

Assessment of Household Out-of-pocket (OOP) Contributions to Health Expenditure in Niger State North Central Nigeria

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Abstract

In Nigeria, revenue for financing the health sector is collected from pooled and un-pooled sources. The un-pooled sources contribute over 70% of total health expenditure, and this can be Out-of-Pockets (OOPs) in the form of fees to healthcare providers at the time of service. The aim of the study was to estimate the out-of-pocket health expenditure of the households in Niger State. A cross-sectional quantitative study was carried out among 1,235 households made up of 6,482 individuals using a multi-stage stratified probability sampling technique. Data was collected using a well-structured survey instrument and analyzed using descriptive statistics and SPSS statistical software version 23. Findings shows that the annual per capita out-of-pocket expenditure on health services was approximately ₦19,463 (\$46.9), and 64% of the total OOP expenditure is spent on public facilities. 32% of the OOP was incurred mainly from accessing maternal health services, with 56% likely to incur catastrophic expenditure. 75% of the sampled population expressed willingness to enroll into a form of health insurance, and an average household is willing to pay a monthly premium of ₦798 (\$1.9) for health insurance. The study shows the urgency with which policy makers need to increase public healthcare funding and provide social health protection plans against informal OOP health payments. Furthermore, for Niger State to achieve the recommended benchmark of 30% OOP as a percentage of total health expenditure, it is critical that the newly signed into law contributory health insurance scheme is well designed, successfully implemented, and financially sustainable.

Keywords: Health Expenditure, Health Insurance, Household, Out-Of-Pocket, Risk Protection.

Introduction

The global drive towards achieving universal health coverage (UHC) by 2030 was reaffirmed by World Leaders at the 74th United Nations General Assembly (UNGA) [1]. UHC is a worldwide priority agenda and key deliverables of the Sustainable Development Goals (SDGs) 3 [2]. The design of health financial systems vis a vis the way a country finances its health care system is a critical determinant for reaching UHC [2, 3]. Appropriate health financing strategies that safeguard financial risk protection underpin sustainable health services and the attainment of UHC [4]. This is so because they determine the existence of health services,

availability, and affordability to the populace. Health financing in Low- and Middle-Income Countries (LMICs) and individuals' access to essential health services depends on Out-of-Pockets (OOPs) [4]. The term 'out-of-pockets (OOP) payment has been defined as the summation of all kinds of direct expenditure or expenses incurred at the point of receiving health care directly made by households either as in patient or outpatient [5, 6]. OOPs involves payment for health care at the point of service. Globally, about 12% of the world population spends at least 10% of their household income to pay for health care which exceeds the threshold of catastrophic expenditure [7]. Catastrophic

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Health Expenditure (CHE) is the healthcare budget share that exceeds a pre-defined threshold, usually 10% of household income or 40% of household non-food expenditure [8, 9]. CHE depletes household income and contributes to the vicious cycle of poverty and diseases [7]. World Health Organization (WHO) estimated over 150 million people incur catastrophic health expenditures while over 100 million are pushed into poverty due to OOP health payments [4, 10].

In Africa, the total health expenditure has grown in the last two decades and is driven mainly by out-of-pocket spending by households [10]. Financial protection is generally low in Africa, requiring most patients to pay for health services from their own household income termed out-of-pocket (OOP) payments [11]. In Sub-Saharan Africa (SSA), 27 out of 48 countries are affected by direct out-of-pocket payments (OOPs) for healthcare services that are greater than the benchmark of 30% [4, 12]. Out-of-pocket health expenditure has adverse effects on family income allocation to essential needs, including food, education, shelter, and utilities [10, 11]. Most low- and middle-income countries (LMICs), including Nigeria, are battling the problem of poverty [13]. Protecting people against the impoverishing effect of health payments is a cornerstone of UHC and will help prevent poverty in Africa. In Nigeria, revenue for financing the health sector is collected majorly from pooled and un-pooled sources. The pooled sources are collected from budgetary allocation, direct and indirect taxation as well as donor funding [3]. However, the un-pooled sources contribute over 70% of total health expenditure, and this can be Out-of-Pockets (OOPs) in the form of fees (informal or formal direct payments) to healthcare providers at the time of service [3]. Out-of-pockets account for the highest proportion of health expenditure in Nigeria. Household out-of-pocket expenditure comprises more than 76% of current health financing in Niger State, well above the 20-30% benchmark for adequate financial protection [3, 12, 14].

Niger State has a highly dispersed population, 47% of which are under the age of 15 years. Approximately 40% are women of reproductive age and children under five with an average life expectancy of 52 years [15]. Based on the largely agrarian economy, Niger GDP stood at (\$8.5 Billion), and GDP per capital is \$1,440, with 34% of the resident below the poverty line [16, 17]. About 60.6% of the State's population is employed, with approximately 90% employed in the informal sector [18]. Analysis of the health services coverage shows that childhood malnutrition and malaria prevalence is higher (21% and 22.6%) respectively, coverage of basic child services is among the lowest in comparison to regional peers, 13.4% of children 12-23 months did not receive vaccinations and only 23.6% of the newborns attend post-natal check-ups within the first two days after birth [17]. Demand for reproductive, maternal, newborn, and child health services, including antenatal care and family planning, are poor. The percentage of delivery by the skilled birth attendant is 41.5%, while women that delivered in a health facility is about 25.8% [17]. These figures are far below the national average and worse compared to other states in the zone. A deep dive into the roots cause shows that poor health system performances include poor geographical access to health services, weak workforce productivity, inadequate supply of quality health services, high out-of-pocket spending, and poor health knowledge and utilization of PHC services. Health care financing and budgeting are different from other budget items because consumption is irregular and unpredictable. This reflects the fact that health care is valuable only in the event of illness, the timing and nature of which is substantially beyond the control of the individual and the onset of which can carry an appreciable risk of physical impairment. Inadequate of commitment to finance health care is reflected as poor health infrastructure, which has led to the excessive financial burden on households forcing consumers to visit the private and

relatively more expensive treatments. Cost of care limits demand for health due to a lack of effective interventions to reduce out-of-pocket health expenditures, particularly for the poor.

Recently, The State reaffirmed its commitment to improving financing for health and have engaged in multiple UHC reforms. The State unveiled the Roadmap for Niger's health sector (Niger 1.0), which affirmed a commitment to providing financial risk protection for the populace to access quality health care [19]. Also, it has successfully embarked on implementing the national PHCUOR policy and is ranked 6th in the country on its reform progress [20]. In addition, the State signed a memorandum of understanding with the Bill and Melinda Gates Foundation to support the transformation of the Niger State primary health care system to deliver quality and affordable health care services to its people. The State is currently implementing the Basic Health Care Provision Fund (BHCPF). Under the scheme, one PHC from each of Niger State's 274 wards will directly receive funds from the federal government, channeled through the State Primary Health Care Development Agency and Niger State Contributory Health Scheme, to cover operational costs and a free provision of a set of the basic minimum package of health services targeted at the most vulnerable and impoverished population in the State. The State Ministry of Health (SMOH) has set up a Health Care Financing (HCF) Unit to coordinate its UHC initiatives as well as inaugurated a multi-stakeholder HCF TWG that led the processes for establishing of the State-owned social health insurance scheme [18]. The scheme unarguably is the most comprehensive initiative of the State on its quest to UHC.

Studies in India documented out-of-pocket expenditure as one of the hidden costs experienced by households and could be an impediment to vaccination coverage [5]. Other studies in Africa show out of pocket expenditure accounting for between 48% - 66% burden of health care expenditure in Africa [21, 22]. At the

threshold of 10% of HHs income, Kenya reported 28.3% of HHs, and Ghana reported 23.2% of HHs are at risk of Catastrophic health Expenditure [23, 24]. In Nigeria, there is a heavy reliance of out-of-pocket payments with a higher catastrophic impact compared to other African Countries [25, 26]. and study by Aregbeshola and Khan shows that OOP health payments led to catastrophic health expenditure and exacerbated poverty [26]. Other studies in South Nigeria shows that Out-of-pocket (OOP) was the most prevalent mode of payment for healthcare (95.6%), with overall occurrences of CHE as 12.8% and 32.8% with reference to the 40% non-food and 10% income-expenditure thresholds, respectively [27]. The study concluded that out-of-pocket payment as the main payment for healthcare and exposes a significant number of households to CHE [27]. In SE Nigeria, estimated CHE in HHs following OOP payment ranges between 15% to 27% (a reference to 40% of non-food expenditure) [3, 26, 28]. These studies opined OPP as the main method of financing health care in developing countries like Nigeria. The Multiplier effect is the CHE capable of dragging millions HHs into poverty. Hence, a dire need of appropriate health financing strategies that guarantee financial risk protection and sustainable health services. These are the hallmark for a country that desires to attain UHC.

There is limited evidence on the effects of OOP health payments in Niger State using nationally representative household survey data. In low-income settings like Niger State that are predominantly subsistent agrarian, this portends a potentially vicious cycle of poor health due to the consequences of catastrophic events. As the state commenced alternative finances, which includes the provision of health insurance, there is a need to provide evidence through research on the catastrophic effects of OOP in order to inform governments and policy makers on the necessity of sustaining state-owned health insurance schemes and other policies that would provide financial risk protection to populations

as a target for Sustainable Development Goals (SDGs). Therefore, the research aimed at estimating the out-of-pocket health expenditure of the households in Niger State. It also aimed at understanding the pattern of expenditures in the Niger State health sector and relative contributions of each financing source to the total health expenditure.

Methodology

The survey was designed as a cross-sectional quantitative study carried out among 6,482 individuals in Niger State North Central Nigeria. The State was created on 3rd February 1976 by the military government of General Murtala Muhammed out of the defunct North-Western State [29]. It is the largest state in Nigeria and lies on latitude 8° to 11°:30' North and Longitude 03° 30' to 07° 40' East, with a landmass of 76,469.903 km² equivalent to about 10% of the total land area in Nigeria [29]. The State is bordered to the north by Zamfara State; to the northwest by Kebbi State; to the south by Kogi State; to the southwest by Kwara State, while Kaduna State and the Federal Capital Territory bordered the state to the northeast and southeast, respectively. Furthermore, the State shares a common international boundary with the Republic of Benin at Babanna in Borgu Local Government Area in the Northwest of the State [29]. The State has an estimated population of 3,950,249 consisting of 2,032,725 males and 1,917,524 females based on the 2006 census

figure [29, 30]. The projected crude population for 2022 is 6,744,552 based on an annual growth rate of 3.4% [29], and many communities reside in remote and hard-to-reach areas. The State is divided into twenty-five Local Government Areas (LGAs), three senatorial districts, Eight Emirate Councils, 274 Political wards, and 6 Health zones.

The sampling frame included all the households listed in the enumeration Areas (23,445) as was used for the 2006 National Population Census by the National Population Commission (NPC, 2006) and is consistent with that used for the 2018 National Demographic and Health Survey (NDHS) [17]. Since out-of-pocket expenditure is predominantly determined by the health-seeking behavior of the household, a robust study sampling strategy yielded a sample size of 1,250 Households, at 5% significance which canvassed across the 25 LGAs of the state using a multi-stage stratified probability sampling approach. The first stage was the stratification of the 25 LGAs and by rural and urban enumeration areas. The second stage was ensuring equal representation to all households of the three geographical areas in the study area by probability proportional to size sampling of Enumeration Areas (EAs) from the LGAs (Average of 5 EAs/LGAs). The third stage was the systematic random sampling of 10 households per EAs. In total we have; $10 \times 5 \times 25 = 1,250$ HHs (Table 1).

Table 1. Distribution of Households Across the Three Senatorial Zones in Niger State

Geographical Zones	Number of LGAs	Number of EAs	Number of HHs
Zone A	8	40	400
Zone B	9	45	450
Zone C	8	40	400
Total	25 LGAs	125	1,250

Data sets were sourced as primary data from sampled households in the survey. A well-structured survey instrument with seven sections was developed, configured on android tablets, pre-tested, and deployed to the field for data

collection. Data regarding the socio-demographic profile, illness, health expenses incurred, health-seeking behavior and service utilization, reasons for seeking care, access to health insurance, and other details were obtained

by interview method using the pre-tested and semi-structured questionnaire. Forty data collectors were selected and meant to undergo a rigorous selection process involving the use of structured pre- and post-test as well as an objective practical test to identify the best three supervisors and thirty enumerators. Data collectors were then divided into three teams (Senatorial Zone A, B & C). Each team was made up of one supervisor and ten enumerators deployed to the three zones for data collection.

Data collected were analyzed using frequencies and descriptive statistics. SPSS statistical software version 23 was used for analysis, and results were presented in the form of tables, figures, and graphs. All costs obtained in Naira were converted to US Dollar equivalent using the Central Bank of Nigeria foreign exchange rate of ₦415 to \$1.

Ethical approval was obtained from the Niger State Ministry of Health Ethical committee. Informed consent was obtained from each of the enumerated households. All the study personnel were trained on relevant aspects of good ethical standards relevant to the survey. Study participants were given adequate information about the study to enable them to take an informed decision about participating in the study.

The right to abstain from participation in the study at any time was emphasized. The interviews took place within the household compound, and participants were given a unique identification numbers to ensure absolute confidentiality.

Results

One thousand two hundred and fifty (1,250) households were line listed and mapped for the study, but only one thousand two hundred and thirty-six (1,236) households were reached with a total population sample of 6,482. The remaining fourteen households were communities ravaged by the wild Fulani herdsmen crisis and not accessible to the data collectors. This represents 98.9% of households reached, which can be considered high, valid, and sufficient for making valuable deductions and reaching conclusions on the research study.

Basic Demography of the Respondents

Considering the socio-demographic characteristics in table 2, the gender pattern was similar to the state population structure for the 2006 census, but the households sample differed in the age group distribution when compared to the state structure. More so, the age distribution shows evidence of demographic transition with a preponderance of the productive age group of 21-40 years (57%). A study done by [31] found an almost similar population (62.68%) from the productive age group [31]. About 90% of the state population attained some form/level of formal education, and as expected, the urban population has more educated people (72%) than the rural population (54%) (Table 3). More so, the occupation of the sampled population shows that only 10% are formally employed while the rest are either students (28%), unemployed (22%), retired (4%) or self-employed (36%) (Table 3).

Table 2. Basic Socio-demographic Characteristics

Gender	Frequency	Percent
Female	3518	46
Male	2964	54
Total	6482	100.0
Age Group (Years)		
0-10	520	8
11-20	1324	20
21-30	1652	25

Gender	Frequency	Percent
Female	3518	46
Male	2964	54
31-40	2081	32
41-50	692	11
50+	213	3
Total	6482	100

Table 3. Educational Level and Occupation of the Participants

Education Level	Frequency	Percent	Rural	Urban
No Education	519	8	22	16
Primary Education	1945	30	21	18
Sec. Education	2463	38	19	22
Post-secondary	1167	18	14	32
Others (Religion)	389	6	24	12
Total	6482	100	100	100
Occupation				
Public Sector Employees	389	6	2	9
Organised Private Sector	259	4	1	4
Self-Employed	2334	36	44	24
Retired	259	4	0	2
Unemployed	1426	22	30	25
Student	1815	28	22	36
Total	6482	100	100	100

Health Service Utilization

Figure 1 showed that malaria (44% and 30%) was the leading reason for seeking both outpatient and in-patient services, respectively. This might explain the reason for malaria contributing 12% of mortality and the second leading cause of death in the country [32]. Fever

from other causes (26% and 15%) and typhoid fever (9% and 16%) are other reasons that the population sought health care for both out and in-patient services. Chronic conditions such as diabetes and hypertension accounted for 15% of the inpatient care, while 10% of other illnesses are responsible for outpatient services utilization.

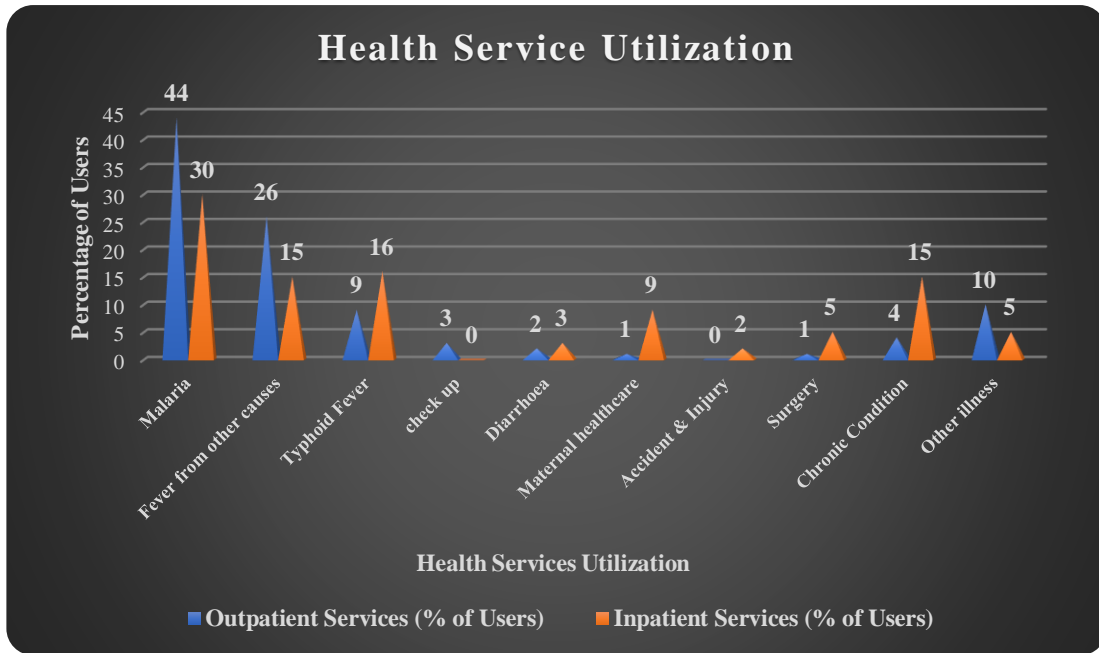


Figure 1. Health Service Utilization (Self-Reported Diagnosis)

Health Service Utilization by Care Provider

In figure 2, the majority of out-patient care was obtained from Chemists/PPMVs (42%), while in-patient care is mostly provided in the

public hospital made up of (Primary Health Care) PHC (20%) and hospitals (48%). This is consistent with findings that reported 63.8% of people visits hospitals and clinic over the primary health facilities [16].

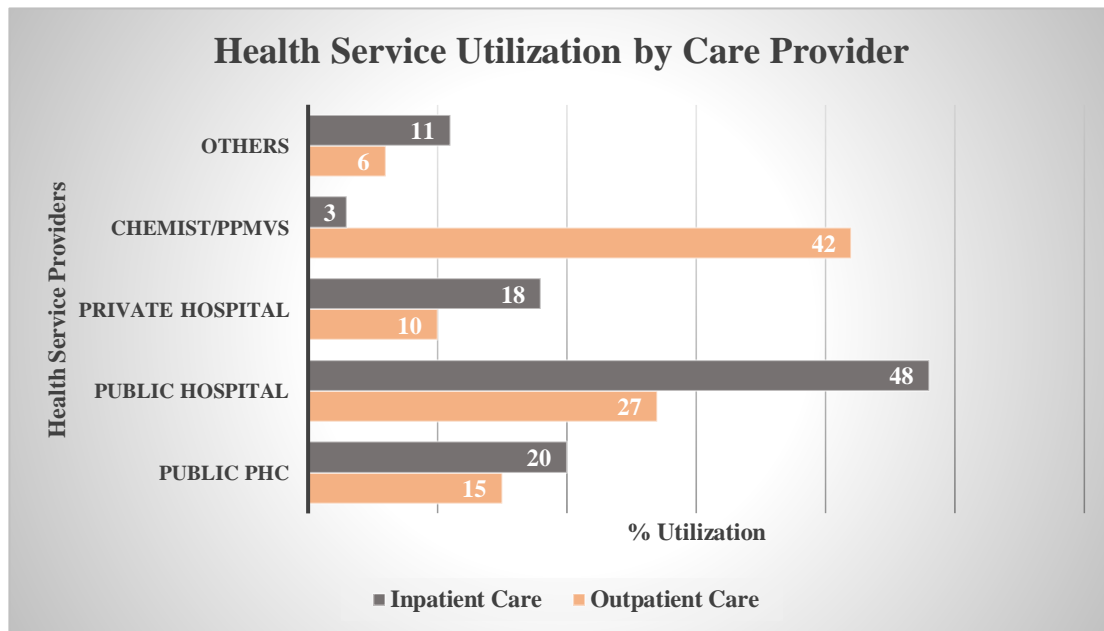


Figure 2. Health Services Utilization by Health Care Provider

Annual Per Capita Out-of-Pocket Expenditure

The annual per capita out-of-pocket expenditure on health services was ₦19,463

(\$46.9), with males (₦19,561) (\$47.1) spending slightly higher than females (₦19,366) (\$46.7) (Figure 3).

Annual Per Capita OOP Expenditure by Gender

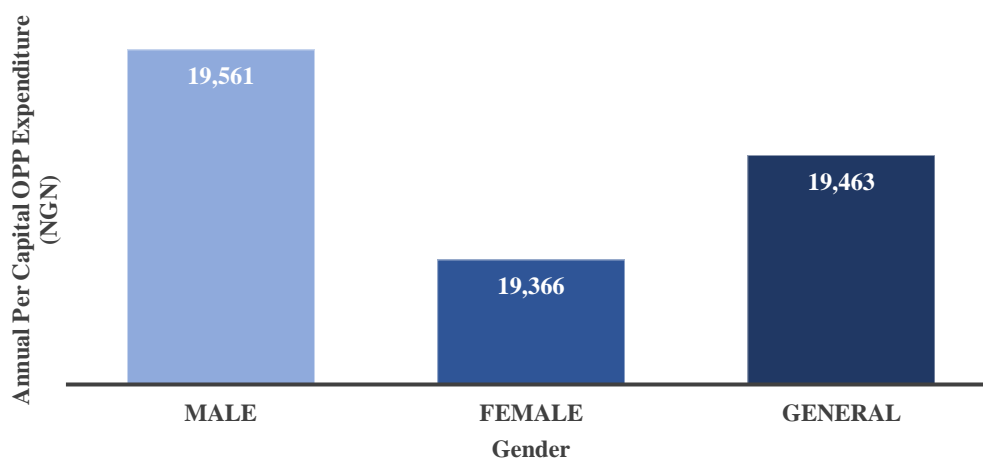


Figure 3. Annual Per Capita Out-Of-Pocket Expenditure by Gender

Share of Total OOP Expenditure by Health Facility Type and Ownership

The share of total OOP expenditure by health facility type and ownership shows that 64% of the total OOP health expenditure was spent in

public facilities, with almost two-third spent on inpatient services. Private hospital share was about 18%, Chemist/PPMVs 6%, while the remaining 3% was spent on other health care providers including traditional healers, self-treatment etc. (Figure 4).

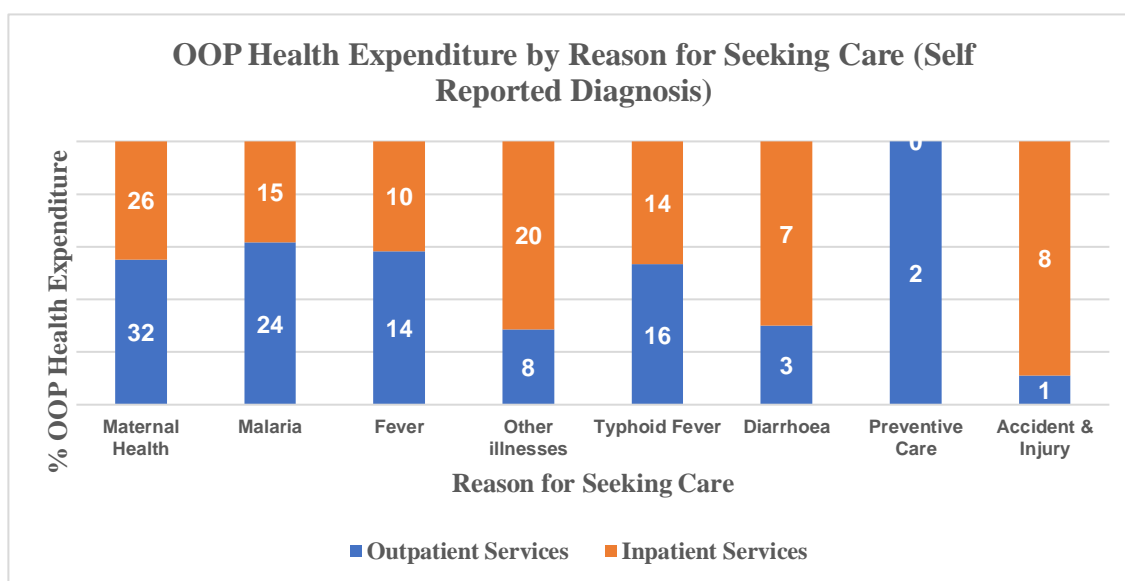


Figure 4. OOP Health Expenditure by Reason for Seeing Care (Self-Reported Diagnosis)

OOP Health Expenditure by Reason for Seeking Care

In figure 5, 32% of the OOP health expenditure spent on out-patient care was mainly on maternal health services (FP, ANC, PNC),

while the bulk of in-patient expenditure was on the maternal services (26%) and other illnesses, including the chronic disorders such as the non-communicable diseases (NCDs). Typhoid fever accounted for equal reasons in both outpatient services (16%) and inpatient services (14%).

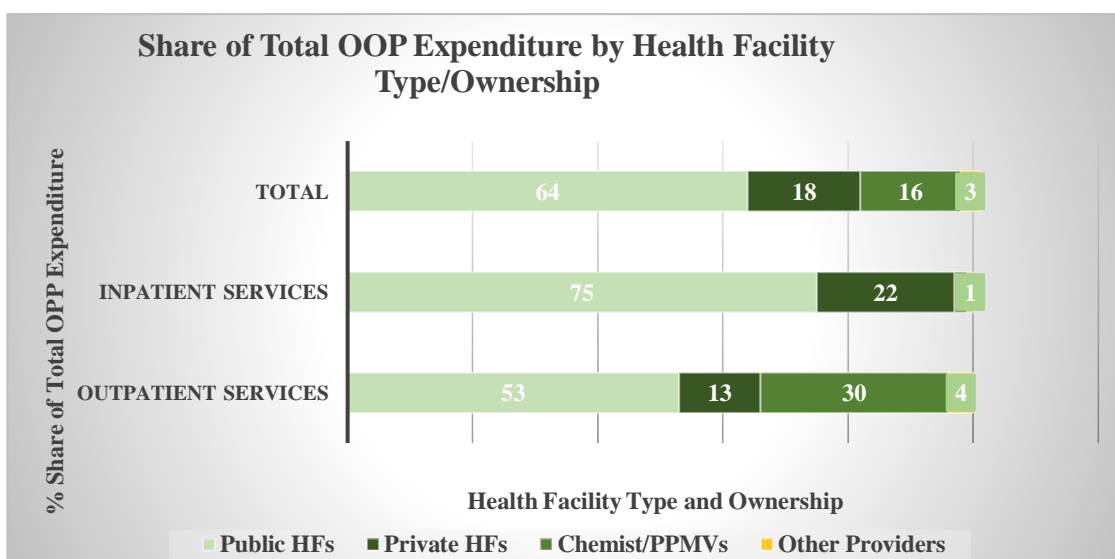


Figure 5. Share of Total OOP Expenditure by Health Facility Type/Ownership

Household Experiencing Catastrophic Expenditure

Analysis shows that at the prevailing OOP and low health insurance coverage levels, 56% of the households in the state are likely to incur catastrophic expenditure from seeking healthcare. The findings were far below the

findings in Southeast Nigeria, in which only 15% of households experienced catastrophic expenditure [12]. The poor (61%), as well as the average (60%) populace, are at risk of catastrophic expenditure. Alarmingly, the poorest households have financial safety (53%) more than the very rich households (44%) (Figure 6).

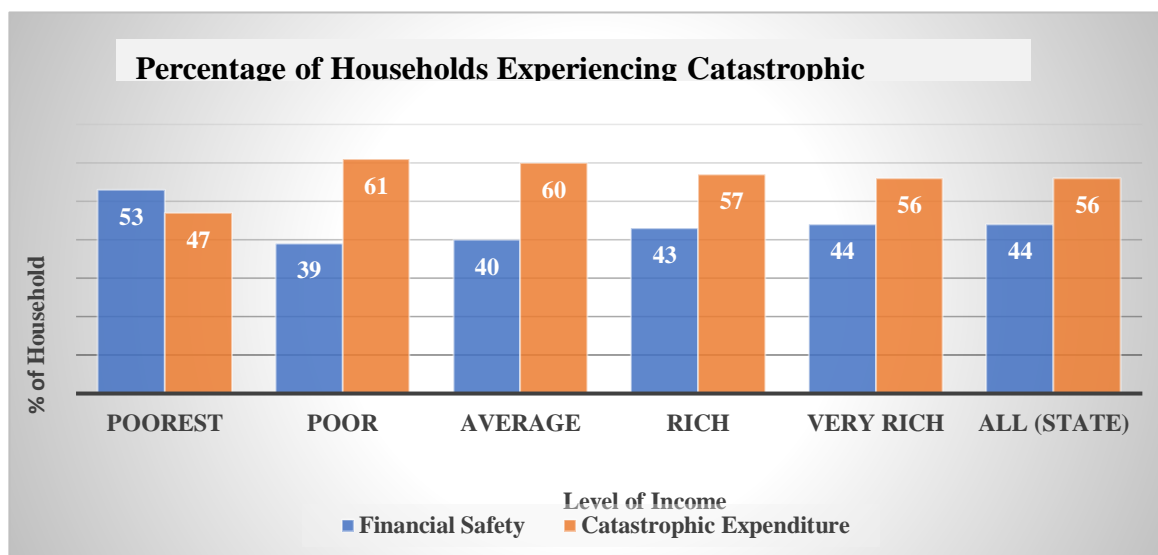


Figure 6. Percentage of Households Experiencing Catastrophic Expenditure (10% of Income Approach)

Awareness and Coverage of Health Insurance

Among the adults (18+years) sampled, only 5% were aware of and understood the concept of health insurance. Out of this proportion, 15%

were covered by some form of health insurance, and three-quarters of those covered reside in the urban areas. However, an equal number of the population residing in both urban and rural areas are aware of the health insurance and not covered (Figure 7).

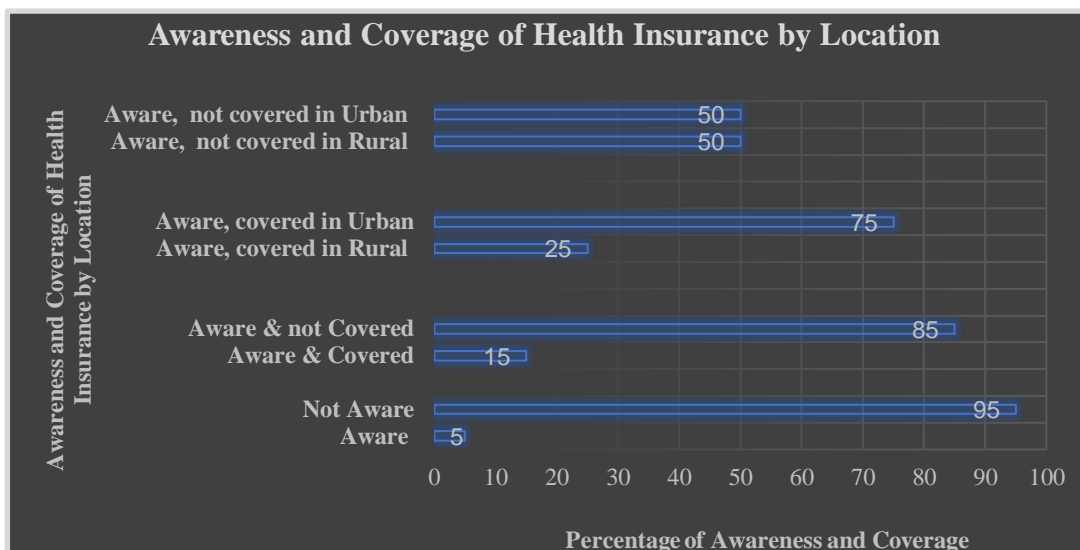


Figure 7. Awareness and Coverage of Health Insurance by Location

Willingness to Join Health Insurance

After explaining to the population, the benefits of health insurance, 71% of the sampled

population expressed willingness to enroll into a form of health insurance (Figure 8). This pattern of desire is seen almost equally in both urban (69%) and rural (72%) areas.

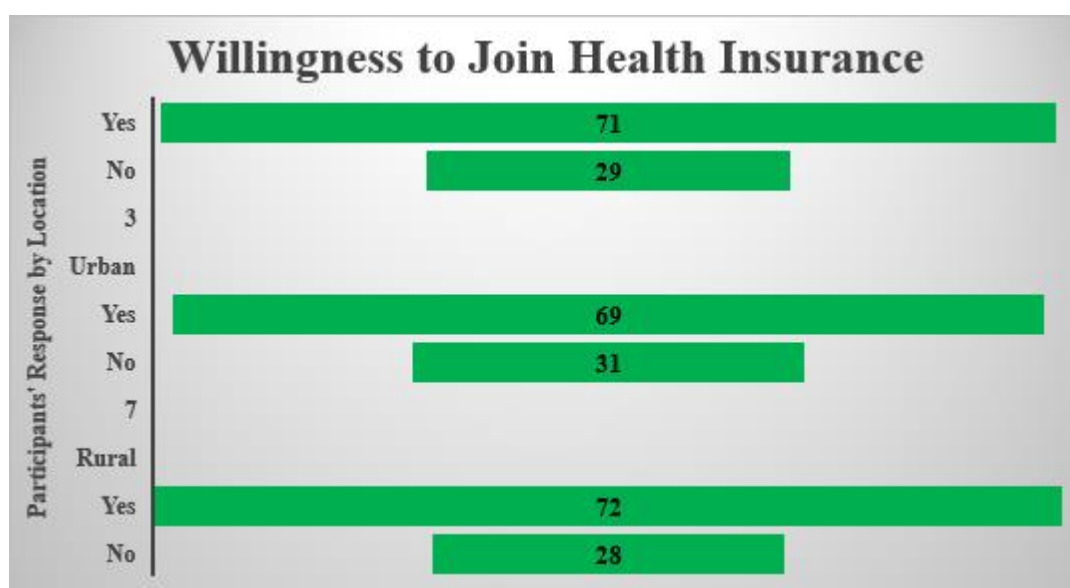


Figure 8. Willingness to Join Health Insurance

Average Amount Household is Willing to pay as Monthly Premium

An average household is willing to pay a monthly premium of ₦798 (\$1.9) for health

insurance. The urban ₦912 (\$2.2) households are willing to pay higher than their rural ₦760 (\$1.8) counterparts (Figure 9).

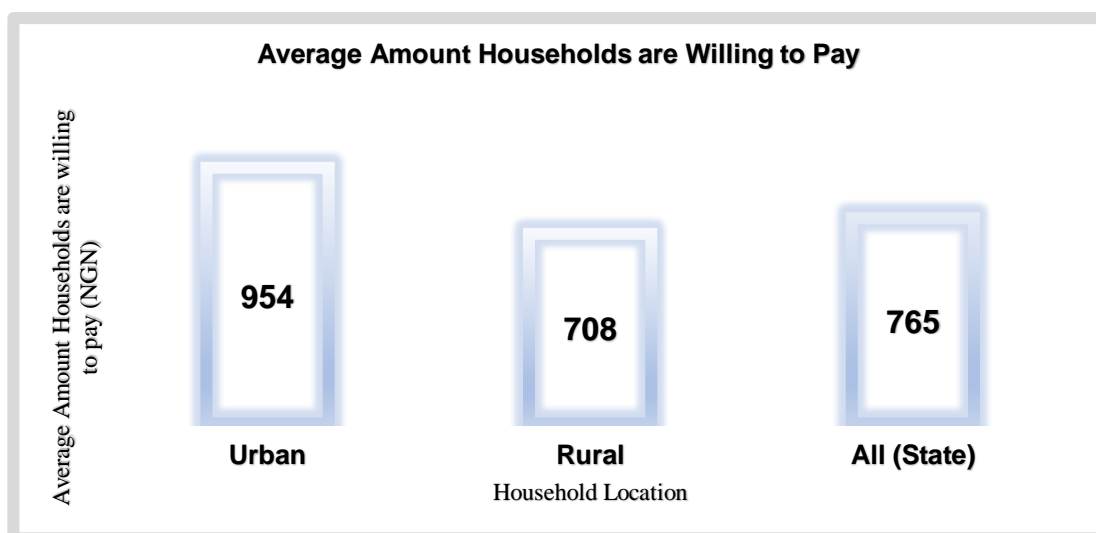


Figure 9. Average Amount Households are Willing to Pay as Monthly Premium

Reason for Enrolling into the Health Insurance

It appears affordability of healthcare (37%) and financial protection (35%) are the dominant

reasons why people would want to subscribe to health insurance in Niger State (Figure 10). 19% and 9% respectively opined that quality treatment and other reasons made the population to enroll into health insurance.

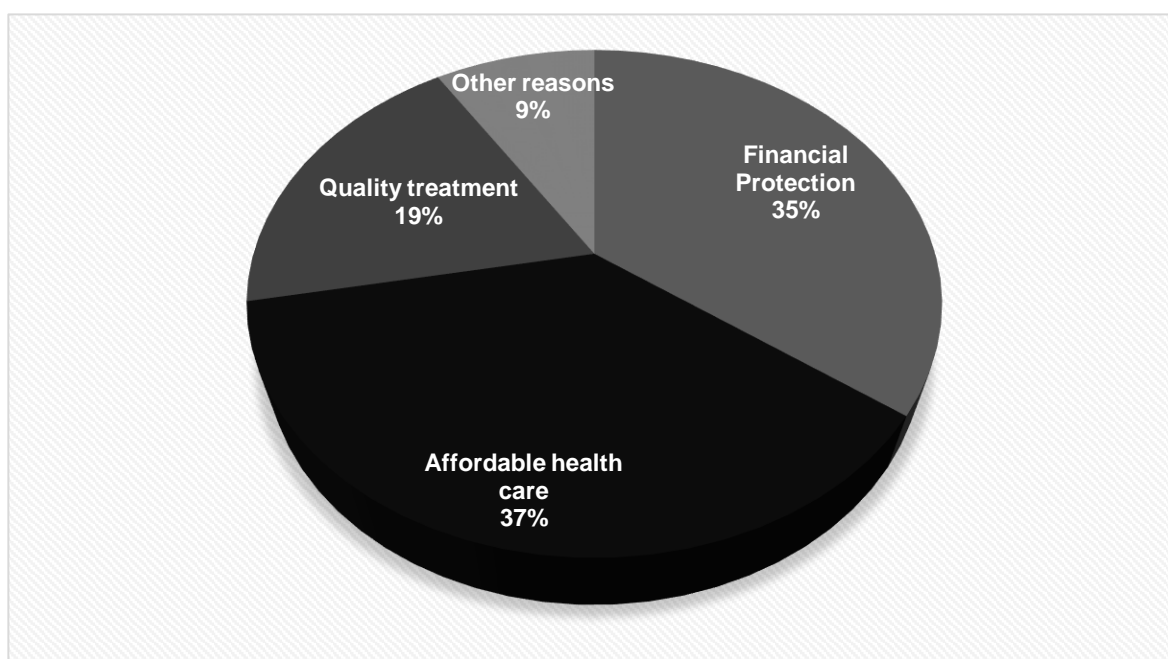


Figure 10. Reason for Enrolling into the Health Insurance

Discussion

Findings show that malaria accounted for the highest health service utilization and followed closely with fever from other causes, other illnesses, and typhoid fever. Almost half of the populace obtained out-patient care from Chemists/PPMVs, while in-patient care was

mostly provided in public facilities. The annual per capita out-of-pocket expenditure on health services was approximately \$46.9 and spent on the utilization of public facilities. The OOP was incurred mainly from accessing maternal health services, with half of the population likely to incur catastrophic expenditure from seeking

healthcare. Very few of the populace are aware of the available risk protection mechanism, less than a quarter were covered by some form of health insurance and reside in the urban areas. Two third of the sampled population expressed willingness to enroll into a form of health insurance and equal for both urban and rural dwellers. An average household is willing to pay a monthly premium of ₦765 (\$1.8) for health insurance, and the finding indicated that financial protection and affordability of healthcare are the dominant reasons the population would want to subscribe to health insurance in Niger State.

Recommendation For Policy Implications

The study was conducted with the objective of estimating OOP contribution to health expenditure in Niger State. It was found that most of the households have low educational levels, poor economic backgrounds, and incurred high health costs due to high disease burden as seen in most predominantly rural/agrarian set ups or low coverage of financial risk protection. At ₦19,463 (\$46.9) per capital annually, the OOP health spending in Niger is significantly (about 29%) higher than the national average of ₦15,045 (\$36.3). The catastrophic consequences thus push some into poverty and aggravate the poverty of others. As a result of OOP level, a good number of households (57%) are at risk of catastrophic expenditure on health care and be just one major sickness away from financial ruin. The high percentage of OOP health payments indicates that households contribute more to overall health expenditure than governments in Nigeria. NHA (2006-2014) shows that the primary reason for high out-of-pocket expenditure was limited pooling and pre-payment schemes in the State. High OOP and willingness to pay for health insurance presents an opportunity for political actors and policy-makers to design health system financing policies that would expand the fiscal space for health through a prepaid and pooled mechanism that will guarantee financial risk

protection to households in the State. Also, the government should aim at preventing people from attaining high health care expenses by increasing their awareness regarding various health insurance schemes, encouraging many community-based health insurance schemes in the country which cover the unorganized and informal sector. Furthermore, insufficient public health financing is a major driver for high levels of OOP health spending in Nigeria. Evidence suggests that increased allocation of public funds to the health sector leads to a decrease in OOP health expenditure as well as catastrophic OOP health spending. Domestic financial resources are key to moving closer to UHC and should be increased on a long-term basis. Our study shows the urgency with which policy-makers need to increase public healthcare funding and provide social health protection plans against informal OOP health payments in order to provide financial risk protection which is currently absent among the high percentage of households in Nigeria. The Abuja declaration of 2001, in which African heads of state pledged to set a target of earmarking at least 15% of their annual budget to improve the health sector, needs to be fully implemented by governments at the national and sub-national levels. Both rich and poor households are at risk of catastrophic expenditure though poor households are more at risk, government Health intervention programs should be made for accessible and affordable to the poor. Health Insurance coverage in the state is low, and more than 70% of the Niger citizens are willing to enroll. An average person is willing to pay ₦798 (\$1.9). Government should use this as a guide for the establishment of affordable state health insurance for risk pooling in the State. There is high patronage of chemists/PMVs for care and treatment services. The government's reform effort toward PHC needs to be sustained and activities of the PMVs better regulated for quality and effective care. PHC system needs to be strengthened, and PHC facilities made functional with the provision of comprehensive benefits packages for the poor

and vulnerable populations in order to improve access to healthcare services and health outcomes.

A pro-poor policy reform with improved quality of care, availability of essential medicines, and equitable distribution of health workers will improve coverage and utilization of healthcare services for the poor and most vulnerable households. Lastly, the study provides baseline data on out-of-pocket expenditure and associated protective mechanisms for risk pooling in the State.

Limitations

The study employed a cross-sectional survey rather than a longitudinal approach due challenges associated with the longitudinal survey. In other words, the study took a snapshot on the financial burden of OOP health payments, which should ideally be estimated by a longitudinal study. Also, it is prone to recall bias since the study relied on the memory of the household, which may affect its accuracy. The survey captured only the direct medical cost, excluding the cost of health worker's time and other indirect costs. Lastly, all diseases and complaints are self-reported, while sometimes the diagnosis is based on the health worker's diagnoses, it's not always the case in other circumstances.

Despite these limitations, the findings provided a baseline burden of OOP health payments on households in Niger State and would inform policy-makers on dire needs of health insurance schemes that would halt the high reliance of OOP health payments which is critical in achieving financial risk protection.

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Conclusion

OOP has remained the dominant mode of financing healthcare in low-income countries like Nigeria and Niger, in particular, a major limitation if a quality healthcare service is to be accessed. The phenomenon leads to poor health-seeking behaviors and inequity. There is a need to pay proper attention to the health of the Niger populace and address issues such as OOP health payments that increase the level of poverty which is an indicator of poor economic growth. High Out-Of-Pocket expenditure and willingness to pay a monthly premium for health insurance presents an opportunity for a limited expansion of the fiscal space for health through a prepaid and pooled mechanism. Therefore, for Niger State to achieve the recommended benchmark of 30% OOP as a percentage of total health expenditure, it is critical that the newly signed into law of the contributory health insurance scheme is well designed, successfully implemented, and financially sustainable. The scheme will expand the fiscal space for health through a prepaid and pooled mechanism such that Niger households are better protected from the financial shock of seeking and paying for healthcare.

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Conflict of Interest

The Author declares no competing or conflict of interest.

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