain factors contributing to unusual trends in state revenues, budgeting, and spending. Validation was done in conjunction with state officials.

**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 Ebonyi’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, we addressed the following questions:

- What is the total volume of state revenues in Ebonyi State and what share of revenues come from federal, state, and donor sources?
- What is the total volume of LGA revenues in the state and what share of revenues come 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 expenditures as a share of total LGA revenues?
State Revenue

In aggregate, state revenues in Ebonyi State averaged NGN 52 billion annually over 2013-17. During this time, the state experienced a period of slow economic development and struggled with inefficiencies in state tax collection. As a result, revenues collected from state-level sources (state-source revenue) were quite low; state-source revenues as a share of total state revenues averaged 23 percent annually over the period (Figure 1).

Because state revenues from the federal level (federal-source) revenues make up most of total state revenues, total revenues to the state are largely dependent on the national macroeconomic environment. Total state revenues were therefore lowest during the national recession years of 2015-16, at NGN 35-37 billion (Figure 2).

![Figure 1. State Revenues by Source (%)](image)

Figure 1. State Revenues by Source (%)

Finally, on-budget official development assistance as a share of total state revenues averaged just 1 percent annually over the period (AG, 2013-17).

State Budget Allocation and Expenditure

Ebonyi 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 809 (US$3), just 3 percent of the globally recommended benchmark in 2017 of $89 (MOB, 2017; Stenberg, et al., 2017).3 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, Ebonyi State government health spending as a proportion of state gross domestic product was only 0.6 percent. Finally, state government health spending as a share of total state government spending was just 2 percent in 2017, as compared to the Abuja Declaration4 target of 15 percent (WHO, 2001). Health

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3 The 2017 World Bank exchange rate of 305.79 was used to convert naira into U.S. dollars.
4 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.
prioritization in the state budget (the health budget as a share of the total budget) averaged 5 percent over the 2013-17 period (MOB, 2013-17).

### Table 2. Ebonyi State Performance on Global Health Financing Targets

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Ebonyi State (2017)</th>
<th>Global Target</th>
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<tr>
<td>General Government Health Expenditure as a Percent of Gross Domestic Product</td>
<td>0.6 percent</td>
<td>5 percent (McIntyre and Meheus, 2014)</td>
</tr>
<tr>
<td>State Government Health Spending as a Percent of Total State Government Spending</td>
<td>2 percent</td>
<td>15 percent (Abuja Declaration)</td>
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</table>

As shown in Figure 3 and Figure 4, health prioritization in both the state budget and state spending peaked in 2014, when the state invested heavily in Ebola prevention measures. In 2016, health prioritization in the state budget reached a period low (3 percent) due to the newly elected governor’s emphasis on the education and works and transport sectors, both of which saw a 367 percent budget increase in aggregate over 2015-16. The following year, health prioritization in the state budget jumped to 6 percent due to the insertion of new capital projects (building of the teaching hospital) into the state budget for that year. However, the construction of the hospital was slow, as reflected by the significantly lower level of health prioritization in state spending than in the state budget that year (MOB, 2013-17).

Health budget performance, as measured by health spending as share of the health budget, is weak in Ebonyi State, averaging 42 percent over the period. The reason for this trend is twofold. First, budget release request memos sent from the state Ministry of Health to the governor’s office (who is in charge of approving releases from the state treasury) generally omit reference to activities in the state Ministry of Health’s approved annual budget. Second, the state’s annual projected revenues chronically exceed actual revenues, which creates a significant bottleneck for disbursable funds for all state government sectors. As shown in Figure 5, health budget performance is significantly weaker in capital costs relative to recurrent costs.
During 2013-17, seven state government ministries, departments, and agencies made expenditures on health. The state Ministry of Health (SMOH) and the Hospital Management Board (HMB) were the top spenders over the period, as depicted in Figure 6. The other five with health spending—State Primary Health Care Board, the State Agency for the Control of AIDS, Central Stores, the Ebonyi State School of Health Technology, and the Health System Development Project—incurred less than NGN 200 million in health spending in any given year. Over 2013-16, Hospital Management Board spending averaged about a quarter of state Ministry of Health spending. In 2017, Hospital Management Board spending rose to 70 percent of state Ministry of Health spending, suggesting a greater prioritization of secondary facility care within state health spending.
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 local government areas in Ebonyi State averaged NGN 20 billion annually over the period. The other source of local government area revenue is internally generated revenue, or income generated from entities within a given local government area. Internally generated revenue for the years analyzed are estimated at 3 percent of federal allocations to the local government areas or an average of approximately NGN 600 million (AG, 2013-17; NBS, 2013-17).

During the years analyzed, estimated annual health expenditures made by all Ebonyi State local government areas averaged, with minimal fluctuation, approximately NGN 620 million.\(^5\)

Results from 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).\(^6\) 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 $98 per person in 2016 on health. If these resources were channeled into prepayments 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.

To quantify and characterize out-of-pocket spending on healthcare among Ebonyi 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 volume of household spending on health in Ebonyi State?
- What amount is spent per capita and per household on healthcare in Ebonyi 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 vs. males
  - Different age groups

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\(^5\) Local government area health expenditure was estimated based on local government area spending nationwide (values from the National Health Accounts 2010-16) and the Ebonyi State population as a share of the national population.

\(^6\) The figure included in the National Health Accounts 2016 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 2016 report for details on the projection methodology.
• 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 Ebonyi 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.** The 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 for 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 Ebonyi State**

According to the results of the household survey conducted for this analysis residents of Ebonyi State spent a total of NGN 73.3 billion on healthcare services and products (Table 3). This averaged to NGN 23,412 per person, or NGN 93,351 per household. The NGN 73.3 billion figure is extraordinarily high compared to the NGN 2.3 billion spent on health by state and LGA governments.

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

<table>
<thead>
<tr>
<th>Source of Healthcare Funds</th>
<th>Amount (NGN)</th>
</tr>
</thead>
<tbody>
<tr>
<td>State government spending (2017)</td>
<td>1.7 billion</td>
</tr>
<tr>
<td>Local government area governments’ spending (2017)</td>
<td>0.6 billion</td>
</tr>
<tr>
<td>Out-of-pocket spending by households (2019)</td>
<td>73.3 billion</td>
</tr>
<tr>
<td>Total spending per person by households</td>
<td>23,412</td>
</tr>
</tbody>
</table>

Figure 7 shows the types of services on which households spent their money. The highest amount of out-of-pocket spending resources was on outpatient care, at nearly 40 percent of total out-of-pocket spending in the state. One quarter and one-fifth of out-of-pocket spending was on chronic illness and care for injuries, respectively. Little was spent on preventive/promotive and inpatient care, relative to the other three healthcare types. Given the rising prevalence of chronic diseases (e.g., hypertension and diabetes) and that 25 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 Ebonyi State**
Ebonyi State households spent an estimated NGN 4.6 billion on inpatient care in 2019. Of this, 42 percent was spent at private providers. The implication is that households spent 58 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 percent of all preventive/promotive care expenditures were spent at each provider type.

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

In this section we examine the equity of out-of-pocket spending according to gender and age groups, 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 both spending measures, spending on male children is considerably higher than that for female children. This could indicate that parents prioritize the health needs of male children over female children, but more analysis would need to be done to confirm such an explanation. Among non-elderly adults, spending on females was significantly higher than males, which is as expected given the reproductive health needs among women in this age group. Spending among adults age 50 and older was significantly higher on both the typical and the average spending measure compared to other age groups.

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

<table>
<thead>
<tr>
<th>Demographic Group</th>
<th>Gender</th>
<th>Spending (Total Sample, NGN per Year)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Typical Spending</td>
</tr>
<tr>
<td>Gender, all ages</td>
<td>Females</td>
<td>6,658</td>
</tr>
<tr>
<td></td>
<td>Males</td>
<td>6,252</td>
</tr>
<tr>
<td>Children, age 0-14</td>
<td>Females</td>
<td>4,251</td>
</tr>
<tr>
<td></td>
<td>Males</td>
<td>5,400</td>
</tr>
<tr>
<td>Adults, age 15-49</td>
<td>Females</td>
<td>6,688</td>
</tr>
<tr>
<td></td>
<td>Males</td>
<td>5,296</td>
</tr>
<tr>
<td>Adults, age 50 and above</td>
<td></td>
<td>12,326</td>
</tr>
</tbody>
</table>

On both typical and average measures, spending rises with age. This was true among females as well as among males.

Spending by Residence. Table 5 compares spending among rural and urban residents. On the typical spending measure, urban residents spend significantly more than rural residents, as would be expected. On the average spending measure, which includes the high spenders, there is near parity between spending by rural and urban residents.
Table 5. Typical and Average Spending by Place of Residence

<table>
<thead>
<tr>
<th>Residence</th>
<th>Spending (Total Sample, NGN per Year)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Typical Spending</td>
</tr>
<tr>
<td>Rural residents</td>
<td>6,093</td>
</tr>
<tr>
<td>Urban residents</td>
<td>10,077</td>
</tr>
</tbody>
</table>

Spending by Socioeconomic Status Quintile. Table 6 compares out-of-pocket spending among Ebonyi 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 virtually double that in the poorest quintile (Quintile 1); 35 percent and 18 percent of out-of-pocket spending comes from the wealthiest and poorest quintiles, respectively.

Table 6. Typical and Average Spending by Socioeconomic Status Quintile

<table>
<thead>
<tr>
<th>Socioeconomic Status Quintile</th>
<th>Spending Per Capita (Total Sample, NGN per Year)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Typical Spending</td>
</tr>
<tr>
<td>Quintile 1 (poorest)</td>
<td>6,130</td>
</tr>
<tr>
<td>Quintile 2</td>
<td>3,862</td>
</tr>
<tr>
<td>Quintile 3</td>
<td>3,942</td>
</tr>
<tr>
<td>Quintile 4</td>
<td>8,286</td>
</tr>
<tr>
<td>Quintile 5 (wealthiest)</td>
<td>10,130</td>
</tr>
</tbody>
</table>

Typical and Average Spending. In all subgroups, there is an observed, large 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 (2 percent) of interviewed household heads (and by extension, their dependents) were enrolled in a health insurance risk pool. If the Ebonyi 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. 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.

7 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.
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 preventive/promotive care sought, there was a roughly even split in care sought from public versus private providers as well. For inpatient care however, only 31 percent of episodes of care were sought at private providers as compared to the 69 percent of episodes sought at public providers, indicating that care from public providers is favored in the sample over care from private providers. However, there is an even split in total inpatient spending between the two provider types, but a lower rate of care sought at private than public providers. This signifies a slightly higher out-of-pocket cost per episode at private providers for inpatient 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 State Health Insurance Agency, Primary Healthcare Revitalization Scheme, and NGN 437 million\(^8\) mobilized through the Basic Healthcare Provision Fund to the state government in aggregate, Ebonyi 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, relative to households, spends very little on health. The high preponderance of out-of-pocket health expenditures, as compared to state government health spending, indicates that there is much to improve in the state’s 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 2013-17, the Ebonyi State health budget as a share of the total state budget averaged 5 percent, just one-third of the Abuja Declaration target of 15 percent. Improvements in budget and expenditure tracking by the state Ministry of Health Department of Planning, Research, and Statistics and the state Ministry of Health accountant will generate the evidence needed to strengthen Ministry budget proposals with data on past financial performance. This evidence can be used to form advocacy arguments for the key decision-makers in the state budget process. Advocacy efforts would be further amplified through forming an advocacy coordination team that develops a coherent advocacy strategy aware of the political economy of the state, of the timing of critical advocacy windows, and of key influencers to engage.

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\(^8\) Figure is as of December 2019
Increase the proportion of the state health budget, especially the capital health budget, that is spent, through improving the quality of budget release requests, enhanced 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 revenues chronically exceed actual revenues. 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 raised in the recommendation above, will also be essential to ensure the prompt and full release of funds to the state Ministry of Health. 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, Hospital Management Board, and State Health Insurance Agency – the three highest-spending state government health institutions - can initiate an inter-sectoral 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 Ebonyi Health Insurance Scheme informal sector⁹ enrollment, in part through developing an informal sector marketing strategy and expand formal sector enrollment through forging compliance among public and organized private sector institutions. The informal sector in Ebonyi State represents roughly 94 percent of the total state population; for that reason, enrolling informal sector workers and their dependents would result in a significant conversion of direct out-of-pocket payments into prepayments into a risk pool.¹⁰ Expanding the pool in this manner will lower premiums for all over time. EBSHIA 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

Individual contributions from the informal sector are a flat premium rate, but formal sector contributions to the Ebonyi Health Insurance Scheme are in the form of an employee payroll deduction. This deduction is 15 percent: 5 percent from the employee and 10 percent from an employer match; or a gross salary deduction of 5 percent, split between 1.75 percent from the

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⁹ In Ebonyi 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.

¹⁰ 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.
employee and 3.25 percent from an employer match. This payroll deduction structure is expected to be applied to both public and formal private sector institutions once the EBSHIA is fully launched. Because the payroll deduction will be mandatory, insurance contributions from the formal sector will be more predictable than premium contributions from the voluntary enrollment of informal sector workers. Still, the EBSHIA and international development partners will need to persuade state authorities to pass legislation formally introducing this payroll deduction and to forge compliance with the deduction among relevant institutions.

Maximize access to services already in the Ebonyi Health Insurance Scheme package which 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 25 percent of Ebonyi’s total out-of-pocket expenditures—while much less (11 percent) is being spent on preventive/promotive care. Chronic disease rates are expected to increase in Ebonyi 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 Ebonyi. 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, EBSHIA should invest in removing barriers to covered services addressing chronic illness, preventive care, and child health. EBSHIA 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.

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 Ebonyi 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.
References


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