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Research Article

National Health Insurance Scheme: Effect of Out-of-Pocket Payment and Access to Health Services. A Case Study of Federal Medical Center, FMC, Jabi, Abuja

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Abstract

A crucial element of universal healthcare is health insurance, which offers financial protection against the expenses of utilizing medical services. Nigeria is one of several African nations where a sizable amount of current health spending is made up of out-of-pocket expenses. The percentage of out-of-pocket spending has remained steady over the past 20 years. The Federal Medical Center (FMC) Jabi in Abuja is where the investigation was conducted. FMC Jabi institution is situated in Nigeria's northern central region. Clients who visited the research facility were given questionnaires by the interviewer. The poll included 500 customers, including men and women between the ages of 25 and 60. The vast majority of them (78%) were above the age of 30. There were 200 men and 300 women present, accounting for 40% of the total. The male: female ratio was 1:1.5, 109 (21.8%) and 17 (3.4%) people were single or divorced despite the fact that 339 (67.8%) of the participants were married. A total of 317 (63.4%) participants, or 100 (20%) and 83 (16.6%), are not public officials or employees of the government. More than half of the participants had monthly incomes below the minimum wage. Household heads are working part-time or being unemployed more frequently these days. In contrast to the WHO requirement of 40% or less, which implies catastrophic household health spending, the mean values of patients who could afford to enroll in the NHIS, undergo extensive medical diagnostics, and purchase pharmaceuticals were/those that cannot stands at 34 (CI 31.8-36.2)/122 (CI 119.8-124.2)/60. The study's findings show the impact of out-of-pocket expenses and payments on access to universal healthcare in the twenty-first century, but the values obtained may be woefully insufficient to inform governmental policy decisions about the amount of money needed to fund the suggested package for patients under the national health insurance program (NHIS). This is true because household health costs are significantly influenced by socioeconomic position..

Keywords: National Health Insurance Scheme; NHIS; Out-of-Pocket; Unemployed; Federal Medical Center; FMC

Introduction

Many countries are interested in health finance, particularly African countries such as Tanzania, Nigeria, and Cameroon. This lies at the heart of the debate over Universal Health Coverage (UHC) and the Sustainable Development Goals (SDGs) [1,2]. Countries fund medical care through a variety of means. Outside of external financing, direct out-of-pocket payments, general taxes, private and public health insurance, and earmarked taxes are the most often used alternatives in many countries. According to the Global Health Expenditure 2019 research, several African countries rely largely on direct out-of-pocket spending, which payments are made when consumers use either public or private health services. Since medical expenses are more frequent in Africa than general taxes and health insurance, receiving medical care may force many households into poverty or even financial ruin. (2018) Ataguba., *et al.* Ichuko., *et al.* (2018). Direct out-of-pocket costs, on the other hand, frequently have a regressive effect, burdening the poor more than the rich [3]. Out-of-pocket expenditures may occasionally rise over time [4,5], owing mostly to the poor's inability to pay for healthcare and decision not to use it at all.

Health care is a requirement and a fundamental human necessity. The Alma Ata Declaration from the primary health care conference in 1978 advocated for social guarantees to ensure that all people's fundamental needs, including food and health, be addressed. This declaration was broadly adopted by all countries at the time [6]. Unfortunately, for the majority of poor countries, obtaining even a basic level of appropriate health care and health remains an unattainable goal. Government investment on health in emerging countries declines even if the need for healthcare increases [7]. Africa's already high disease rate is made worse by the AIDS pandemic, and the region also has the lowest worldwide health spending (World Bank, 2018 [8]). Many people have criticized Sub-Saharan African governments' health spending as being insufficient, unfair, and unsustainable [9,10]. Growing poverty, the range of health issues, and the outcomes of economic policies, particularly structural adjustment programs, have all been noted as major contributory reasons to the funding gap between health care requirements and available resources [11-13]. These have made it harder for individuals to get healthcare, both physically and financially [14]. The effects of inadequate health expenditure are made worse by the fact that disadvantaged people, particularly women and children, have disproportionately limited access to services. Because of this, the benefit of already few resources that these communities most need is diminished [15].

Numerous health financing solutions have been proposed as a solution to the problems connected with limited financial access to healthcare. Health finance is one of them, as is increasing household health expenditure through, among other things, user fees, social insurance, and other forms of community funding [16-18].

Health insurance is intended to reduce the expense of medical treatment by pooling resources and sharing the risk of unforeseen medical problems. Risk-sharing agreements are especially important in Sub-Saharan Africa, where the majority of nations do not invest sufficiently in health care and the majority of medical services, including prescription medications, are paid for privately. Ekman (2018), Musgrove., *et al.* (2020), WHO (2019) (2020). Studies on the pricing, availability, and affordability of pharmaceuticals have been undertaken in 20 African countries, including Ghana, Kenya, Nigeria, Tanzania, and Uganda, with assistance from the World Health Organization (WHO) and Health Action International (HAI) (WHO 2019). According to the World Health Organization, medicine costs vary greatly between and within countries, are infrequently covered by insurance, are higher in the private sector, and are usually paid for out of pocket by individuals. The most expensive original products often cost more than 20 times the international reference price, whereas the most reasonably priced generic medications typically cost 9 to 25 times the international reference price [19]. Through the improvement of health-care systems, it might be possible to lower the price and improve access to essential medications. In order to increase the number of individuals with health insurance and lower out-of-pocket costs, the WHO Regional Committee for Africa has created a regional health finance plan that encourages the deployment of prepayment systems [20].

In Sub-Saharan Africa, a number of community-based, social, commercial, and governmental health insurance systems are expanding and changing [21]. The majority of Sub-Saharan African countries have tried to implement Bismarckian social health insurance schemes since gaining independence [22], which primarily safeguard workers in the formal sector and demand joint contributions from the employee and employer. There are currently about 600 community-based health insurance systems operating in 11 countries in West Africa, and commercial and CHIS have formed to offer insurance coverage to the uninsured and informal sectors [23].

For instance, in Ivory Coast, there were 47 operating CHIS in 2006, up from 9 in 1997, serving more than 500,000 clients [24]. From 2 in 1995 to 78 in 2004, Ghana saw a rise in the number of CHIS. In (2018) Batussen., *et al.* Access to treatment may be improved and households can be protected from the costly effects of disease thanks to health insurance [25-28]. Inpatient care is typically covered by health insurance coverage to reduce the financial impact of a hospital stay. Families in low- and middle-income countries (LMIC) spend a large portion of their own health-care budgets on drugs [29-31]. In 2002, low-income households earning less than US$1 per day spent 53% of their health-care expenditures on pharmaceuticals, with medications accounting for more than half of these households' whole health-care budget [32]. Including outpatient pharmaceuticals in health insurance coverage may reduce out-of-pocket medication expenses, increase access to required medications, and provide incentives for proper utilization [33].

The National Health Insurance Scheme (NHIS) was introduced by the federal government of Nigeria in 2005 in an effort to provide universal coverage with precautions against financial risk. However, six years after the program's launch, just 4% of the population (mostly federal government employees) obtained health insurance, largely because of the NHIS's formal sector social health insurance program (FSSHIP). Furthermore, just three of Nigeria's 36 states-Bauchi (2008), Cross River State (2007), and Enugu (2010)-had adopted the program, showing that there are adoption hurdles that need to be found and removed.

Despite the fact that the public sector provides the bulk of health services, personal payments are anticipated to account for 69.63% of health-care funding in 2018. According to a household survey performed in 2014, poverty affects 37.5% of the population. Population-based health care finance is expected to have an impact on equity and redistribution. People's or families' discretionary income is lowered after paying for medical bills, which limits the usage of health care services and worsens the wealth gap between the rich and the poor. Like the impact of taxation, the impact of out-of-pocket medical spending on families varies depending on the architecture of the health payment system. Unlike other studies, this one investigates the amount of wealth disparity among patients at the Federal Medical Centre Jabi in Abuja as a function of current healthcare finance schemes. The study especially looks at whether or not out-of-pocket household payments for health care in the nation narrow or widen the gap between poor and wealthy households. Comparing the post-payment income distribution to the prepayment distribution in order to assess the degree of unfairness brought on by out-of-pocket spending is a typical technique for reaching this aim.

After paying for medical expenses, people's or families' discretionary income is reduced, which restricts the use of health care services and widens the wealth gap between the rich and the poor. The effect of out-of-pocket medical expenses on families varies depending on the design of the health payment system, much like the impact of taxes. In contrast to other studies, this one examines how the current healthcare financing models affect the level of wealth disparity among patients at the Federal Medical Centre Jabi in Abuja.

Income affects one's capacity to pay for medical treatments. According to table 1, households in Nigeria account for the vast majority of health care spending. The amount of household spending is reflected in the value of private spending as a percentage of total health care spending. Estimates for total household healthcare spending in 2010 and 2018 were 70.2% and 69.6%, respectively Jutting J P (n.d.) (2019). (Figure 1). Households, especially those that are below the poverty line, are likely to suffer from the rising cost of health services and health care. In addition, high out-of-pocket costs and a decline in government spending on healthcare impose financial constraints, lower affordability, and restrict access to healthcare, especially for the poor. Two of the most serious health-care funding issues are inadequate and subpar public expenditure allocations concerns confronting African health-care systems. Lorenz (2019) defined health payment concentration curves.

Year	External	Government	Health insurance	NGOs	Companies	Out-of-pocket	Total
2010	82.96	172.19	10.89	30.85	26.62	763.82	1087.35
2011	135.88	190.76	9.01	111.58	27.72	778.53	1253.47
2012	93.11	192.91	74.84	96.07	28.98	791.95	1277.86
2013	84.84	201.17	79.27	40.20	30.70	809.10	1245.28
2014	135.78	271.30	87.13	66.67	32.50	824.81	1418.19
2015	127.32	200.13	92.57	60.59	34.34	898.14	1413.08
2016	131.39	209.51	96.91	61.51	35.94	934.76	1470.01
2017	123.67	126.24	95.16	55.31	37.21	984.09	1421.68
2018	116.69	151.60	92.63	50.44	38.72	1031.80	1481.88

Table 1: Lists the sources of funding for health care (in millions of 2018 US dollars). (2021) 20:227 Knoema World Bank Atlas Sources.

Even though out-of-pocket costs are higher, family involvement in health care financing can enhance resources for the public health sector and possibly boost the utilization and quality of healthcare services [34,35]. But out-of-pocket medical costs, which have a progressively depressing impact, disproportionately affect low-income households [36-38]. Payment obligations can be made easier by establishing prepayment programs like social insurance, which can offer financial assistance for medical care.

Every country has acknowledged that the health sector is the main driver of growth and development. Nevertheless, despite the health sector's excellent contributions to economic growth, it has experienced instability that has negatively impacted the advancement made at various times.

15% of children in Nigeria do not live to be five years old. Malaria and diarrhea are the two main factors in child mortality, each

accounting for 30% of deaths. twenty percent. Malnutrition is a factor in 52% of child mortality under the age of five. According to a 2003–2004 government household census, 63.3 percent of people live in poverty, with rural areas having a higher percentage at 54.4%. (2020) (HERFON). Nigeria has one of Africa's worst poverty-related health indices, and poverty there is becoming more common. Poverty increased significantly between 1992 and 1996, with an estimated third of people surviving on less than $1 and nearly two thirds on less than $2 per day. (FMoH, 2018). Lack of fair and sustainable health care financing, unequal economic and political relations, the Nigerian state's neoliberal economic policies, corruption, illiteracy, very low government spending on health, high out-of-pocket expenditure on health, the absence of in-home care, and inadequate health facilities and structures are just a few of the factors that affect the health system's overall effectiveness.

A larger strategy to attain universal health care should include expanding access to health insurance (UHC). UHC involves protecting all citizens from the potentially disastrous financial repercussions of poor health as well as guaranteeing that all residents have access to and utilize high-quality healthcare services. UHC may significantly influence better health outcomes for all residents, especially the most vulnerable. Nigeria is anxious to acquire UHC. The National Health Insurance Scheme (NHIS), which was founded in 1999, has been the primary effort in Nigeria to enhance access to health insurance. However, as of the middle of 2012, barely 3% of the population was still protected by the NHIS. Officials in Nigeria are eager to learn from other emerging nations' successes in extending health insurance coverage. In 2013, the NHIS reform program will gain momentum as numerous proposals are taken into account. One of them is a piece of legislation to establish a "health fund" to pay for health insurance for particular groups of people. NHIS initiatives are increasingly focusing on the formal and independent sectors, with variable degrees of success. The formal-sector program serves as a health-care social insurance scheme. To reach more Nigerians, the NHIS has launched a rural-focused social health insurance system.

Adoption, on the other hand, has been hesitant. If access and financial protection in the context of health are to be expanded to reach the majority of the people, Nigeria will need to make critical decisions. Given the possibility that the 2008 National Health Bill will be passed by the lower house of Parliament in 2013, Nigerian authorities should now consider the unfinished agenda for health funding. To assist in this quest, the Health Policy Project performed case studies of three nations' experiences developing national policies to achieve universal health care: Colombia, India, and Thailand. The lessons learned should be helpful to the stakeholders in the NHIS who are seeking to grow and improve it.

While attempting to increase healthcare coverage, each country has obstacles. Several nations have pledged to attain healthcare parity by incorporating healthcare aspirations in human rights declarations, constitutions, and health policy initiatives. Governments use increasing health insurance as a tactic to improve everyone's health, especially that of the most vulnerable. It is one method for low-income nations to enact universal healthcare (UHC).

UHC involves ensuring that everyone, especially the poor, has access to and uses high-quality healthcare services as well as protecting everyone from the debilitating financial impacts of disease. Nigeria wants all citizens to have access to healthcare by 2015. It is one of the few countries in Africa that began to increase health insurance in the last five years. The country's National Health Insurance Scheme (NHIS) provides programs for those who are theoretically employed, urban independent contractors, college students, military personnel, some expecting mothers, small children under the age of five, as well as groups like the disabled and prisoners. In accordance with the National Health Insurance Act of 2008, the NHIS introduced a rural community-based social health insurance program in 2010. (RCSHIP).

The NHIS is undertaking an evaluation phase to analyze the benefit package for its members as well as the different premium contribution options. The Nigerian government considers expanding the population coverage of the NHIS to be a major goal. The NHIS now serves 5 million members, or 3% of the entire population, based on the number of identity cards issued. One of numerous approaches to enhance coverage is to force federal government employees to register for the NHIS. Nigeria must assess its method to obtaining universal health care, as well as the possible role of health insurance in that process.

Nigeria will need to make crucial decisions if access and financial protection in the context of health are to be expanded to include the majority of the population. Given the chance that the National Health Bill [39] may pass through the lower house of the National Assembly (Parliament) in 2013, Nigerian policymakers should now consider the unfinished agenda for health financing. One proposal is to make NHIS contributions mandatory for formal-sector employment. This might be accomplished via the Health Bill

or by including a provision when the 1999 constitution is reviewed and changed.

Another bill, commonly referred to as the "NHIS reform bill," that was introduced in the National Assembly at the beginning of 2013 calls for the creation of a "health fund" that would be funded by a "health tax" set aside for this purpose on the value of luxury goods (at a 2% tax rate), as well as any other funds suitable for it. A particular group of citizens, such as children under the age of five, seniors over the age of 65, people who are physically challenged or disabled, inmates in prison, and the poor, as well as pregnant women who require maternity care, would have their health insurance contributions paid for by the health fund. If this health fund is successful, Nigeria could be able to expand the NHIS to cover more people. However, the ability to collect the luxury goods special tax as well as the yearly income will be necessary for the implementation to be effective.

There is a desire in Nigeria to go beyond the current basic minimum of health insurance coverage, as indicated by the prospect of establishing a health fund to offer health insurance coverage for vulnerable people and the likelihood that NHIS contributions will be required. These initiatives follow in the footsteps of other countries that have enhanced health-care coverage in order to achieve UHC. Nigerian stakeholders are eager to learn from other countries' experiences in this regard as they have expanded access to health insurance. It is also important to examine how other nations have avoided the issues associated with expanding programs while maintaining access and high standards of treatment.

Health Insurance Plan Types There are various different forms of health insurance, which are essentially characterized by the method used to pay the premiums. A country may choose from a number of options to guarantee that the most people are covered. What benefits are practical given the premium plans are determined by the financing options for each form. As a result, the following design factors are frequently in use when the public sector selects a health insurance type from a list

- Regardless of their health status or affiliation, all citizens are fully covered by national health insurance, often known as government-managed health insurance, which is mostly funded by general taxes. In this instance, the term "broad taxation" refers to the absence of a targeted tax. It is also possible to use debt reduction and alternative revenue streams like tolls and the sale of public property. Most of the time, people are not forced to contribute any additional funds on top of their taxes. Any other types of health insurance, including private voluntary health insurance, can coexist with these government-funded health insurance programs. The National Health Service of the United Kingdom is an example of a national health insurance program.
- Employers and workers both contribute payroll taxes, which are used to finance social health insurance (SHI). An institution, like the government, is usually obligated to provide this contribution.
- One of the key human qualities that supports both social and economic development is health. Better health increases human and social capital, which raises national productivity and results in a more equitable distribution of revenue [40,41]. "An arrangement in which payments are made by or on behalf of people or organizations (members) to a purchasing institution (a fund) that is responsible for procuring covered services from providers on behalf of scheme members" is how a health insurance scheme is defined [42].
- Either the employer and employee make equal contributions, or one makes more than the other. For instance, the National Hospital Insurance Fund in Kenya mandates contributions from all formal employees while allowing optional participation from individuals working in the unofficial sector. Additionally, SHI has a central management structure that is in charge of managing funding and paying service providers. For low-income or marginalized groups to take part in the program, the government may step in and make payments on their behalf.
- A wide range of initiatives with at least three of the following characteristics fall under the umbrella of "community-based health insurance" (CBHI): community control, not-for-profit healthcare prepayment schemes, and voluntary participation. The community in question might be recognized by a particular spot (like a hamlet) or by another obviously established connection. Among the various CBHI systems are programs that address both high-cost, occasional incidences and low-cost, frequent occurrences. CBHI initiatives are also known as mutual health groups (mutuelles de santé), informal health insurance, and micro-health insurance programs (Gottret and Schieber, 2019 [43]).

They are prevalent throughout West and East Africa, as well as the rest of Sub-Saharan Africa. Many low-income countries also offer private for-profit insurance in addition to these strategies that draw on local or national resources. Nigeria is one of several

Sub-Saharan African countries with a small but growing market for these insurers. These private insurance markets only provide coverage to individuals who can afford the premium payments, therefore their expansion is reliant on both an increase in overall income and the size of the insurer pool. They currently don't offer a workable way to lessen the burden on the public sector in Sub-Saharan Africa when it comes to financing health care.

In Nigeria, additional sources of funding for healthcare include

General tax revenues

When productivity and income permit it, wealthy Western nations with sufficient economic stability frequently fund public health through general tax revenues. But in less developed countries like Nigeria, where tax revenues are lower and distributed among other essential public goods, other public health initiatives like education, infrastructure, and economic expansion are given less attention. As a result, the revenue base and stability required for creating, implementing, and maintaining public health programs are typically absent from general tax monies utilized to finance public health operations. Taxes are categorized as direct, indirect, or excise when they are used to fund public health initiatives. Direct taxes must be paid by individuals to the government; they cannot be avoided through spending or other activities. People are subject to direct taxes based on their citizenship or property ownership. When transactions take place within a government's territorial jurisdiction, indirect taxes are required. Consumption taxes are frequently referred to as indirect taxes. The seller charges the client a tax at the moment of sale or service, which is then transmitted to the appropriate government agency. Common indirect taxes include sales taxes, value added taxes (VAT), and goods and services taxes (GST). As a result, indirect taxes are more general and apply to all goods and services, whereas excise taxes are much more specific and are levied on the production or sale of a specific good or service, and governments can use them to influence public consumption patterns by increasing the price of that good or service. For example, increasing the excise tax on cigarettes raises the price for customers while increases tax income (WHO 2020 [44]).

Voluntary Insurance

Voluntary insurance refers to arrangements made by employers and/or individuals with private insurers to cover potential income losses brought on by illness or the costs of health care use. Many nations use voluntary insurance systems to meet the population's health needs rather than social insurance systems. In these countries, voluntary insurance provides approximately two thirds of the non-elderly working population's health needs, though the ratio varies and tends to decline during periods of slow economic growth. As a result, both social and optional insurance financing models place a higher priority on the provision of acute health care services than on the fundamental duties of public health services.

However, social insurance, whether it be social or voluntary, provides a variety of services, such as disease management and health promotion in addition to public-private partnerships for particular diseases and health education. For instance, close cooperation with other medical professionals is necessary for efficient HIV/AIDS prevention and treatment. Public health won't be able to effectively treat the sick without the help of commercial insurers because the tax funds designated for HIV/AIDS prevention won't be sufficient to handle prevention and treatment at the individual patient level.

Charitable donations

Financial Support No country, regardless of wealth, history, or position on the market maximization or reduction spectrum, can emphasize the importance of charitable gifts, financial assistance, and the work of non-profit organizations in the development and funding of public health. Some nonprofit organizations provide services that are equal to or similar to those provided by governments or for-profit companies. Other people are the only providers of services that meet demands that governments and for-profit businesses are unable to satisfactorily address.

Diabetes associations, for example, will function as catalysts for launching research through promoting health by educating the people.

The Heart and Stroke Foundations and cancer groups do comparable duties. To the greatest degree possible, these organizations meet the needs of individuals by promoting disease prevention and providing resources and information that local and federal governments are unable to provide. If these charitable organizations do not give financial and technical help, the pressures on government funding to address these people's requirements will increase significantly. It is also worth noting that international humanitarian aid is divided into three categories: non-governmental organizations (NGOs), bilateral aid, and multilateral aid. Non-governmental organizations (NGOs) are frequently established to operate independently of governmental institutions, and as such, they provide services ranging from emergency care to financial and technical assistance for specific health needs, as well as community outreach

activities. For instance, multinational NGOs working in the field of health, like Oxfam, spend over €991 million year to address issues with the poor's access to various public health programs and financial disparities. The creation, upkeep, and implementation of programs are also investments made by international non-governmental organizations (NGOs).

Individual Out-of-Pocket Payments Finally, even in affluent countries with universal health coverage, out-of-pocket charges account for a sizable portion of health-care spending. These payments are sometimes provided in full payment for a single therapy, or they are made as cost sharing imposed by insurance or government programs in the form of coinsurance, deductibles, and copayments. The supply and demand economic idea is applicable in this scenario. However, consumers may use fewer services if out-of-pocket costs for health care services are increased or added. Customers who pay cash may run into issues because they may compare the advantages of doing so with the caliber and quantity of services they obtain.

With so many competing priorities, this will determine which services are accepted. As a result, a person's health can be determined by their rate of consumption because some people may choose not to use services because they are too expensive. The demand curve will intersect the vertical axis more frequently the higher the consumer price (WHO 2020). This junction is linked to a decline in the use of services, which lowers total healthcare costs. More people will have access to healthcare services offered in the typical private sector as costs for consumers are reduced. When something is considered private, its usage limits who may use it and could even exclude people who can't afford it. A patient who breaks their ankle and needs an x-ray, for example, is consuming a private good if markets are used to distribute healthcare since they are taking away from the ability of the doctor and x-ray machine to screen further people. Therefore, the exclusion or limitation of individuals who cannot afford the services or who have more important priorities will be increased by direct out-of-pocket payments. Therefore, direct out-of-pocket costs for healthcare services may make it more difficult for people to acquire therapies that improve their health. Some study indicates that out-of-pocket spending that exceeds 20% of overall healthcare costs is a significant barrier. The table below displays the funding sources for health care services. Out-of-Pocket Payments are sums paid for medical treatments at the time of the visit. User fees are assessments made for health care services, albeit their reach is somewhat programmable and may include prescription costs, medical costs, entry fees, and consultation fees. The majority of healthcare costs in Nigeria are borne out-of-pocket.

From 1998 to 2002, out-of-pocket spending as a percentage of total health expenditure (THE) averaged 64.5% before increasing to 74% of THE, indicating that households in Nigeria accounted for the bulk of healthcare costs. However, the Nigerian government introduced user fees in 1998 as part of the Bamako Initiative, which emphasized cost sharing and community involvement to improve the sustainability and quality of health care services. User fees were expected to improve healthcare financing, improving equity and effectiveness. The dispute is about whether user fees should be retained or removed as a source of health funding in Nigeria because it is uncertain how they will affect revenue generation, health care seeking behavior, access to care, efficiency, and service consumption. There is also a strong case to be made that user fees will result in low use of health care services if they do not encourage affordability and service quality improvement, because willingness to pay does not necessarily translate into ability to pay. The ability of Nigerian customers to pay for the services they receive is impacted by the country's slow economic growth. Households may have to give up their long-term financial security to pay for health care. A sacrifice of this nature is referred to as a catastrophic health expense. The federal government and many state governments have eliminated user fees for the treatment of malaria in children under the age of five and pregnant women. Exclusions and/or waivers have been suggested in a number of circumstances, but because of the difficulties in putting them into practice, they are frequently worthless. For instance, issues with the standards used to categorize people as poor, a lack of administrative capability, the willingness of healthcare providers to enforce the requirements for waiver and/or exemption, and the uneven way in which exemptions are granted have all raised concerns. However, due to these obstacles, only a tiny number of advantages for waiver and/or exemption have been established, raising concerns about whether they may be viewed as attractive policy choices for health consumers (WHO 2020 [45]).

During its 26th National Council of Health meeting in July 1984, the federal government of Nigeria resolved to establish a national health insurance program as an alternative method of paying for medical services. Health insurance is the pooling of funds from different people or organizations to pay for all or a portion of the medical services that are covered by a policy or by the law. This calls for risk sharing through payments, in which those who are fortunate enough to be healthy cover the costs of those who are ill in exchange for later reimbursement from the latter. Health insurance is a sort of managed care in which monthly financial contributions from members are pooled to pay a network of healthcare providers for a certain set of medical services. These clinicians are then in charge of cost containment and improving patient outcomes. It is hard to overestimate the importance of health in economic progress. The capacity of a nation to expand is dependent on the health of its people; thus, if that nation is to thrive, it must provide its residents with access to great healthcare.

According to Johnson and Stoskpt, the National Health Insurance Scheme was established in Nigeria during the First Republic in 1962. (2019). The Federal Government authorized the Federal Ministry of Health to launch the program throughout the country in 1993. On May 10, 1999, the then-head of state, General Abdulsalami Abubakar, signed Decree No. 35, which enlarged the system. The fundamental goal of the NHIS is to ensure the provision of health insurance that entitles insured persons and their dependents to the benefits of a variety of high-quality, low-cost treatments. The following were added to the list of NHIS's particular objectives

- The introduction of universal healthcare in Nigeria.
- To limit or reduce the arbitrary cost of healthcare in Nigeria.
- To shield households from the exorbitant expenditures of healthcare.
- Ensuring that all socioeconomic groups contribute a fair part of the cost of healthcare services.
- To provide high-quality healthcare to program participants.
- Encourage increased private sector engagement in Nigeria's healthcare system.
- To distribute healthcare facilities across the country in a fair and efficient manner.
- To guarantee that the primary, secondary, and tertiary healthcare providers in the federation are fairly rewarded in order to sustain and supply a proper flow of funds for the initiative and the healthcare industry as a whole.

WHO (2019a) asserts that the provision of high-quality, conveniently accessible, and fairly priced healthcare remains a significant problem due to insufficient financing and a lack of government commitment to healthcare policies that cover all people. Typically, the government allocates between 2% and 3.5% of its yearly budget to the health sector. A social health insurance program offers financing based on need and means (WHO, 2019 [46]).

Nigeria is one of the developing nations with a low gross national product (GNP) per person, a low ratio of taxable surplus to GNP, and a limited revenue base due to widespread poverty, the composition of unemployment, and administrative challenges. With significant budgetary expenditures, the government has responded over the years with a range of efforts to solve the seemingly intractable difficulties in the health system. The health sector received 17.076 million pounds during the first National Development Plan Period (1961-1968). That sum climbed to N43 million during the fourth National Development Plan Period (1981-1985).

Less satisfaction with the delivery of health services is caused by the enrollee's knowledge of health insurance, whereas this satisfaction only increases if the enrollee is well-versed in the operation of the health insurance program and is aware of all of its benefits. Less understanding of health insurance activities leads to participants being dissatisfied with the offers in terms of service delivery. Due to higher service satisfaction, a better understanding of enrollment may improve relationships between patients and healthcare professionals. There are inclinations for those who are unaware of the insurance services available to give programs a low evaluation (European Commission, 2020 [47]).

The Nigerian government, according to Ibiwoye and Adeleke (2018), thinks that the NHIS will probably help to solve the problem of healthcare access and lessen the problem of healthcare inequalities. But there have been reports of providers failing to provide enrollees with their full entitlements, and some charging extra fees while pretending that the service was not part of the benefit package. Once more, insured people have complained about the attitude and conduct of service providers working for the health insurance program (NHIS, 2006 [48]).

WHO (2019a), Oba (2018), Omoruan, Bamidele, and Philips (2019) all state that the availability of high-quality, affordable healthcare in Nigeria, like in most African countries, is still a major challenge. This is a result of the persistent shortage of professionals in the health industry, as well as the lack of funding, outdated medical equipment, and corruption. Evidence suggests that in 2004, the industry only got 4.6% of the GDP from both the public and private sectors. (WHO, 2019a).

According to the World Bank (2018) and the United Nations Development Programme (2018), only 35% of births in Nigeria between 1997 and 2005 were attended by trained medical personnel, and only 35% of births in Nigeria between 2000 and 2005 were attended by skilled medical personnel. Only 48% of infants aged 0 to 1 had got the necessary number of measles and TB immunizations in 2005. Experts leave Nigeria regularly for other nations. According to a UNDP research, 21,000 medical professionals were employed in the United States and the United Kingdom in 1986. However, due to the departure of more than 1,500 medical experts for other nations, the Nigerian health system was deficient in staff (Akinkugbe, 2019 [49]). Okaro, Ohagwu, and Njoku (2018) found that the high level of understanding of the existence of the plan does not translate into participation as more than half of the respondents did not register with the program. Based on this supposition, the researchers investigated the knowledge and attitudes of the national health insurance scheme at Nigerian research institutions.

Nigerians are split on the NHIS's effectiveness in addressing the country's health issues after more than four years of the system due to the sad reports on the state of the nation's health. For in-

stance, just one million people in Nigeria, or 0.8% of the population, are covered by the NHIS, according to a World Bank (2008) report on the system, while many more must pay for medical care out of their own pockets or go without it. According to the poll, many low-income individuals won't become eligible for NHIS for at least another ten years. Less than 3% of Nigeria's population was covered, according to an appraisal of the effort after four years of operation (Okaro, Ohagwu and Njoku, 2018 [50]). The researchers investigated the knowledge and viewpoint of Nigerian research institutes towards the National Health Insurance Scheme based on the aforementioned.

According to the World Health Organization, the three fundamental aims of a healthcare system are excellent health, meeting public expectations, and financial equity. The first objective, which is to improve general health, is self-explanatory, but the other two require additional detail. The term responsiveness relates to the speed with which the healthcare system reacts to patient expectations. Fairness is defined as "the greatest possible degree of separation between contribution and utilization." It asks that financial responsibility be based on ability to pay, and that access to the healthcare system be based on medical needs rather than financial capability. According to the World Health Organization (WHO), each of a healthcare system's three ultimate goals should be given equal weight. The one and only approach to improving societal well-being is insufficient. To ensure the responsiveness and financial stability of a health system, the effects of policy decisions on health must be carefully evaluated, especially those that affect the most vulnerable. For those who are most at risk, even a little absolute risk can have a big impact on their health and financial situation.

Therefore, without taking into account how their health policies would affect the least disadvantaged groups, policymakers cannot achieve any of the three goals of the healthcare system. The financial effects of healthcare policy on the poor carry even more weight in an era of global crises and reduced healthcare spending.

Although all forms of healthcare financing fall under the umbrella of financial security, out-of-pocket (OOP) medical expenses are of particular significance. Some experts argue that by looking at how the weight of OOPs is distributed throughout society; the fairness of the healthcare system should be "put to the test." When the public component of funding for healthcare becomes insufficient, spending on private healthcare must make up the shortfall. If the balance between public and private funding is incorrect, the health system's purpose of financial protection is jeopardized.

OOP spending makes up 20% of all medical costs, according to data from the Organization for Economic Co-operation and Development (OECD). Direct home healthcare contributions serve a purpose other than financial gain. Cost sharing has both positive and negative consequences for the healthcare business. On the one hand, patient engagement in healthcare finance increases awareness of treatment costs and lowers the use of unnecessary medical services. On the other hand, it may make it harder for the sick and disadvantaged to receive necessary treatment. As a result, out-of-pocket health care costs should be affordable to the poorest. Otherwise, inequities in access to medical services would grow across society, and healthcare institutions will be unable to respond to everyone's needs equally.

Hypotheses

- **Ho**: Non-enrollment with NHIS by patients attending FMC Jabi has no significant consequences /impact on assessments of medical services, such as the cost of pharmaceuticals, comprehensive medical exams, and proper diagnoses.
- **Ha**: Non- enrollment with NHIS by patients attending FMC Jabi (whether they are in or out) suffer significant consequences in terms of the costs of pharmaceuticals, comprehensive medical exams, and complete medical diagnoses.

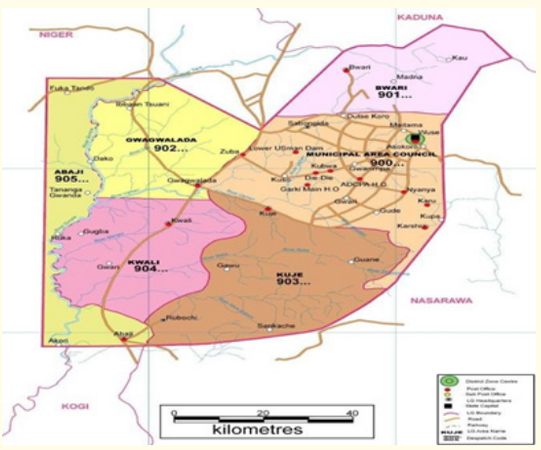


Figure a: Federal Medical Centre Jabi, Abuja.

Methodology

Study Area

The investigation was conducted at the Federal Medical Center (FMC) Jabi in Abuja. The capital of Nigeria is Abuja, and FMC Jabi is located in its north central zone.

The healthcare center employs a wide range of healthcare professionals, such as physicians, pharmacists, nurses, laboratory scientists, and others. All public institutions charge user fees, albeit the amounts vary depending on the service needed, and patients also have to pay for their prescription drugs. The exclusions include treatment for HIV, leprosy, and other infectious diseases.

Two methods were used to produce the data for this publication: a study of pertinent literature and the usage of questionnaires. A detailed evaluation of the literature, policy documents, and grey literature was conducted. The materials analyzed provided information regarding health care financing, notably in Nigeria. We searched PubMed, Medline, The Cochrane Library, Popline, Science Direct, and the WHO Library Database using terms like funding for health care in Nigeria, public health financing, financing health, and financing policies. We located additional publications by searching references cited in relevant papers and reports. Patients who visited the GOPD (General Out Patient Department) and the NHIS (National Health Insurance Scheme) clinic both received questionnaires.

- **Study/Research Design:** The study employed a cross-sectional descriptive design. The research population consisted of clients/patients who went to the Federal Medical Center in Jabi, Federal Capital Territory, Nigeria. The interviewer distributed a questionnaire to find out how the household and the interviewee paid for their medical treatment.
- **Population of study:** Five hundred (500) clients or patients in total participated in the study. Patients who attend GOPD (General Outpatient Department) and NHIS (National Health Insurance Scheme) clinics make up the population. Including both males and females between the ages of 25 and 60 (average age for employment).
- **Inclusion criteria:** All patients who attended the hospital's GOPD unit and NHIS clinic and gave their agreement to participate were sequentially included in the trial. Participants were between the ages of 25 and 60 years who willingly and freely agreed/consented to the usage and reviewal of their archival medical records in order to corroborate their other clinical information. Throughout the study, confidentiality was guaranteed, maintained and preserved.
- **Criteria for exclusion:** People under 25 and over 60 were not allowed to participate.
- **Choosing a sample size:** The sample size in terms of the number of households was calculated using the method for determining the sample size in household surveys provided by the Department of Economics and Social Affairs, Statistics Division, United Nations:
- The sample size (e2) nh is equal to (Z2) (r) (1-r) (f) (k)/(p) (n) = nh.
- z = standard deviation normal
- The sample design effect, deff, is assumed to be 2.0 and corresponds to a 50% estimate of the main indicator. (default setting)
- Assuming a 45-year-old average and multiplying it by 0.03 to get p, the target population's proportion of the total population is 1.35. The average number of households reported by developing countries is 6. The margin of error to be achieved (10%) is denoted by n.
- **Sampling technique***:* The participants, who were between the ages of 25 and 60 and were of working age, were selected using a multistage sampling procedure. The investigation was conducted at Federal Medical Center in Jabi due to logistical and scheduling considerations. The decision was made based on the location of the facilities, the services offered, and the population size in proportion. **A tool for gathering data:** Questionnaire: A pretested, semi-structured, interviewer-administered questionnaire was used to collect information on the participants' sociodemographic characteristics, income level, how they pay for health care services, and any diseases that had occurred in their homes in the month preceding to the study.
- **Data analysis:** The Z test and the IBM Statistical Package for Social Sciences (SPSS) version 21.0 for Windows were used to analyze the data once it was been extracted. The sociodemographic aspects were evaluated using descriptive statistics. Using the chi-square test and the Z test, the relationship between the variables was assessed, and it was shown to be significant at $P < 0.05$.
- **Ethical consideration:** After getting complete information, each participant signed a permission form. Participants were told that their participation was entirely optional, that they might leave the interview at any moment, and that all information would be kept strictly confidential.
- The Federal Medical Centre jabi Abuja gave ethical clearance for the research with the number FMCBA/0876/VOL.1/57.
- **Method of data collection:** Over the course of four months, data were gathered by trained research assistants using a comprehensive questionnaire that was created using information from previous studies. A semi-structured questionnaire that was pretested was used to gather the data.

Results

The participants' ages ranged from 25 to 60. The bulk of them (78%) belonged to the over-30 age group. There were 300 women and 200 men, or 40% of the total. 1:1.5 was the male to female ratio. Even though 339 (67.8%) of the participants were married, 109 (21.8%), and 17 (3.4%) were single or divorced, respectively.

The majority of participants, 317 (63.4%), are neither public employees nor civil servants, with 100 (20%) and 83 (16.6%) respectively. As may be seen in fig. 1 below, more than half of the participants make less money each month than the minimum wage.

Variable	Frequency (n=500)	Percentage (%)
Sex		
Male	200	40
Female	300	60
Total	500	
Age group (yrs.)		
15-19	3	0.6
20-24	57	11.4
30-34	50	10
>30	390	78
Total	500	
Marital status		
Single	109	21.8
Married	339	67.8
Divorced	17	3.4
Others	35	7
Total	500	
Variable	Frequency (n=500)	Percentage (%)
Occupation		
Civil servant	83	16.6
Public servant	100	20
Others	317	63.4
Income status		
₦10,000-<₦25,000	302	60.4
₦25,000- <₦ 40,000	41	8.2
₦40,000- <₦ 55,000	23	4.6
₦55,000- <₦ 70,000	26	5.2
₦70,000-<₦ 85,000	21	4.2
₦85,000-<₦ 100,000	52	10.4
₦100,000- >₦ 125,000	35	7
Household size		
Less than 6	347	69.4
More than 6	153	30.4
Is your household covered?		
No	472	94.4
Yes	28	5.6
Health insurance status		
Lack insurance	467	93.4
Have insurance	33	6.6

Figure 1: Participant sociodemographic data.

The average age of the head of house was 45 years, with 375 (75% of them) being male, 339 (67.8%) being married, and 425 (85%) having experienced a non-chronic illness at least four weeks prior to the study. As seen in figure 1, more head of houses are either jobless or underemployed.

Variables	Frequency (n=500)	%)
Yes	425	85
No	75	15
Total	500	

Figure 2: Shows how participants budget for health care services, the history of illness in the household in the previous month, and how health services are paid for

Mode of payment for Health care services

Out-of-pocket payment 358, 71.6

Outcome	Frequency	%
Self- medication	156	36.7
Ignored the illness	30	7.1
Patronized native doctor	18	4.2
Delayed seeking care	221	52
Total	425	

Figure 3: Financial outcomes for individuals who had a history of sickness in their home before to the research.

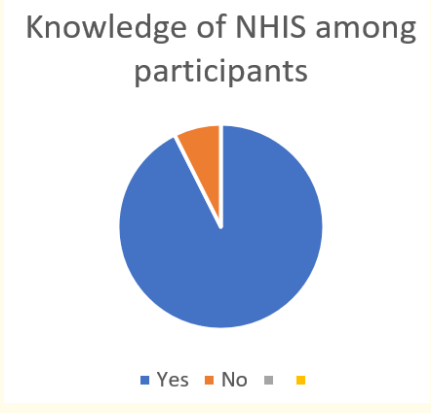


Figure 4: Knowledge of NHIS among participants Have you heard of NHIS? Frequency (n = 500) %.
Yes: 463-92.6 , No: 37-7.4

Treatment seeking behavior

In spite of the fact that 375 (75%) of the head of houses in this research were males, more women than men reported to the General Outpatient Department (GOPD) and NHIS units at Federal Medical Center, Jabi, between January and April 2022. This tendency is seen in fig. 5 below. 425 (85%) of the individuals in this research had a medical history from one month prior. Self-medication and delaying medical treatment owing to financial difficulties brought on by out-of-pocket expenses were two ways that the participants used medical care. The study's qualitative findings have revealed some differences between male and female participants as well as rural and urban settlements.

Male	Female	Total	Month
329	633	962	January
401	906	1307	February
399	846	1245	March
362	782	1144	April

Figure 5a: Women who visited the NHIS clinic from January to April 2022.

Male	Female	Total	Month
801	1417	2218	January
685	1345	2030	February
899	1641	2540	March
697	1370	2067	April

Figure 5b: Number of women visiting GOPD clinic between January to April, 2022.

Due to the poor impressions of the treatment quality that PHCs have historically been associated with, rural dwellers, who made up 381 (76.2%) of the study's participants, prefer to visit patent medicine vendors more frequently than primary health care clinics (PHC).

The disparity in mean value between those who can and cannot afford to enroll in the NHIS and receive critical treatments demonstrates the burden that out-of-pocket health expenses place on consumers.

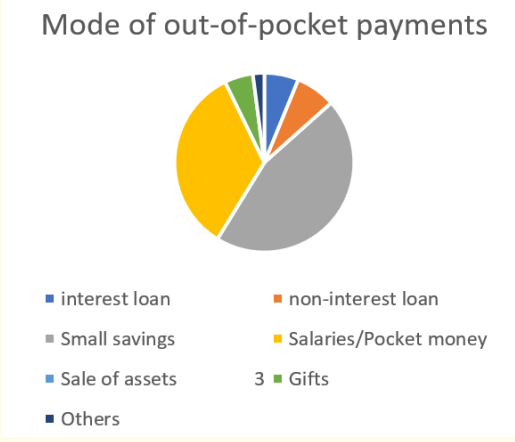
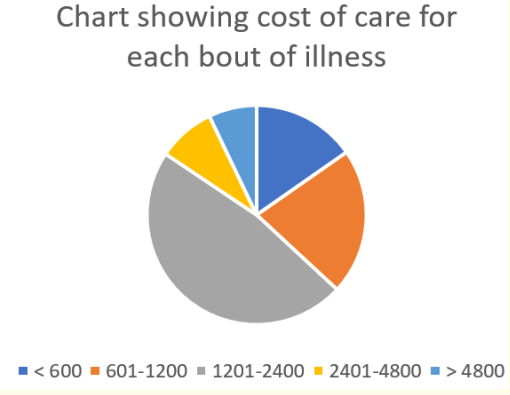


Figure 6: Out-of-pocket payments for health-care services. The distribution of percentages of different types of out-of-pocket payment (OOP) is presented below. Salary/pocket money (33%), modest savings (44%), asset sale (3%), interest loan (6%), non-interest loan (7%) and NGO were the various modes of OOP.

Health problems	Frequency	%	Incidence (0/00)
Fever	80	18.8	16
Difficulty walking	2	0.5	0.4
Typhoid	60	14.1	12
Diarrhea & Vomiting	43	10.1	8.6
Conjunctivitis	5	1.2	1
Abdominal pain	15	0.5	0.4
Vaginitis	2	0.5	0.4

Figure 7: Health care issues experienced by households throughout the one (1) month before to this investigation.



Cost of care (₦)	Frequency	%
< 600	65	15.3
601-1200	92	21.6
1201-2400	202	47.5
2401-4800	36	8.5
>4800	30	7.1
Total	425	100

Figure 8: Distributions of household health-related out-of-pocket spending from the month before this study.

Those who can pay for prescription medications, healthcare, and diagnostics, as well as those who can enroll in the NHIS	Encompasses both individuals who are eligible to participate in the NHIS and those who cannot afford to pay for prescription medicines, medical treatment, or medical diagnostics.
34 (95% CI 31.8- 36.2%)	122 (95% CI 119.8-124.2)

Figure 9: Mean values for patients who can pay for medical services, prescription drugs, and a thorough diagnosis as well as enrollment in the NHIS.

Capacity to pay (CTP)	Income of household #	Subsistence expenditure #	Ratio of out-of-pocket payment %
80% of house	200,000	120,000	60

Figure 10: Catastrophic health expenditure on household.

The percentages of individual house-holds that don't have the capacity to pay for their health services and therefore undergoing catastrophic health expenditure as stated by WHO 40% or less.

Discussion and Conclusion

Discussion

The primary goal of health finance is to ensure that there is enough money available so that everyone may obtain high-quality private and public health care. This is achieved by preventing circumstances in which people are denied access to health-care services because they cannot afford them, which has been a major issue in many nations, including Nigeria (WHO, 2018). According to the findings of this study, 472 (94.4%) of the participants lacked health insurance, so they were responsible for covering their own medical costs while seeking care for themselves and any dependents or family members. This group of uninsured persons expressed difficulty assessing high-quality medical care due to their poverty. Those who took advantage of the NHIS prepayment scheme, on the other hand. According to several research, OOP payments are typical in low- and middle-income nations (LMIC). Figure 6 shows that the majority of respondents claimed to have paid the OOP using household funds. In certain instances, participants were required to wait until they received their paychecks before beginning or continuing to use healthcare services. It is obvious that the practice of delaying access to care until salary is paid (figure 3) or disrupting ongoing care. Similar to this, household finances are regularly utilized to pay for other important household costs like past-due rent and school fees. The use of such meager resources on healthcare (figure 3) may make it difficult for households to fulfill their other legal duties.

The allocation of the limited financial resources available to households requires difficult judgments. Borrowing enables a household to satisfy vital requirements when the cost of doing so exceeds the overall income of the household, particularly for those making less than the federal minimum wage. One of the coping mechanisms used to fund OOP payment for healthcare services when household wages were insufficient was borrowing from cooperative groups like micro finance banks and lending shacks as well as selling household assets like land.

Although cooperative loans can seem simpler to get than commercial loans, they come at a catastrophic opportunity cost since they reduce future household income while being repaid. Similarly, replacing sold assets drains household wealth and cuts into future resources (Onwujekwe., *et al.* 2020 [65]).

Therefore, one of the key determinants of the use of health services is inability to pay for them. Despite the fact that there is a great unmet demand for healthcare, under-utilization of health services, particularly by the poor and disadvantaged, continues to be an issue in developing nations (Guun, 2020 [66]).

Despite the National Health Insurance Scheme (NHIS) having been around for 14 years, the survey revealed that just 5.6% of eligible people had signed up. However, this falls within the claimed enrollment range of 1–10% for various African nations (De Allegri., *et al.* 2019 [67]).

Bottlenecks, a subpar governance structure that favors federal control, mistrust between the federal, state, and local tiers of government, corruption, ignorance of potential beneficiaries, and aggressive behavior on the part of members of organized labor and trade union organizations are likely to be the causes of the appalling enrollment in the NHIS (Ogaji and Brisibe , 2019). The findings of this study imply that participants may be shielded from financial ruin by utilizing the accessible healthcare.

The issue is made worse by out-of-pocket payments, a common strategy for boosting government funding, because willingness to pay for health care services does not equate to ability to pay (Guung, 2020 [68]).

Additionally, reliable research indicates that lowering or eliminating out-of-pocket expenses at the moment of use enhances the use of healthcare services (Emmett, 2018 [69]).

Individual out-of-pocket payment was implemented in Tanzanian public hospitals in 1994, which resulted in a 53% decrease in attendance. Evidence from other low-income nations like Uganda, Burundi, Zambia, and Niger demonstrates that doing away with out-of-pocket expenses at the point of use immediately affects the way people utilize healthcare and even results in lives being saved.

This study highlights the issue that the majority of clients/patients and their dependents at Federal Medical Center, Jabi, Abuja, find it challenging to obtain high-quality healthcare services by paying for them out of pocket and as a result are subject to catastrophic medical costs. It is recommended that the government reaffirm its dedication to expanding the NHIS prepayment program in order to advance universal access to high-quality healthcare.

General tax revenues, which were formerly the most important source of funding for health care, have long been insufficient as a source of health care finance expenditures brought on by population increase, the global economic downturn, and sector-specific conflicting needs (Sambo, 2021 [71]). Currently, approximately 43% of all expenditures in Africa are made by the private sector, compared to 37% by the government and about 25% by donors. Nigeria's government barely devotes 14% of its overall budget to health, compared to 79.2% of private spending, despite the country's $260 per capita GDP.

This illustrates that out-of-pocket costs are the main way that healthcare is paid for in Nigeria. Nigeria invests $5 per capita on health, which is much less than the $14 and $34 that the WHO Macroeconomic Commission for Health and the World Bank for Africa propose for low-income nations to provide basic health care (WHO, 2020, Palmer., *et al.* 2020 [73]).

Patterns of use of health care services may be influenced by geographic characteristics such as topography, economic accessibility, literacy level, and perceived derivable advantages. Participants who reported symptoms of non-chronic illness for weeks prior to this study had higher rates of delayed seeking of care (52%) and self-medication (36.7%) compared to those who used other forms of care.

The poor socioeconomic position of the research population and the persistent out-of-stock syndrome (OS) at government-owned healthcare institutions may be the causes of the study population's preference for self-medication, procrastination in seeking care, and use of local doctors. As a result, household heads with limited means cannot afford to pay for the aforementioned instead of going to a medical institution. The majority of those who offer pharmaceuticals for self-medication lack the official expertise necessary to prescribe or administer medications, which increases the risk of patient damage. This point must be made emphatically.

According to this report, people who live in rural areas 381 (76.2%) don't have access to government-run medical services and must rely on private pharmacies. Some of these vendors lack the fundamental knowledge necessary to dispense the proper treatments or medications. There has hardly been any effort made by the government to increase their capacity, despite the fact that these patent stores are frequently the only sources of healthcare.

From fig. 9, it is evident that people who can afford health care, drugs, and an accurate diagnosis as well as being registered in the NHIS have a mean value of 34 as opposed to those who cannot, who have a mean value of 112. This makes it quite evident that, despite their salary level, which is below what is considered substantial, they cannot afford to enroll in or obtain the requisite services when they are needed.

The household capacity to pay (CTP), in relation to catastrophic health spending on households, is used to estimate the proportion of households that would incur such costs (CHE). The WHO considers 40% of the household CTP to be a reasonable CHE threshold. As a result, the CTP equals the household's income minus its subsistence expense. Total expenditures will serve as an indicator of effective income since they correctly reflect the household's purchasing power. The entire amount spent by the household on food is used to determine the subsistence expenditure. In order to compute CTP, the entire cost is subtracted from the subsistence ex-

pense. Additionally, this will provide the ratio of OOP health care payments to CTP, which will show the total cost of medical bills for the family. The household is deemed to have CHE if the sum is equal to or greater than 40%. The results show that 80% of our respondents are coping with catastrophic medical expenditures as a result of the CTP value being 60%, which is greater than what the WHO advised

Conclusion

The study's findings highlight the impact of out-of-pocket expenses and universal access to healthcare in the twenty-first century, but they might not be sufficient to inform government policy choices regarding the necessary funding for the proposed package of under-five care under the national health insurance program. This is due to the fact that household health expenses are significantly influenced by economic position. Given its advantages for resource mobilization, encouraging efficiency, sustainability, and private sector growth, others may consider out-of-pocket spending as a funding alternative; however, the nation's endemic poverty still poses a serious threat to its adoption, particularly among the poor.

This underscores the necessity for further pro-poor initiatives, such as the proposed under-five social health insurance system within the National Health Insurance Scheme (NHIS). However, the efficacy of this program will be determined by evidence-based information as well as adequate stakeholder input in its development and execution.

This study demonstrates that safeguarding the poor is critical to mitigating the negative consequences of OOP payment and that effective activities are necessary to enhance the socioeconomic level of families.

"Reducing or eliminating all user fees in government-run health care facilities would be a constructive step towards protecting households from high costs of illness," but such an approach still needs additional funding to accommodate the anticipated increase in demand for healthcare services as well as to ensure that the quality of care is enhanced and maintained. To avoid negative effects, these modifications must be properly planned and implemented in agreement with Gilson and McIntyre.

It is also suggested that improving the accessibility and standard of service in the public health care system will encourage people to seek treatment there and protect them from paying more and obtaining subpar care in the private sector or skipping treatment altogether. Primary health centers must be improved in terms of resources and care quality if they are to alter public perception and become the initial site of treatment. Physical accessibility may be improved by building primary healthcare facilities in underserved areas. Increasing access to high-quality healthcare could also be accomplished by using properly qualified and government-funded community-based health workers. If this doesn't happen, families will keep self-medicating, going to their neighborhood physicians, postponing care, or even ignoring their illnesses, as has already been demonstrated.

According to Breman, households cannot be completely shielded from the expenses of disease even if health care systems are enhanced. He suggests that conversations and research on health policy be expanded to include initiatives beyond the health field; initiatives that improve household livelihoods, protect the vulnerable, and boost incomes. These theories are supported by the study, which also suggests interventions like supporting microfinance programs that finance small and medium-sized businesses and giving people access to ways to make weekly or monthly savings goals. Plans that provide widows and female household heads special attention are necessary to guarantee access to healthcare and protect against catastrophic expenditures.

Since damaging widowhood traditions are still practiced in Nigeria and 67% of Nigerian women survive their husbands, Onotai contends that every woman is a future widow. To provide the social protection of this population's most vulnerable members, state and federal laws protecting women from these practices must be established and put into effect (widows and siblings). The fact that there were more women than men in this study emphasizes how crucial it is for the government to fully participate in financial empowerment and protection of women, especially widows.

In light of the research participants' very little usage of public health facilities to treat their various ailments, it may be concluded that their level of investment in health care is minimal. Given that it is now believed that more than 4 in 10 people in the nation live below the federal poverty line, this may be a reflection of the extent of poverty in the nation.

Recommendations

- The health sector should receive more funding
- Tax revenue from the wealthy should be utilized to pay for health services for the underprivileged.

- The private sector should be encouraged to pay for its workers' health care services
- To entice people to enroll, health insurance should provide coverage for most, if not all, medical diagnoses and pharmaceutical care.
- All healthcare institutions should have an integrated system for disease prevention, surveillance, and treatment to reduce the possibility of disease outbreaks.
- This study suggests interventions like supporting microfinance programs that finance small and medium-sized businesses and giving people access to ways to encourage weekly or monthly savings. Plans that prioritize widows and female heads of families in particular are essential for assuring access to healthcare and safeguarding against catastrophic expenses.
- This study suggests that discussions and research on health policy be broadened to include initiatives that benefit households' livelihoods, safeguard the weak, and increase their incomes.

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