

**ANALYZING HEALTH FINANCING AND THE IMPLICATIONS ON HEALTH
ACCESS AND EQUITY IN CANADA, NIGERIA AND GHANA**

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List of Acronyms

CBHI	Community Based Health Insurance
CBO	Community Based Organisation
CHT	Canada Health Transfer
CIHI	Canadian Institute for Health Information
CSDH	Commission on Social Determinants of Health
CSO	Civil Society Organisation
CST	Canada Social Transfer
DAH	Development Assistance for Health
DF	Donor Funding
DMHIS	District Mutual Health Insurance Schemes
FBO	Faith Based Organisation
FCT	Federal Capital Territory
FMOH	Federal Ministry of Health
FSHIP	Formal Sector Social Health Insurance Programme
GAVI	Global Alliance for Vaccines and Immunisation
GC	General Comment
GDP	Gross Domestic Product
GFC	Global Financial Crisis
GMHE	Global Minimum Health Expenditure
HCP	Health Care Provider
HIC	High Income Country
HMO	Health Maintenance Organisation
ICESCR	International Covenant on Economic, Social and Cultural Rights
ILO	International Labour Organisation
IMF	International Monetary Fund
LMIC	Low and Middle Income Country
NHIA	National Health Insurance Authority

NHIF	National Health Insurance Fund
NHIL	National Health Insurance Levy
NHIS	National Health Insurance Scheme
NGO	Non-Governmental Organisation
ODA	Official Development Assistance
OECD	Organization for Economic Co-operation and Development
OOP	Out-of-Pocket Payments
OHCSF	Office of the Head of Civil Service of the Federation
PAHO	Pan American Health Organisation
PHI	Private Health Insurance
PCHIS	Private Commercial Health Insurance Schemes
PMHIS	Private Mutual Health Insurance Schemes
RCSHIP	Rural Community Social Health Insurance Programme
SHI	Social Health Insurance
SSA	Sub-Saharan Africa
SSNIT	Social Security and National Insurance Trust
TFF	Territorial Formula Financing
TIIFHS	Taskforce on Innovative International Financing for Health Systems
THE	Total Health Expenditure
UHC	Universal Health Coverage
USSHIP	Urban Self-Employed Social Health Insurance Programme
UN	United Nations
UNICEF	United Nations International Children's Emergency Fund
US	United States of America
WHO	World Health Organisation
WTO	World Trade Organisation

Abstract

This major research paper examined health financing and the implications for health equity and access to care in North America and Sub-Saharan Africa (SSA) countries with emphasis on Canada, Nigeria and Ghana. Relevant scholarly journal articles and books were reviewed to meet the objectives of this paper. Literature analysis was used to examine the data obtained for this study. Research findings show that health financing is driven by free market economy (neoliberalism) in both SSA and Canada.

Moreover, in making comparison of health financing in the developed and developing nations from 2000 to 2014, the study revealed that the total health expenditure as a percentage of GDP for both Nigeria and Ghana is less than half that of Canada. Also, the government of Ghana is stronger than Nigeria in terms of public health care funding, although both countries are making positive progress in health financing. Generally, the public health financing in Canada is larger than in both Ghana and Nigeria. In the perspective of global health financing, this indicates the presence of inequality in government health expenditure in HICs and LMICs.

Furthermore, the analysis shows there are many barriers to the attainment of health financing objectives. This study recommends reform of health care financing systems and giving higher priority to health in government budgetary allocations in various countries as a way of addressing these barriers.

In conclusion, it is appropriate for governments of every nation to utilize resources efficiently and equitably for healthcare and ensure prudent spending of money for proper policies in health finance and enhanced health care delivery.

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Chapter 1

1.0 Introduction

The World Health Organization (WHO) Report (2000) stated that the aim of health system financing is to make funds available, as well as to set provider incentives to enable individuals to access health-care services in a timely manner when required. In 2007, the aforementioned definition was extended as follows: “A good health financing system raises adequate funds for health, so that people can use needed services protected from financial catastrophe or impoverishment associated with having to pay for them. It provides incentives for providers and users to be efficient” (WHO, 2007). According to Olakunde (2012), health financing is also significant in closing disparity gaps within an economy as “the first wealth of a nation is its health”. The occurrence of health care financing and its viability have now become a main theme of health policy in developed countries such as Canada, United States of America (US), and Europe (Hsiao, 2007; Canadian Health Services Research Foundation, 2007; Thomson, et al., 2009; Nichols, 2007). In addition, as joblessness rises, incomes drop and burdens on health budget and public infrastructure could reach its limit; thus, Evans (2002) argued that public health systems financed through taxes can be more reactive to financial burdens and more effective in the consolidation of health expenses.

Money is crucial in health care, but it is not a necessary condition for efficient and rightful well-being. Extra health spending does not necessarily translate to better-quality health results (Hsiao, 2007). Hence, money can be converted into equitable health care with proper financing methods and involvement of human resources (Garrett, 2007). Repeatedly, discussion on health policy according to Hsiao (2007) focuses narrowly on how to generate more funds for health care, disregarding the health financing methods. Moreover, health financing method plays an important

role in cost control as cost burdens have influence on every country. However, it is evident that health financing methods affect health spending inflation in a different way with resultant effect on the viability of equitable health care (Gottret and Schieber, 2006). According to Kutzin, Cassin, and Jakab (2010), health financing in the larger perspective of economic policy would help support a more informed dialogue between health sector leaders and authorities of the ministries of finance. Also, the health sector would get better value from existing funds if there is better stability of funding and timely expenditure, resource distribution and equality in procuring methods within the health sector.

Internationally, there is a strong connection between economic development and health expenditure, specifically with government health spending. “Health spending as a share of gross domestic product (GDP), per capita health spending, the share of government spending in total health spending, and the share of health spending in the total government budget increase as national income increases” (Fleisher, Leive, and Schieber 2013). The World Bank data shows that the link between macroeconomic and fiscal performance and government health spending is not driven by per capita GDP alone, but by the ability of low-income countries to reduce the levels of their debts and increase the efficacy of their efforts in revenue collection (Fleisher et al., 2013). Hence, macroeconomic and fiscal policy should be considered in government health spending to enhance the overall well-being of the people and economic development. When government prioritises health in its budget, and considers macroeconomic growth, the population growths of countries are facilitated, and service delivery and financial protection are enhanced (Maeda et al., 2014). Governments of nations prioritise health in their budgets differently, with the share of total general government expenditure allocated to health averaging 11.5 percent across 157 countries (World Bank, 2015).

Government policy on financing health services might affect equitable delivery of health care. Hsiao (2007, p.956) argued that in every country, different health financing techniques affect health spending inflation differently with subsequent effect on the viability of equitable health care. This research paper therefore elucidate health financing and the implications on health equity and access in North America and Sub-Saharan Africa countries.

1.1 Objectives

The broad objective is to analyse how health financing impact health equity and access in the developed and developing countries. The sub-objectives include: 1) to examine the current health care financing in the continents of North America and Sub-Saharan Africa with particular emphasis on Canada, Nigeria and Ghana; and 2) to make comparison of how health financing in the selected countries affect access and equitable distribution of health care.

1.2 Structure of research paper

The structure of this research paper include: the first chapter explains the introduction which contains the objectives of the research. The second chapter discusses the definitions of key concepts - health financing models, health access, health equity and inequity, health and human rights, and health and globalization/neoliberalism. The third chapter reviews literature on health financing taking into consideration public, private, and innovative health financing, and discussion on their different types in Canada, Nigeria and Ghana. Also, the chapter discusses the implications of health financing on health equity, and how LMICs could ensure equity in health financing. The fourth chapter makes comparison of health financing in Canada, Nigeria and Ghana. Finally, chapter five concludes with implications for research and practice.

Chapter 2

2.0 Definitions of Key Concepts

2.1 Health financing models

Health care systems are comprised of financing models. A nation's health care system cannot be adequately supported with just one model (Kulesher & Forrestal, 2014). Thus, different types of models exist in a country's health system. *Beveridge model* known as the National health model is characterized by health care coverage for all citizens by a central government. It is financed by general tax revenues. In this model, the health care providers are either owned or controlled by the federal and regional/state governments (Kulesher & Forrestal, 2014). Examples of this model are found in Denmark, Ireland, and the UK (Graig, 1999; McPake et al., 2002).

Bismarck model also known as the social health insurance model is characterized by health care coverage that is funded by employer, employee, and private insurance funds. This model is also referred to as tax-based insurance because it is funded through occupation taxes, and it is under the control of the government or private bodies (Kulesher & Forrestal, 2014). Examples of this model are predominantly found in Germany, Belgium, Netherlands and France (Graig, 1999; McPake et al., 2002; Reid, 2010; Saltman & Figueras, 1997; Freeman, 1998). Also, this model occurs in a small percentage in SSA countries such as Nigeria and Ghana (White et al., 2006).

Another health financing model is the *national health insurance model*, which is a combination of both Beveridge and Bismarck. Payment emanates from a government operated insurance program that every citizen pays into. It is a single payer system without requirement marketing, thus, there is no financial ground to refuse claims. This model is found in Canada (Health Care Systems, n.d.).

Moreover, the *private insurance model* is characterized by employment-based or individual purchase of private health insurance financed by individual and/or employer contributions. The ownership and management of service delivery and financing of this model is done by the private bodies operating in an open market (Kulesher & Forrestal, 2014). This model have been espoused by the USA (Graig, 1999; McPake et al., 2002), and this model is not found in Canada, Nigeria and Ghana. Table 2.1 beneath displays the characteristic features between Bismarck and Beveridge model. In the case of Bismarck, service entitlement basis is centred on the contribution made by an individual toward the services required. Non contributors cannot benefit from the service, whereas Beveridge model offers services only to a country's resident or citizen (Verma et al., 2015).

Table 2.1: Characteristic features between Bismarck and Beveridge model

Feature	Financing models	
	<i>Bismarck</i>	<i>Beveridge</i>
Entitlement basis	Contribution	Citizenship/residence
Funding base	Wages	All public revenues
Insurer	Occupational	State
Benefit package	Explicit	Implicit
Management	Independent	Government
Providers	Privately contracted	Salaried and publicly contracted

Source: Verma, et al. (2015).

Also, from the above Table 2.1, the funding base for Bismarck is the salaries received by the contributors'; conversely, Beveridge uses all the public revenues such as taxes from diverse sources. Concerning Bismarck, the insurer for the services is occupational whereas in Beveridge it's provided by the state. Benefit package is clearly stated (explicit) and in detail, without doubt

of any kind in Bismarck model and implicit that is, implied and not clearly stated in Beveridge model (Verma et al., 2015). In the case of Bismarck model, the management is independent but the Beveridge model is managed by the government. Lastly, services providers in Bismarck are privately contracted while in Beveridge model, they are salaried and publicly contracted (Verma et al., 2015). The public, private and other health financing models are discussed in the later part of this research paper.

2.2 Health care access

Access to health care is often identified as a goal for health care policy, and it may be defined as “a measure of potential and actual entry for a given population into the health system” (Khan and Bhardwaj, 1994). It also implies the empowerment of an individual by decision makers to use health care services when desired. This process involves exchange of information between the health system decision makers and community members. In support of this aforesaid statement, Donabedian (1973) and Penchansky (1977) affirmed that access is not a passive concept but relates to the communicative interaction between individuals and the health care system. From another viewpoint, access is construed as a supply concept relating to the availability of services (Guagliardo, 2004; Perry and Gesler, 2000; Rosero-Bixby, 2004). On the other hand, Falkingham (2004) and Jutting (2001) explain that access is construed as a demand concept that related to the ability to remunerate for services.

The notion of access is based on three dimensions: availability, affordability, and acceptability (McIntyre et al., 2009). Hence, it is the interaction between these dimensions that determines access. *Availability* or physical access is concerned with whether the applicable health care providers or services are supplied in the right place and at the right time to meet the prevalent needs of the population. In LMICs, the limited hours of service mostly at the primary care level

have influence on people's choice of provider, even with the higher costs of using the private sector. Hours of service are also an important aspect of availability in HICs (McIntyre et al., 2009). For example, the current use of capitation payments at the primary care in Ontario enable providers to reduce office hours without loss of income. *Affordability* or financial access is concerned with the individual's ability to pay for the service in the context of the family budget and other demands on that budget (McIntyre et al., 2009). However, affordability goes beyond 'ability to pay' by also requiring the possible effect on family well-being of their incomes to cover the full cost of individual's health care expenditure (Russell, 2001). Affordability also depends on the form of payment (either cash or in-kind) required by the health care provider or system (Jutting, 2001; Lieu et al., 1993; Waters, 2000). *Acceptability* or social access is concerned with the fit between provider and patient attitudes towards and expectations of each other. Acceptability is critical to ensuring the individual's empowerment to use services and hence is an important aspect of achieving public health goals that depend on patient compliance. Acceptability problems arise where health care services are organized from the perspective of the system and its providers as opposed to from the perspective of individuals or patients, that is, a positive perspective concerned with the conditions required to empower individuals to use services (Gilson, 2007).

2.3 Health equity and inequity

Health *equity* can be generally defined as the decrease of avoidable and unfair inequalities in health (Commission on Social Determinants of Health (CSDH) Report, 2008). Similarly, Qidwai et al. (2011) describe equity in health care as "when health resources are allocated and health care services are received according to need". Health *inequity* is disparity in health or its social determinants that benefit the more privileged groups in the society (Braveman and Gruskin, 2003). Thus, *health inequities or disparities* could be detrimental to people's well-beings as a result "a

toxic combination of poor social policies and programmes and unfair economic arrangements” (CSDH Report, 2008). Moreover, equity could be defined in terms of horizontal or vertical. *Horizontal* equity signifies the degree to which people who are equals are treated equally; “this can apply to access, financial contributions, health services utilisation or health outcomes”. *Vertical* equity signifies the degree to which people who are dissimilar are treated in a different way (Wagstaff, 2010; Wagstaff and Doorslaer, 2002; Folland et al., 2010). Barugahare and Lie (2015) defined *global health inequity* as health inequity among individuals irrespective of national borders, or health inequities between and within countries. The occurrence of health inequities is connected largely to the unequal distribution of social determinants of health (SDH), and subsequent influence by arrays of public health policy. Even with the availability of an energetic non-governmental organization (NGO) motivating health equity, Canada is inferior to other countries in the implementation of policies that would improve SDH (Raphael, 2011; Edwards and Cohen, 2012).

2.4 Health and human rights

A human right to health occurs in international law through treaties, the most significant of which is the 1966 International Covenant on Economic, Social and Cultural Rights (ICESCR). Article 12 of ICESCR (United Nations (UN), 1966) recognizes the right of every individual to health. The UN Committee on Economic, Social, and Cultural Rights issued General Comment 14 (GC 14) which interprets the right to health as extending beyond timely available and appropriate health care to incorporate access to other determinants of health. Further, the GC 14 put emphasis on the special obligations of state to provide for the satisfaction of health needs of people whose poverty, disabilities, or background make them the most susceptible (Committee on Economic, Social, and Cultural Rights, 2000). The GC 14 core obligations related to right to health will

therefore influence state party to comply with these obligations. The rights contained within ICESCR are universal, as they apply to all individuals in all places thereby promoting human self-esteem (United Nations, 2010). In addition, Kickbusch (2003) posited that in terms of foreign policy and development aid, Canada is signatory to international treaties that identify the right to health such as the Universal Declaration of Human Rights (1948) and the ICESCR (1976). The Canadian Government also played a central role in founding the Ottawa Charter for Health Promotion in 1986, a statement emphasizing the impact of the social determinants of health (Kickbusch, 2003). Also, in 1991, Canada approved the UN Convention on the Rights of the Child with emphasis on the health care rights and well-being of children. Lastly, “the concept of health as a human right is central to the creation of equitable health systems “(UN, 1948, Pillay, 2008). According to the United Nations High Commissioner for Human Rights (2008), the right to health (Article 16) is also recognized in the African Charter on Human and Peoples’ Rights (1981). Nigeria signed this Charter in 1982 while Ghana signed it in 2004 (African Commission on Human and Peoples' Rights, 2017). The World Trade Organization (WTO) Constitution agree that it is the fundamental right of every individual to have access to timely, adequate and inexpensive quality health care. The right to health means that Countries must ably create healthy conditions for their citizens (WTO, 2013).

2.5 Health and globalization

Globalisation is a process of integration of world finances and markets; in other words, it involves cross-border transactions among people, assets, goods and services (Karakowsky and Guriel, 2015). According to Bertocchi and Canova (2002), the post-colonial experience in the Sub-Saharan Africa (SSA) led to the modeling of western forms of capitalism, and the adoption of neoliberalism. Globalisation affects health financing, and it is generally known amidst the major

healthcare financing mechanisms that out-of-pocket (OOP) payments are connected with most welfare losses to individual families and the society (ILO/PAHO, 1999). Also, most of the Western nations including Canada currently have little OOP expenses as shown in the proportion of health spending from OOP payments for organisation for economic cooperation and development (OECD) countries in 2002 (OECD, 2005). The prevalence of these payments in many countries has risen from the neo-liberal ideologies that depend on borrowing from international donor organizations. In many SSA countries, expenditures on health and other social services were cut down, and the burden of financing health care became driven by market forces and economic power (Knaul, et al., 2006). Thus, the discussion on how globalisation applies to health financing systems will be discussed under the overview and comparison of health financing in Canada (high income country), Nigeria and Ghana (low medium income countries) in the later chapter of this paper.

2.6 Methodology

2.6.1 Areas of study

Canada is a high-income country with a population of 35,151,728 in 2016 (Statistics Canada, 2017), and a land mass of 9,093,507 km² (or 9 984 670 km² including inland water). The country is bounded by the US to the south and the north-west (Alaska), the Pacific Ocean in the west, the Atlantic Ocean in the east, and the Arctic Ocean in the far north. In terms of the system of government, Canada is a constitutional monarchy based on a British-style parliamentary system. It is also a federation with two constitutionally recognized orders of government. The first order is the central or “federal” government, while the second order comprises of the ten provincial and three territorial governments which provides main parts of publicly financed and administered health services (Marchildon, 2013).

Nigeria is a lower middle-income country (LMIC) situated on the western coast of Africa with a population of 185,989,640 in 2016 (World Bank Data Report, 2017). The country covers an area of 356,668 sq. miles and borders with the North Atlantic Ocean, between Republic of Benin and Cameroon. The Nigerian health system is devolved into a three-tier structure with distinct responsibilities at the federal, state, and local government levels. There are 36 States and a federal capital territory (FCT) Abuja, and 774 Local Government Areas. All three tiers of government share responsibilities for providing health services in Nigeria (Okebukola and Brieger, 2016).

Ghana is also a LMIC in West Africa with a population of 28,206,728 in 2016 (World Bank Data Report, 2017), and a land mass of 238,535 km². The country is bordered with Côte d'Ivoire to the west, Burkina Faso to the north, Togo to the east, and the Gulf of Guinea and the Atlantic Ocean to the south. Ghana has a well-developed, integrated health system which comprises community-based health zones; health centres; regional and teaching hospitals; private health providers; and non-governmental health-related organizations. The Ministry of Health superintends the highly decentralized health system in Ghana (Schieber et al., 2012).

2.6.2 Data collection method and Analysis

In this major research paper (MRP), a literature review is used to explore health care financing and its impact on health access and equity in the developed and developing countries. The study used secondary data sources of scholarly journal articles and books relevant to the research topic across the selected continents of North America (Canada), and Sub-Saharan Africa (Nigeria and Ghana). A systematic method of conducting a literature review as described by Creswell (2014, p.31) was used for the purposes of this paper. The secondary literature review searches a variety of scholarly journal articles and books dealing with various aspects of health

financing, health equity and access in the global context with particular reference to Canada, Nigeria and Ghana. Catalogue searches for journal articles and books were done through the online portal using keywords - “health care financing”, combined with “health equity”, “health access”, “health and globalization” AND Canada OR Nigeria OR Ghana OR Sub-Saharan Africa as search terms. The literature searches located a great deal of material, and the final journals and books were selected based on their years of publication and relevance to the research topic. Mostly, current journal articles and books were carefully chosen for this research paper, although a small number of journal articles with printed date of over twenty years were useful. The books utilised for this research provided demographic and health expenditure data, which are basically from Canada’s health agencies, the WHO and the World Bank.

A critical analysis was used to examine the literature obtained for this study. The information from the journal articles and books were categorised for purposes of classification and tabulation of data to main themes (Kondracki and Wellman, 2002). In this case, the demographic and health expenditure data were classified and analysed based on the objectives and themes of the research. This research also make use of figures and tables for data interpretation and discussion of the findings. In this perspective, the comparison of findings on health care financing in the developed and developing nations of Sub-Saharan Africa might be useful for the development of health policy.

2.6.3 Limitations of data

This research can have some limitations; data collection through documents such as scholarly journals, books and public documents such as government reports can be time consuming because the researcher may require much time to search for relevant information. In addition, there is the possibility that the materials may be incomplete, and the selected documents may be

unauthentic or inaccurate as well (Creswell, 2014, p.192). If the qualitative data sources are prone to bias, this may affect the interpretation and final research findings.

After discussion on health financing models, health care access, health equity and inequity, health and human rights, health and globalisation, and methodology of the study, the next section reviews literature on health financing and their different types with emphasis on Canada, Nigeria and Ghana.

Chapter 3

3.0 Literature review on health financing

Health financing system is a procedure by which returns are collected from sources (such as out-of-pockets, indirect and direct taxes, donor funding, co-payment) and the use of these returns to purchase goods and services from public and private providers for people's needs (Gottret & Schieber, 2006; Carrin et al., 2007; Murray & Frenk, 2001). Additionally, health financing is one of the six pillars of a health system that provides the resources and financial motivations for the operation of health systems. Furthermore, it involves the basic functions of revenue collection, pooling of resources, and purchasing services (Abekah-Nkrumah et al., 2009). Table 3.1 below depicts functions and objectives of health financing.

Table 3.1: Functions and goals of health financing

Functions	Objectives
Raising revenue	Raise sufficient and sustainable revenues in an equitable manner to provide individuals with a basic package of essential services to improve health outcomes and provide financial protection and consumer satisfaction.
Pooling risk	Manage these revenues to equitably and efficiently create insurance pools.
Purchasing services	Ensure that the purchase of health services are allocated in a technical efficient way.

Source: Adapted from Gottret and Schieber (2006).

The *revenue collection* function involves how health systems raise money from families, industries, and external sources. It therefore deals with the sources of revenue for health care, the

type of payment, and the revenue collection agents (WHO, 2000). The agents that collect revenue include the government or independent public agencies, private insurance funds, or health care providers (Islam, 2007). *Pooling of resources*, which is the second function of health financing is the accumulation and administration of revenues so that members of the pool share collective health risks, thereby protecting individual pool members from big, unpredictable health expenditures (WHO, 2000). *Purchasing* is the third function, and it refers to the mechanisms used to acquire services from public and private health providers. In this circumstance, the pooled funds are paid to providers to deliver a specified or unspecified set of health interventions (Schieber et al., 2006).

It is therefore important that countries focus on successful implementation of the three health financing functions in order to achieve better health outcomes, ensure financial security, and respond to consumers in an equitable, efficient and viable manner (Gottret and Schieber, 2006). This research paper will focus on raising revenue and risk pooling, and relate these health financing functions to equity issues. This aspect is explained in the next chapter of this paper.

Although health care financing has been a major concern globally, there are numerous ways by which healthcare costs are financed in any country and these are categorized as *public* and *private financing*. Public financing includes tax revenue and social health insurance. Private sources of funds for healthcare services include private health insurance schemes, out-of-pocket payments, employer financed services, charitable donations, community self-help and fund raising (WHO, 1978; Mossialos and Dixon, 2002). These include:

3.1 Public financing

Public financing mechanisms for health, including general tax revenues, are the most equitable form of financing. It includes all governmental sources of finance for healthcare services,

and it addresses the exclusion of people on the basis of their health status and inability to afford care. In countries where government hospitals dominate the health care institutions, government provides the needed resources to health care sector from budgetary provisions (Ackon, 2003). General tax revenues are limited by competition with other public sectors for the allocation of raised revenue. Other limitations are the reliability of income to fund health care, lack of consideration of varying income levels, and pooling of funds enable the poor to subsidize the rich. The constraints of public financing, and the attainment of better equity in the system could be addressed through provision of government subsidies to the poor and income dependent financial contributions as embraced by the Brazilian government (Musgrove, 1996). This type of financing is most common in developed nations that have well managed tax revenue systems (Fried and Gaydos, 2002). In developing countries, tax revenue base is narrow, and consists basically of indirect taxes (e.g. value added tax and service tax that are paid to the government with the tax burden shifted by the taxpayer to someone else) but, some governments allocate tax revenues to finance their health systems (Green, 2007).

Social health insurance (SHI) is another type of public financing that manages health care based on risk pooling (Wagstaff and Doorslaer, 1992). The SHI funding enables each person in the contributory regime group to enroll and make contribution based on his or her ability to pay (Hsiao and Shaw, 2007). Moreover, Hsiao and Shaw (2007) argued that SHI could be an answer for a critical part of a nation's health care problem, but is not necessarily an answer for the entire problem. In addition, SHI scheme allow contributions to be collected quite easily through salary deductions, making it easier for organizations to identify subscribers (Busse, Saltman, & Dubois, 2004). The main shortcoming of SHI scheme is that it is often linked to salary-related contributions without coverage of the entire population. This case is predominant in LMICs where the large

informal working sector is not covered by the SHI because it is not subject to government guideline and tax policy (Busse, et al., 2004). SHI financing represents about 2 percent of total public spending on health in LMICs of SSA and 30 percent in high-income countries (White et al., 2006). Furthermore, Hsiao and Shaw (2007) asserted that SHI is a tool used to mobilize additional funds for health, encourage equal access to health care, prevent poverty, and enhance the quality of health care. In conclusion, Carrin et al. (2005) recommend that health financing systems through general taxation and SHI are usually acknowledged to be powerful means of achieving universal coverage and suitable financial protection for everyone against healthcare expenses.

3.2 Private financing

The private health insurance (PHI) is a leading source of private health care financing; the PHI schemes are voluntary systems that individuals subscribe to. The funding of the scheme is based on premiums paid by members, and the benefit package is determined by the amount of premium paid, which is also dependent on the health risk (Green, 2007). According to Sekhir and Savedoff (2005), PHI provides access to financial safeguard and offers opportunity to families to avoid large out-of-pocket spending on their well-being. Similarly, it enables mobilization of resources to a greater degree than that of governments and this may be essential to health systems during the period of economic instability (Himmelstein, Thorne, Warren, & Woolhandler, 2009). This scheme could also limit access to care on a financial basis if premiums are set beyond what individuals could afford within the population. In the United States (US), this has led to many cases of financial hardship (Himmelstein et al., 2009). Mossialos and Dixon (2002) argued that government could use tax credits or tax relief to subsidize the cost of private health insurance. PHI schemes also permit market competition with various providers to which users may subscribe.

This competition has some benefits for the user. These include providing an incentive for PHIs to innovate in the delivery of health care, and reduce subscription fees (WHO, 2000).

Community-based health insurance (CBHI) schemes are designed to ensure that sufficient resources are made available for members to access effective health care (World Health Report, 2010). Carrin et al. (2005) explained that CBHI is a health care financing scheme in Nigeria and Ghana, particularly within the poorer rural communities. It is a not-for-profit health insurance, and members frequently pay lesser premiums into a combined pool of funds, which are then used to pay for their needed health services. Moreover, CBHI accounts for a very small portion of total health expenditure, for instance, it was only 1% in the early 2000s in Ghana (McIntyre et al., 2008). In contrast to developed nations like Canada where publicly funded health systems/insurance provision are completely regulated, healthcare provision in many developing countries remains fragmented and non-universal. CBHI has occurred as a potential strategy to make the universal health coverage (UHC) possible as recognized by international organizations such as the WHO, the World Bank and the United Nations Children's Fund (UNICEF) (Universal Health Coverage Studies Series, 2013).

Out-of-pocket (OOP) payments consist of a direct financial transaction between an individual and a health-care provider. These fees are not reimbursed by insurance or state-funded schemes but entirely borne by the patient (Schieber, Baeza, Kress, & Maier, 2006). Knaul et al. (2006) stated that OOP payments are the most inequitable means of financing health care, it dominates healthcare financing in many countries, particularly in poorer countries of SSA (the disadvantaged people are the most vulnerable to its negative effects). In low income countries (LICs), they account for about 51 per cent of total healthcare financing, while it is nearly 20 per cent of total health expenditure worldwide (WHO, 2011). Likewise, Xu et al. (2005) stated that

OOP expenditures create financial obstacle to accessing health services for 1.3 billion persons all over the world every year.

OOP payments constitute more than 50 per cent of total expenditure on health care in 15 African countries including Ghana and Nigeria (UNICEF/WHO, 2006). A review of the literature indicates that poorer countries, on average, rely more on OOP to finance health care than richer countries (Knaul et al., 2006; Ataguba, 2011). Also, poorer countries bear greater burden of financial catastrophe and impoverishment than richer countries. In Nigeria, the level of OOP expenditure as a share of total health expenditure is very high at around 65% (National Health Insurance Scheme Nigeria, n.d.), while the number is lower at about 45% in Ghana (McIntyre et al., 2008). OOP spending represents the most regressive form of financing as it deters people from accessing health care when they need to (WHO, 2000). It is evident from an experiential study that OOP payments in Ghana is regressive, as the poor pay more of their income compared to the rich folks (Akazili et al., 2011). This implies that the vertical and horizontal equity in financing are more adversely affected by OOP payments in Nigeria than Ghana.

Another source of private financing is donor funding (DF), it is a vital method of revenue-increasing for developing countries such as Nigeria and Ghana, and emanates in the form of grants and loans from various external sources (WHO, 2010). These include contributions from bilateral and multilateral donors such as the World Bank, WHO, global health initiatives, and charitable organizations. Donations could be in the form of cash, equipment, building or healthcare supplies. In terms of supporting health care as a share of total spending it constituted 4.9% in Nigeria and 14% in Ghana for 2009 (World Bank Health Data, n.d.). Also, debt relief is a form of DF that has contributed significantly to the healthcare financing in Nigeria (WHO, 2009), and the donor-

pooled funds in Ghana constitutes the lowest health financing source for a period of five years, 2003-2007 (Akortsu, and Abor, 2011).

External aid, largely in the form of development assistance for health (DAH), represents a critical contribution to health system financing in LMICs, accounting for 20 percent of health expenditure (Schieber et al., 2006). Despite increases in overall DAH, allocation towards health sector support has remained a relatively small proportion of total DAH (Ravishankar et al., 2009). The reasons for dependence on external aids are often due to political instability and post conflict damage to the health system. Scheiber et al. (2006) observe that the external aid accounts for 7 percent of all health spending in LMICs. Nevertheless, external aid plays a key role in health financing in Sub-Saharan Africa countries.

3.3 Innovative financing

The various models of health system financing have their advantages and limitations and in practice a country rarely utilizes one method exclusively but rather draws upon the merits of various mechanisms. Hence, it is desirable to explore alternative funding methods such as innovative financing in order to accelerate efforts towards a more equitable approach to health system financing mainly in LMICs where there is over-dependence on OOP and external aid (Ologunde, 2013). A number of innovative financing options that could be used to raise additional revenue are in existence (TIIFHS, 2009a). The first option is by generating viable income for health financing through an obligatory levy on airline tickets. In France alone this levy generates €180 million a year in revenue (TIIFHS, 2009a).

Moreover, voluntary or private contribution is an alternative method of revenue collection that is incapable to raise substantial funds compared to taxes (TIIFHS, 2009a). This method may

be difficult to implement in LMICs due to feeble economies and limited financial contributions from taxes because of predominant informal sectors (TIIFHS, 2009a). Financing could be derived from contributions linked to tourism, travel products (such as hotel rooms and car rentals) and mobile phone use. Other sources of financing are research grants which are significant source of funds mostly for a teaching hospital. Pharmaceutical companies also provide funding to hospitals to test new drugs and products (Lane and Nixon, 2001).

3.4 Healthcare financing in Canada

Globally, health care systems are affected by the historical, environmental, ethnic, and socio-economic factors that are unique to each country. Health insurance began in Canada in 1655 (17th century) when a hospital in Montréal initiated and prescribed treatment of injuries for an annual fee (Bannerman, 1977). The federal government of Canada through the Canada Health Act created five funding criteria as follows: public administration (section 8), comprehensiveness (section 9), universality (section 10), portability (section 11), and accessibility (section 12) (Health Canada, 2011). The power, organization and distribution of health services is highly decentralized in Canada (Axelsson, Marchildon & Repullo-Labrador, 2007), and the federal government provides funding for health research, and substantial financial support for programs and services in the provinces and territories on a continuing basis. These programs include: the Canada Health Transfer (CHT), the Canada Social Transfer (CST), Equalization and Territorial Formula Financing (TFF). In particular, the CHT and CST support the health care, higher education, social services, and child care policy areas (McGraw and Robichaud, 2016). Also, it is the principal policy responsibility of the provinces in Canada to finance and administer health care (Marchildon, 2013). McGraw and Robichaud (2016) argued that Canadians do not know the cost of health care because the services are free at the point of use, and are covered by the tax-funded health care

insurance. Another reason is the inability of Canadians to determine the value of their contributions to public health care insurance. Simpson (2012) stated that health care takes between 42 and 45 percent of provincial program spending, and this spending is draining the budgets of the provinces in Canada. Health care costs have been increasing more rapidly than government revenues and economic growth. It is therefore affirmed that health care is likely to consume more than half of each province's budget in the coming years (McGraw and Robichaud, 2016). In developed countries like Canada, healthcare systems are alike and face common problems such as increasing health care costs. Consequently, it became necessary to hold costs in many parts of the world (OECD, 2004). Also, there is a concern that the aging population in Canada will probably lead to more requests for health care services and higher rate of health spending (McGraw and Robichaud, 2016). In Canada, health care is financed by both the public sector and the private sector. The public sector consist of the federal, provincial/territorial, and municipal governments and social security funds. Private-sector spending comprises out-of-pocket by individuals and private insurance coverage (Canadian Institute for Health Information (CIHI), 2005). Looking at the health spending trends in Canada from 1975 to 2004, the growth in total expenditure on health care overtook inflation. As at 2004, Canada spent an estimated amount of \$130 billion on health care (see *Appendix 2*). Likewise, the total spending as a percentage of GDP shows a substantial increase in the early 1980s and 1990s, and the health spending exceeded 10% of GDP in 2003 and 2004 (CIHI, 2005) (see *Appendix 3*). In addition, McKillop et al. (2004) stated that nearly 70% of total health financing in Canada emanates from public sources while 30% comes from non-public sources (see *Appendix 4*).

Private-sector funding primarily through private health insurance and OOP payments accounts for between one-fifth and one-third of health expenditures in most OECD countries. At

30% in 2004, Canada falls within this range. The private sector principally pays for medicines, dental and vision services apart from hospital care. Canada's private share is similar to what is obtainable in Spain and Australia, but higher than that of the United Kingdom, France, Germany and Sweden (OECD, 2005). Most private-sector health spending in many OECD countries comes through OOP payments. In Canada, private health insurance and OOP payments pay for roughly equal shares of private-sector spending (OECD, 2005). Also, over the years, less than half of OECD countries experienced increases in the private health care spending, while for others it was constant or decreased. Other countries saw public-sector spending growth outpace that in the private sector. Canada's private share rose from 28% in 1994 to 30% in 2004 because of increased payments through private health insurance plans (OECD, 2005). Private health care spending varies considerably between nations. In contrast to many nations, Canada's health care funding is almost completely through taxes. In other parts of the world, the user fees and copayments are quite common sources of funding (WHO, 2002). Private insurance and OOP payments in Canada tend to be higher for services not covered under the *Canada Health Act* (Commission on the Future of Health Care in Canada, 2002). In 2002, Canadians paid an estimated \$17 billion (out-of-pocket) to cover various health care services. For instance, they spent \$3.6 billion OOP health care dollars on over-the-counter drugs and personal health supplies, \$3.4 billion on dental care, \$2.9 billion on prescribed drugs, \$3.0 billion on nursing homes and other institutions, and \$2.0 billion on vision care respectively (CIHI, 2005).

Furthermore, the WHO (2002) posited that the private health insurance is supportive to publicly financed systems in most OECD countries. Colombo and Tapay (2004) argued that the private health insurance accounts for 10 to 17% of total spending on health in Canada, the Netherlands, and France. Similarly, a large percentage of private health insurance is generally

provided by employers in OECD countries (Colombo and Tapay, 2004). Again, the private health insurance plays a complementary role through coverage of services excluded from public insurance. Thus, in Canada, complementary insurance is available for outpatient drug costs, dental care and various services not covered by the provinces and territories (Health Evidence Network, 2004). Supplementary insurance is another type of the private health insurance that covers services provided by public health insurance systems. This type of insurance could be referred to as “double coverage”. Prior to the Supreme Court judgement in Quebec in 2005 (that overturned the ban on private health insurance to obtain needed treatment), it was unlawful to use private insurance to pay for health care services covered by provincial insurance plans in six of Canada’s 10 provinces, as such insurance remains uncommon in the other four provinces (Canadian Health Services Research Foundation, 2001).

Furthermore, public spending in Canada was \$91 billion in 2004, and it covers most public health care (including care for indigenous people) and programs, and physician services. The public sector also pays part of the cost of home care, prescription drugs and ambulances. The greater part of the public-sector health budget is administered by the provinces and territories, and other part is financed through federal transfers of cash and taxation (Office Consolidation Canada Health Act, 2005). Health expenditures per capital in Canada in 2012 was estimated to be \$5948CAD or 11.6 percent of GDP (CIHI, 2012). This level of health expenditures agree with expenditures in OECD countries (OECD, 2011), and is above the “minimum” estimate of US\$40-45 needed for important services (Commission on Macroeconomics and Health, 2001). Additionally, approximately 70 percent of Canadian health expenditures were funded from public sources across various sub-sectors (CIHI, 2012). In 2011, the US had the highest ratio of total health expenditures to GDP, at 17.7% while Canada was at 11.2% in 5th position for the selected

30 OECD countries (see *Appendix 1*). The US had the highest health expenditure per person, at US\$8,508, and Canada, with a spending of US\$4,522 per person was among the six countries with the highest per capita spending on health (OECD, 2013). According to OECD (2005), some economically developed countries rely, to a varying extent, on the public sector, private insurance and OOP payments by individuals to cover the costs of health care. Thus, the OECD (2005) posited that Canada's private sector funds a larger share of health spending than other OECD countries of Japan, Italy, Germany and France except the U.S. Moreover, Table 3.2 underneath shows the sources of revenue as a percentage of total expenditure on health Canada for a period of years.

Table 3.2: Sources of revenue as a percentage of total expenditure on health in Canada, 1995-2010.

	1995	2000	2005	2006	2007	2008	2009	2010
General taxation	71.2	70.4	70.2	69.8	70.2	70.5	70.6	70.5
OOP	15.9	15.9	14.6	15.0	14.7	14.6	14.6	14.7
PHI	10.3	11.5	12.6	12.4	12.6	12.7	12.7	12.8
Social insurance funds	1.1	1.4	1.4	1.4	1.4	1.4	1.3	1.3

Source: OECD (2011a).

In Table 3.2, the proportion of revenue from the four main sources changed only marginally between 1995 and 2009. General taxation accounted for over two-thirds of all finance for health. PHI grew more quickly than OOP payments because PHI is a main part of employment-based insurance benefit packages in a place of work. Also, social insurance is the smallest portion of health funding in the provinces and territories in Canada.

The Canadian Institute for Health Information (CIHI) was established in 1994 to coordinate the collection and interpretation of financial and organizational health data of the three tiers of government in Canada. It is worth mentioning that the Health Canada is responsible for financing

about 80% of the CIHI while the remaining funds comes from provincial government. This will help in health database management and dissemination of health information (Marchildon, 2013, p.34).

3.5 Healthcare financing in Nigeria

The federal government expenditure on health services in the 1980s and 1990s during the military regime was less than 2 per cent (Orubuloye and Oni, 1996; Nwosu, 2000). But, the return to civilian regime in 1999 enhanced public financing, and total federal government expenditure increased to 4.4 percent in 2005 and 7 per cent in 2006 respectively. On average, most states in Nigeria spend less than 5 per cent of their total expenditure on health care. Expenditure from the three tiers of governments amounts to less than 25 per cent of total health spending, while 75 per cent is provided by the private sector. Household OOP payments account for over 95 per cent of the private sector expenditure (World Health Organization, 2011). The federal government funds mainly the tertiary health institutions and regulates the entire health system. State governments also receive and pool funds to purchase secondary care public facilities, while Local Government Areas (LGAs) funds the primary care sector. As a group, the three tiers of government enable citizens to access providers either through OOP, CBHI, PHI or the NHIS (Odeyemi and Nixon, 2013).

According to Lawanson and Olaniyan (2013), two sources of revenue for financing the health sector exists in Nigeria (see *Appendix 6*). The pooled sources are collected from budgetary allocation, direct and indirect taxation, and donor funding, and the un-pooled sources from OOPs contribute over 70% of total health expenditure (THE). In spite of these health financing options in Nigeria, the funds are still inequitably distributed across the health system (Lawanson and Olaniyan, 2013). Further, there is frequent criticism that insignificant amount is allocated to the

health budget in Nigeria. For instance, 3.2% was allotted to health in 2003 which has implications for equity and quality of health care resources (Metiboba, 2011; Dienye et al., 2011). Moreover, the Abuja summit in 2001 agreed that African governments should commit 15% of their annual budgets to their health sectors (EQUINET, 2008). In the case of Nigeria, therefore, this target remains to be met. In Ghana, tax contributes about 70% of the funding envelope for the NHIS (Witter & Garshong, 2009) and it is more integrated with the NHIS compared with Nigeria. In contrast with Nigeria, the government of Ghana also met the Abuja target of allocating 15% of its budget to health care, which includes NHIS funding (Witter & Garshong, 2009). In Nigeria, individuals bear the burden of health-care financing, with private expenditure amount to 70 percent of total health expenditure and OOP expenditure on health totalling 90 percent of private expenditure. Over the years, government financing of health expenditure in Nigeria has contributed less than 20% of total health financing, while OOP financing have constantly been higher than 67 percent of total health financing (Soyibo et al., 2009).

Uzochukwu, et al. (2015) argued that the policies and plans of the Nigerian government in addressing health care financing include the National Health Policy, Health Financing Policy, National Health Bill and National Strategic Health Development Plan (2010-2015). The Federal Ministry of Health (FMOH) (2005) specified that the *National Health Policy* in relation to health financing are to expand financial options for health care and strengthen the contribution of the private sector and prepayment based approaches for financing. It also entails community-based schemes for the financing of primary health care services. Again, this policy supports public-private partnerships at all operating phases for the enlargement of health financing alternatives. The FMOH (2006) pronounced the National Health Financing Policy with the general aim of ensuring that sufficient and sustainable funds are available and allocated for efficient and

equitable health care delivery. In addition, this policy is connected to the 2000 Abuja declaration whereby the federal, state and local governments were mandated to allocate at least 15% of their total budgets to health. According to Uzochukwu et al. (2015), the federal government of Nigeria budget allocation to health from 2009 to 2011 accounts for 5.4% of the total federal budget and 0.7% of the national GDP. Thus, this allocation for health is far short of the Abuja declaration target of 15% of the national budget. According to Saka (2012), the *National Health Bill* which has not been signed into law by the President made provisions for a Basic Health Care Provision Fund. When this *bill* is passed, it will significantly enhance government financing for PHC. Lastly, the *National Strategic Health Development Plan* (National Health Plan) aims to develop and implement health financing strategies equitably at federal, state and local levels in a sustainable fashion (Uzochukwu, et al., 2015).

The advancement of the NHIS in Nigeria began since the post-independence era of 1962 (NHIS Nigeria, n.d.). The government initially funded universal and free health care in predominantly public facilities using revenues from oil exports and taxes. However, the global fall in oil prices in the 1980s led to a situation whereby the Government could no longer provide free health care. Several cost recovery mechanisms based on OOP charges were introduced in conjunction with a growth in the privatisation of health care (McIntyre et al., 2008). In addition, the introduction of the Structural Adjustment Programme in 1986 reduced the budget of the health sector. Other stresses that led to the founding of the NHIS include: the overall poor condition of the country's health care services, the over dependence on government owned health facilities, decreasing funding of health care, and poor integration of private health facilities in the country's health care system (NHIS Nigeria, n.d.). The NHIS, an agency under the Federal Ministry of Health was created by the federal government in May 1999 (Odeyemi and Nixon, 2013). The

NHIS regulates, monitors, enforces quality controls and administers the health care system in Nigeria (NHIS Nigeria, n.d.; Awosika, 2005). According to Odeyemi and Nixon (2013), the NHIS contains three main sub-schemes that caters for different segments of the population: the formal sector social health insurance programme (FSHIP); the urban self-employed social health insurance programme (USSHIP); and the rural community social health insurance programme (RCSHIP).

The FSHIP commenced in 2005, and it covers the public and organised private sector employees. It is mandatory for organizations with ten or more employees. The FSHIP is implemented by Health Maintenance Organisations (HMOs) and NHIS-accredited providers. They operate through the 'managed care' model which has its origins in the US as a potentially more cost-effective way of delivering health care in comparison with free market PHI (Folland et al., 2010; Awosika, 2005). In this scheme, employee registers their family members with a health care provider (HCP) of their choice, which could be changed after a minimum period of three months if they are dissatisfied with the services provided. Revenue-raising in the FSHIP is shared by the employer and employee, who pay 10% and 5% of the employee's basic salary, respectively (NHIS Nigeria, n.d). Thus, revenue-raising in the FSHIP is equitable but is likely to be regressive generally because of proportional contributions of income with flat rate co-payments and user charges (Odeyemi and Nixon, 2013). The FSHIP covers some benefits to an employee, a spouse and four biological children under the age of 18 years. But, this scheme excludes coverage of antiretroviral drugs, and treatment of terminal illnesses such as cancer and AIDS, and chronic health problems such as diabetes, renal dialysis and hypertension (NHIS Nigeria, n.d.; Metiboba, 2011).

The USSHIP is a non-profit health insurance plan covering occupation-based User Groups (UGs) with common economic activities. It is administered by a Board of Trustees, and UGs must contain at least 500 members to ensure adequate pooling of financial resources. In relation to revenue-raising, participants pay a flat monthly rate with contributions depending on the health package chosen by members of the UG. Health care benefits are delivered by accredited providers, likewise the formal sector (Odeyemi and Nixon, 2013).

The RCSHIP is also a non-profit health insurance programme for an organized group of families or individuals (including pensioners) that form a community. The scheme is administered by its members with involvement of Community Based Organisations (CBOs), Faith-Based Organisations (FBOs), Non-Governmental Organisations (NGOs) and Civil-Society Organisations (CSOs). Members of the identified community choose the health care benefits based on their health needs, and made contributions in cash, flat monthly rate, and instalments. Although, both USSHIP and RCSHIP are voluntary schemes, but in terms of equity, they provide ways of increasing NHIS participation separate from the mandatory formal sector scheme (Odeyemi and Nixon, 2013).

Relatively, enrolments of NHIS in Nigeria seems to be slow because the implementations were done in phases. Thus, in 2011, there were only 5.3 million Nigerians (about 3.5% of the population) enrolled in this scheme and the principal participants were those in the FSHIP element (Mohammed et al., 2011). As at 2012, the participation in the NHIS had improved, and the system has been making progress (Odeyemi and Nixon, 2013).

3.6 Healthcare financing in Ghana

Ghana shares a similar post-colonial history to Nigeria in terms of health care in the country (NHIS Ghana, n.d.; Nguyen et al., 2011). The healthcare system in Ghana was modelled to Britain, and the first government health services was established in 1880 in Gold Coast to provide healthcare specifically to the Europeans and government officials. According to Dummett (1993), the colonial government and the missionaries were solely involved in healthcare funding at this time. Healthcare was mainly provided in a traditional setting on a fee-for-service basis preceding the independence. Further, Twumasi (1975) explained that free healthcare services were provided to Ghanaians in the post-independence era through public health facilities. There were no OOP payments in these facilities and care was financed exclusively from tax revenues.

In addition, the economic problems in the 1970s prompted the introduction of user fees through legislations, but these proved inadequate to meet the needs of the health sector (Twumasi, 1975). Between the 1970s and early 1980s, the unexpected global oil crisis in the international market harshly affected Ghana with subsequent economic instability. As a result, the World Bank and the International Monetary Fund (IMF) proposed structural changes and removal of subventions to improve the economy. This led to reductions in the health budget and serious economic burden on the health sector (World Bank, 1993). In 1985, the government introduced a cost recovery programme known as the “user-fees” system through an enabling Laws. Arhin-tenkorang (2000) argued that the introduction of user fees significantly reduced the use of health services as most people could not afford the fees. In spite of the introduction of the user fees, government still bore a considerable proportion of the expenditure in healthcare. In order to improve access to healthcare services after the failure of numerous health financing mechanisms, including OOP to guarantee financial accessibility and universal health coverage to the populace

(Arhinful, 2003; Agyepong & Adjei, 2008), a Law (Act 650) establishing a national health insurance scheme (NHIS) was enacted in 2003 (Republic of Ghana, 2003). Thus, Ghana became the first sub-Saharan African country to introduce NHIS in 2003, and its implementation began in 2004. Under the NHIS amended Act 852 (2012), every Ghanaian is mandated to register with a health insurance scheme. This constitutional provision is however not effectively implemented because of large informal sector and administrative problems of the National Health Insurance Authority (NHIA) in Ghana. Schieber et al. (2012) alluded that among the LMICs that have enacted legislation and begun the transition to universal health insurance coverage, Ghana is one of the few countries in Sub-Saharan Africa to begin the public health financing to the underprivileged people.

In Ghana, the NHIS consist of three types of schemes: the District Mutual Health Insurance Schemes (DMHIS), the Private Mutual Health Insurance Schemes (PMHIS), and the Private Commercial Health Insurance Schemes (PCHIS). The National Health Insurance Authority (NHIA) implements the scheme's objectives, and ensure that all citizens of Ghana have access to basic health care services (Odeyemi and Nixon, 2013). In addition, the National Health Insurance Fund (NHIF) facilitates funding revenues from the Government of Ghana through direct and indirect taxes, which includes subsidies for individuals exempted from premiums; 2.5% National Health Insurance Levy (NHIL); 2.5% Social Security and National Insurance Trust (SSNIT) as deductions at source from formal sector workers. *Appendix 7* listed sources of Ministry of Health revenues in Ghana as at 2009. Other sources of funding are returns from investment, DF and premiums collected at the State level for non-formal sector workers (Jehu-Appiah, et al., 2011). In contrast to NHIS coverage in Nigeria, with limited number of children to a couple, there is no such limitation of children per couple in Ghana (there is coverage for polygamous households). In 2003,

before implementation of the NHIS, only 6.7 % of private health spending was attributed to prepaid insurance plans in Nigeria (NHIS Nigeria, n.d.), while in Ghana it remained at under 1% of the population pre-and post-NHIS implementation (McIntyre et al., 2008; WHO, 2000). Evidence from Ghana and Nigeria, proposes that the uptake of voluntary PHI is predominant among richer individuals from urban populations (Carapinha et al., 2011). Also, Ghana's NHIS scheme has been relatively successful than NHIS in Nigeria because 66.4% of the population had been covered by 2010, with 29.6% in the informal adult sector. Hence, the system is liberal as members do not pay any co-payments or deductibles (NHIS Ghana, n.d.; Odeyemi and Nixon, 2013).

In terms of provision, the NHIA has a wide benefit package that covers '95% of the disease situations in Ghana' (NHIS Ghana, n.d.). The extensive nature of the benefit package and the growing rate of population coverage would provide sufficient returns for health care providers, and ensures equity in health care delivery. In contrast to the Nigerian NHIS, the basic benefit package is the same for all DMHISs and membership categories in Ghana. Like Nigeria, however, similar exclusions occur in Ghana comprising: cancers apart from cervical and breast cancers, dialysis for chronic renal failure, services such as immunization, family planning and antiretroviral drugs, unlisted drugs on the NHIS Drug list, and HIV/AIDS.

Figure 3.2 show changes in the public, private, OOP, and externally funded shares of total health spending in Ghana. Although the share of external funding dropped from about 30 percent of total spending in the early 2000s to about 14 percent in 2009, the public share rose after 2004, except for a slight decrease in 2008 and 2009, which may have been related to the global financial crisis (WHO, 2011).

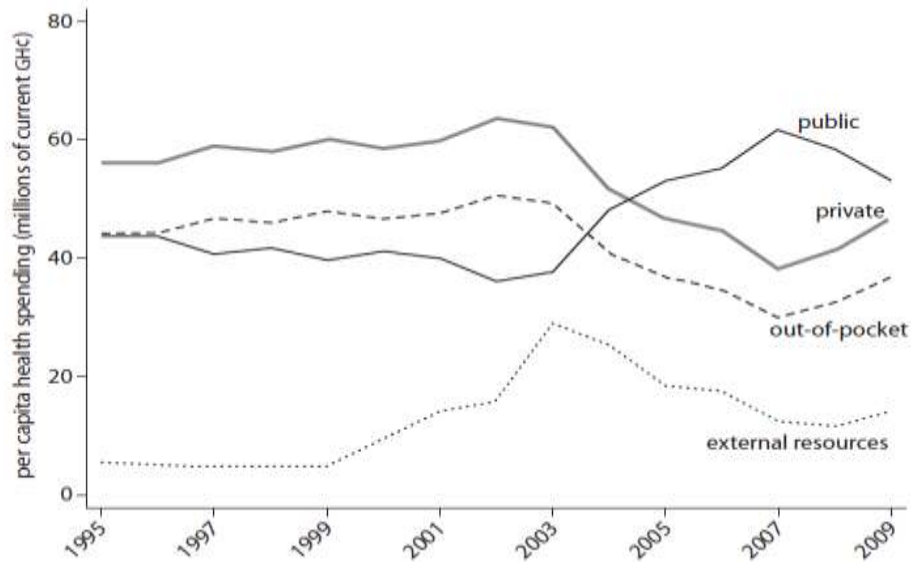


Figure 3.2. Composition of total health spending in Ghana, 1995-2009. Source: WHO (2011).

The private and OOP shares declined except for a minor rise in 2008 and 2009. Thus, it would appear that the implementation of the NHIS in 2005 is associated with a larger share of public financing on health and a smaller share of OOP spending (WHO, 2011). According to the World Bank (2011b) and WHO (2011), OOP spending on health accounted for 79 percent of private health spending and 37 percent of total health in Ghana in 2009, levels that were at or slightly above the levels of its global comparators. Based on the WHO's 15-20 percent OOP criterion, however, financial safeguard in Ghana was insufficient (World Bank, 2011b; WHO, 2011). Figure 3.3 below depicts the composition of health spending in Ghana as percent of GDP from 1995 to 2009. Total health spending as a share of GDP in Ghana fell from 5.3 percent to 4.9 percent of GDP over the 1995-2009 period. Public spending on health as a share of GDP increased significantly between 2004 and 2007, but its 2009 level was only slightly higher than its 1995 level. As a percentage of GDP, private and OOP spending decreased gradually since 1995 (WHO, 2011).

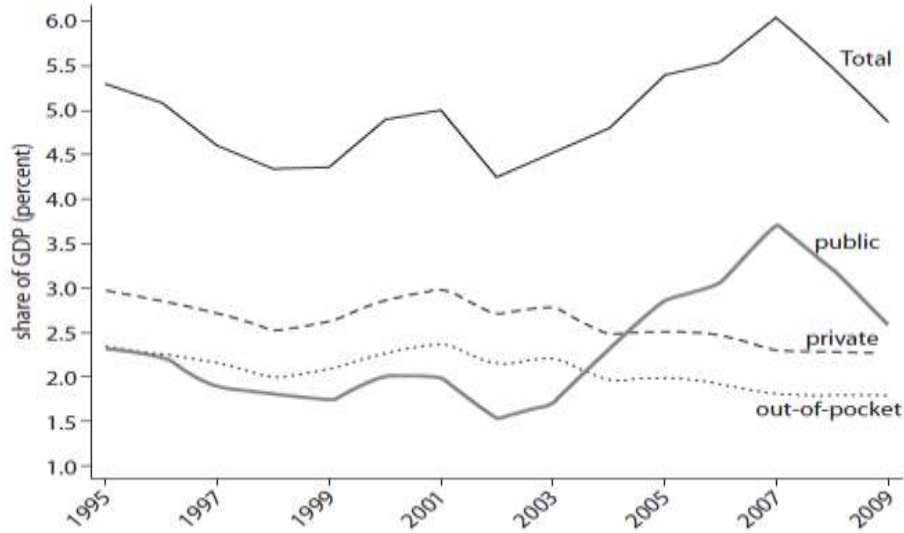


Figure 3.3. Composition of health spending in Ghana as percent of GDP, 1995-2009. Source: WHO (2011).

Ghana is one of the few countries in SSA spending a quite high percentage of its GDP on health. Ghana's total expenditure on health as a percentage of its GDP was 5.4% in 2013 compared to 3.9% in Nigeria (World Bank, 2015). Likewise, the percentage of government budget allocation to health in Ghana was 10.6% of total government expenditure (Ministry of Health, 2014), moving gradually nearer to the Abuja target of 15% (WHO, 2016). It is worth mentioning that between 1995 to 2009, Ghana reduced the share of GDP it assigned to total health spending in comparison with Nigeria and other SSA countries (see *Appendix 5*).

Furthermore, Odeyemi and Nixon (2013) stated that Nigeria and Ghana are both making positive progress and have evolved to LMIC status, with GDP growth rates well above those of most developed nations. This suggests a growing capacity to health care funding and delivery that is confirmed by comparable per capita health care spending for both countries. However, as a share of GDP both countries spend less than half the OECD mean, which implies opportunity for greater growths in health spending that could enhance equity in health care. Similarly, Odeyemi and Nixon affirmed that between 2000 and 2010, Nigeria and Ghana have gradually enhanced their health

outcomes. Again, the findings indicate strong inequalities, with a continuous and growing advantage for Ghana (Odeyemi and Nixon, 2013).

3.7 Globalisation and health financing

It is important to ascertain the impacts of markets and political economy on health financing in Canada, Nigeria and Ghana. Odeyemi and Dixon (2013) explained that the Nigerian government used oil revenues and taxes to fund universal free health care in 1962 after the country's independence. On the other hand, the decline in the international oil prices in the 1980s, together with economic and political insecurity and the poor state of Nigeria's health facilities, necessitated the upgrading of Nigeria's health infrastructure. Accordingly, Baba and Omotara (2012) argued that the poor performance of Nigeria's National Health Insurance Scheme (NHIS) and worsening public health service is due to lack of co-operation between the federal and state governments, absence of resources, and high levels of poverty faced by Nigerians (Baba and Omotara, 2012). Moreover, the office of the Head of Civil Service of the Federation (OHCSF) (2013) and Dogo-Mohammad (2006) discussed that when the federal government 'could no longer afford to provide free health care', it decided to use the contributory methods to complement other sources of healthcare funding for all Nigerians. Also, the recommendations of the Ministerial committees in the mid-1980s led to the establishment of a NHI policy. Similarly, in the context of neoliberalism, Ruger (2005) emphasized that the development of NHIS could be attributed to the support from development agencies comprising the World Bank and the International Monetary Fund that backed the idea of public-private partnerships. Manderson (1999) argued that Western medicine under the colonial arrangement was meant primarily to serve the colonial incomers, but later, medical cure had to be extended to the natives to maintain a healthy labour force. Hence, in accordance with the Alma Ata Declaration, the emphasis on traditional curative care was changed

and re-model by creation of the National Health Policy in 1988 (Ichoku et al., 2013). The drive was to make primary health care available to most Nigerians, and to re-orientate the medical personnel concerning the provision of primary health services particularly in the rural areas. But, the interests of the elites undermine access to social services which systematically shifts responsibility for healthcare costs directly to households (Ichoku et al., 2013). Furthermore, after Alma Ata and the adoption of a structural adjustment program in 1986 in Nigeria, the for-profit amenities increased and health experts moved from the less funded public sector to connect with capitalists in the private sector. Thus, more money was circulated in for-profit private care than in public care (Plateau State Ministry of Health Nigeria, 1992). The private sector operated under unrestrictive circumstances, and there was criticism against the neoliberal assumption that reinforcement for-profit private health care contributes to equity and efficiency (UNDP, 1993). In Nigeria and other SSA countries, this elitist approach has resulted to social alienation rather than development (Ichoku et al., 2013). The structural adjustment programs of the IMF and the World Bank destroyed public health infrastructure in Ghana. For instance, the consequence of introduction of user fees, between 1990 and 1999 saw half of the Ghanaian doctors laid off (Epstein, 2001). Also, the structural adjustment implementation of the Rawlings government led to the migration of 1600 doctors from Ghana. Thus, in 1998, Accra the capital of Ghana had 2000 doctors for every million population, and there was only one doctor in the main hospital of the northern Ghana (Horton, 2001).

Again, the advocates of neoliberalism and free market economy and powerful policy leaders who thought publicly funded system of health care cannot be sustained in Canada advocated serious cuts to health care and tax increment to manage the increasing expenses of public health care (Dodge and Dion, 2011). These free-market advocates thought individuals

should buy private insurance and allow health providers to charge fees accordingly (Skinner and Rovere, 2011). Similarly, Canada has been implementing several neoliberal policies in the past years (for instance, cost-cutting in health and social aid programs, regressive tax reforms with consequent decrease of government revenue, reduction of the cost of labour, and decrease to inexpensive housing programs) that produces further inequitable health circumstances. Bryant et al. (2011) posited that Canada's liberal welfare system in contrast to the welfare systems of the conservative and social democratic OECD countries put less emphasis on the security and welfare of its citizens. And this leads to lesser quality and bigger commodification of resources associated with SDH. Hence, ultimately, worldwide occurrence such a Global Financial Crisis (GFC), have direct effects on the well-being of the citizens because of less protection from market fluctuations and societal concerns. Despite the fact that this proposed system might not be equitable or well-suited with Canadian ethics, it was evident the system cannot be sustainable. It is against this idea of neoliberalism that Bhatia (2012) suggested that continuous investment and reforming of health care system in Canada and around the world is what is needed to enhance the well-being of the citizens for a sustainable healthy living.

3.8 Implications of healthcare financing on health equity

According to Hurley (2001), health care usually comprise of goods, services and activities with the main objective of maintaining or improving health. Health is ethically good because of its final contribution to gladness, capabilities and realization of a normal life plan. Argument about ethical nature of health is not enough, but the reflection about just level and distribution of health in the society is desirable. It might be challenging to maximise the level of health in society because health cannot be directly redistributed among the individuals. From the standpoint of a welfare state, Culyer and Wagstaff (1993), and Culyer (1995) argued that it is simply ethical to distribute

health equally, and not to intentionally reduce one individual's health status to equalise health levels. In the same way, Cuyler (2001) discussed that unequal access to good health care is a main factor limiting the health care status in many developing countries. Access to health care can be physical or financial, but in developing countries, financial access becomes important because many poor individuals lack sufficient resources to seek for suitable health care. This raises concern about equity in health care delivery because it is thought that health care should be distributed according to need instead of the willingness and ability to pay (Cuyler, 2001).

Marchildon (2013) explained that equity in financing concerning individual's health can be progressive, proportional or regressive. A health financing source is *progressive* if the proportion of income an individual pay increases with income. A *regressive* financing source is when the proportion of income an individual pay decreases, while the *proportionate* financing source occurs when the proportion of income an individual pay remains the same at all income levels. "The more progressive the health-financing system, the greater the equity in financing" (Marchildon, 2013, p.132). Additionally, in discussing the allocation of limited health care resources and equality, Lenaway et al. (2006) argued that resource rationing is a clear and fair process that guide decisions, and how resources are invested to address societal needs. Furthermore, resource rationing for health policy is vital to channel resource allocation to main priority areas; to address equity problem; and to strengthen the links between research and policy (Okello and Chongtrakul, 2000).

Moreover, Ruckert and Labonte (2014) posited that the federal government of Canada, under its austerity initiative regulated and reduced the amount of financial transfers to the provinces for health and social programs. This implies that provinces with higher deficits than the federal government are expected to make more reductions to health and social services. In Ontario

health care, the total spending as a percentage of GDP has decreased in each year since the global financial crisis, with increases in private spending going up more quickly than in public spending (CIHI, 2005). Hence, the goal of achieving greater regional equity has shaped health system financing in Canada. This “geographical” equity is pursued through the instruments of *equalization* and the *Canada health transfer* (Marchildon, 2013).

3.9 How LMICs could ensure equity in health financing

The World Health Organization (WHO) declaration (1978) stated that “the existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries” (WHO, 1978). After this statement, high-, middle- and low-income countries had a combined duty to improve global health with equity as one of the major aims. But, the obligations of countries to make contributions to global health equity generally without consideration to health financing which is a particular requirement of LMICs. Again, the LMICs are not given much attention in their efforts to fulfill the health needs of their citizens within their limited resources. Although it is important to organize resources outwardly to fill the health gaps in LMICs, research findings recommended the need for potential obligations of LMICs in health financing (Castro-Leal et al., 1999; Gostin et al., 2010; Makinen et al., 2000; Orem and Zikusooka, 2010; Peters, 2008; Ruger, 2006; Røttingen, 2014). Several authors believe that weaknesses in health financing within LMICs cause health inequities in those nations. Thus, it is obvious that these national inequities are normally replicated in the global health context when there are international health comparisons among nations. Furthermore, Barugahare and Lie (2015) argued and suggested that LMICs should allocate a certain proportion of their domestic resources to health, in order to equitably fulfil the health needs (or rights) of their citizens through, among

other things, equitable health financing. Similarly, the concerns about LMICs not getting access to quality healthcare, and the huge gaps in access to health services prompted governments, development agencies and civil society organizations to demand for effective strategy to enhance health equity (Chopra et al., 2012).

Again, Barugahare and Lie (2015) opined that Global Minimum Health Expenditure (GMHE) per capita is the average cost of financing an ‘Essential Health Package’ per person per year in each country, or ‘a certain minimum level of health opportunities per capita’. Etienne and Asamoah-Baah (2010) stated that the notion of the “minimum” consist of “Universal Coverage” for all persons which “does not necessarily mean coverage for everything”; and the ‘progressive realization of the right to health’. In the global perspective, all these views indicate that every individual has a right to a definite limited health opportunities as mentioned by the WHO (1978) declaration on health care. In addition, if the cost of covering the GMHE per capita are not shared equitably between HICs and LMICs (considering the resource capacity of each of them), then the source of injustice could be identified by seeing actor(s) who have not fulfilled their quota of obligation (Barugahare and Lie, 2015.)

According to Barugahare and Lie (2015), it is evident that LMIC governments allocate a smaller proportion of their yearly internally generated budget resources to health than they could afford. Also, in 2001, the Governments of African countries realised that small percentages of their budgets were allocated to health in the midst of growing amounts of resources needed to respond to various types of illnesses. The financing gaps in the health sectors across Africa due to low priority given to health budgets prompted the countries to be dedicated to the Abuja Declaration by distributing at least 15 % of their annual budgets to health (African Union, 2001). It is worth mentioning that few African countries have met this target since 2001; and presently the trend is

retrogressing. In response to this reverting trend, some scholars thoughts that Africa countries needed to move from “just 15 % (Abuja obligation) to ‘15 % plus’” by expanding both per capita investment in health, and social determinants of health (African Union, 2001). Further, the WHO suggested that the budget should offer better priority to health, and from the World Health Report of 2011, “it is clear that some countries need to increase their own investments in health either through reallocation within their own general budgets or by making larger claims on their funds from debt relief which are to be preferentially allocated to social spending” (WHO, 2001).

Olaniyan et al. (2013) posited that equity is one of the basic principles in the health financing policy in Nigeria. Although, there was an obligation to the implementation of this policy through various pro-poor health programs, the level of health inequity and access to elementary health care interventions remain high. Further, Ichoku (2005) reported that research findings from Nigeria proposes that the present method of health financing is not accomplishing the objective of income redistribution. People finance their health care needs in percentage to their ability to pay for such services. Again, research results show a substantial amount of horizontal inequity (unequal health care payments by individuals in the same group) (Ichoku, 2005). Furthermore, the research conducted by Ichoku and Fonta (2006) on the distributional impact of health care financing in Enugu State, Nigeria showed high occurrence of catastrophic healthcare financing in the populace. Similarly, the general finding of a study by Akazili et al. (2011) on equity in financing in Ghana shows that financing is progressive because of the positive impact of taxes. The NHII levy and formal sector NHII payroll deductions were found to be slightly progressive. Also informal sector NHI contributions were found to be regressive. Despite the creation of the NHIS, it was recognized that OOP payments are regressive.

The literature review on different models of health financing, impacts of globalisation on health financing, and the implications of health financing on health equity with reference to LMICs will lead to the analysis of healthcare financing in Canada, Nigeria and Ghana. Based on the review of literature on health financing models and health equity, it is assumed or expected that public health financing mechanism through general tax revenues are the most equitable form of financing because people are not excluded on the basis of their health status and inability to afford care. In conclusion, equity will be more likely under the public health financing than the private health financing, and the next chapter will elucidate this assertion.

Chapter 4

4.0 Analysis of healthcare financing in Canada, Nigeria and Ghana

This section makes comparison of health financing in the developed and developing nations in the perspectives of equity and access. The data for this analysis is obtained from the current 2017 World Bank Health Data. Table 4.1 below shows the demographic and health expenditure in Canada, Nigeria and Ghana over the period of 2000 to 2014. Canada is a High Income Country (HIC) in North America. Nigeria and Ghana are categorized as LMICs. Both countries are located in the West part of Sub-Saharan Africa (West Africa). The population of Canada risen from 30.8 million in 2000 to 35.5 million in 2014. As well, the population of Nigeria increased from 122.4 million in 2000 to 176.5 million in 2014, while Ghana has a much smaller population that risen from 18.9 million in 2000 to 26.9 million in 2014.

Expenditure on health varies significantly between countries with contrasting performance in terms of the equity in financing, quality, and access to healthcare (Ologunde, 2013). Table 4.1 also indicates that total health expenditure as a percentage of GDP improved from 8.7% in 2000 to 10.4% in 2014 for Canada, but an inconsistent trend is noticed in the increment to 11.2% in 2010 and then reduced to current figure. In contrast, Nigeria was spending 2.8% in 2000 which increased to 3.7% in 2014, while in Ghana, it risen from 3.0% in 2000 to 5.3% in 2010 and reduced to 3.6% in 2014. In making comparison with Canada, the level of spending each year for both Nigeria and Ghana is less than half of each year in Canada, which indicates that there is opportunity for bigger increases in health spending that could enhance equity in health care. The higher level of total health spending from 2000 to 2014 in Canada unlike in Nigeria and Ghana corroborate the CIHI (2005) findings that significant increase occurred in the total health spending as a percentage of GDP in Canada from 1975 to early 1980s and 1990s. This implies that health spending

increment has been consistent, and follows the same trends over the years in Canada as a result of better economic policies than the developing countries of Nigeria and Ghana.

Table 4.1 Demographic and health expenditure in Canada, Nigeria and Ghana 2000-2014.

Indicators	Canada			Nigeria			Ghana		
	2000	2010	2014	2000	2010	2014	2000	2010	2014
<i>Demographic</i>									
Population (millions)	30.8	34.0	35.5	122.4	158.6	176.5	18.9	24.5	26.9
<i>Health expenditure</i>									
THE (% GDP)	8.7	11.2	10.4	2.8	3.5	3.7	3.0	5.3	3.6
Public HE (% GDP)	6.1	7.9	7.4	0.9	0.9	0.9	1.5	3.8	2.1
Private HE (% GDP)	2.6	3.3	3.0	1.9	2.6	2.7	1.5	1.5	1.4
Public HE (% THE)	70.4	70.4	70.9	33.5	26.2	25.1	50.0	71.8	59.8
Private HE (% THE)	29.6	29.6	29.1	66.5	73.8	74.9	50.0	28.2	40.2
Public HE (% GE)	15.1	18.2	18.8	5.9	5.7	8.2	7.8	14.9	6.8
OOP HE (% Private)	53.7	49.2	46.8	92.7	95.7	95.7	63.6	65.4	66.8
External resources for health (% THE)	-	-	-	16.2	7.6	6.7	14.8	17.7	15.4
HE per capita (current US\$)	2100	5348	5292	17	80	118	12	71	58

Notes: GDP = Gross Domestic Product; THE = total health expenditure; GE = Government Expenditure; OOP = Out of pocket. Source: World Bank Health Data, 2017.

In addition, data for public health expenditure as a percentage of total health expenditure shows a large difference between a developed nation - Canada, and developing nations of Nigeria and Ghana. In Canada, the figure increased marginally from 70.4% in 2000 to 70.9% in 2014. In comparison, the figure reduced from 33.5% in 2000 to 25.1% in 2014 in Nigeria, while in Ghana the figure increased from 50.0% in 2000 to 71.8% in 2010, and subsequently decreased to 59.8% in 2014. This information discloses that the government of Ghana is stronger than Nigeria in terms of public health care funding with sudden increases from 50% to 59.8% while in Nigeria, a

reduction is observed from 33.5% to 25.1% over the same time. This affirmation about Nigeria's lower health spending in comparison with Ghana agree with Uzochukwu (2015) finding that the federal government of Nigeria budgetary allocation to health in the late 2000s is lower than the mandated 15% expected from every SSA country. It is noteworthy that Ghana achieved a higher expenditure of 71.8% than 70.4% of Canada in 2010, this increment in Ghana might be as a result of the creation of NHIS in 2003. The higher health expenditure in Ghana validate the Republic of Ghana (2003) discovery that the enactment of Act 650 made Ghana to achieve better health expenditure than any other African country. Overall, the public health care funding in Ghana in 2000 and 2014 were lower than the figures from Canada implying that the public health financing in Canada is larger than in Ghana and Nigeria.

Again, Table 4.1 shows that the governments of Nigeria and Ghana allocate small percentages of their annual national budgets to health. While the public health expenditure as a percentage of government expenditure for Canada increased from 15.1% in 2000 to 18.8% in 2014, in Nigeria it was 5.9% in 2000, decreased to 5.7% in 2010 and then increased to 8.2% in 2014, while in Ghana, the public health expenditure as a percentage of government expenditure was 7.8% in 2000, increased to 14.9% in 2010, and then decreased to 6.8% in 2014. Despite the fact that the percentage of government expenditures are low in both Nigeria and Ghana, the data shows inconsistency in government health expenditures in both West Africa countries (an example of inter-LMIC inequity) in contrast to Canada where the government health expenditure increased over the years. Health expenditure increment is in accordance with Axelsson (2007) finding that the federal and provincial governments in Canada provides substantial health funding to people on regular basis. In the perspective of global health financing therefore, this implies the presence of disparity in government health expenditure in HICs and LMICs.

Moreover, the analysis shows that the percentage of private expenditure that emanates from OOP sources in Canada decreased from 53.7% in 2000 to 46.8% in 2014, on the contrary, in Nigeria, the figure was very high at 92.7% in 2000, and it increased slightly to 95.7% in 2014. Likewise, in Ghana, the OOP expenditure was 63.6% in 2000 and it increased marginally to 66.8% in 2014. Thus, the percentage of private expenditure that emanates from OOP sources in Nigeria and Ghana are higher than that of Canada from 2000 to 2014. This higher percentage of OOP payments from Nigeria and Ghana corroborate the findings of UNICEF/WHO (2006) that OOP payments is the central method of health financing in many developing nations especially in SSA. According to Odeyemi and Nixon (2013), health financing in Ghana has become less regressive since the formation of the NHIS, while in Nigeria very high OOP payments as a share of private health expenditure have persevered.

External resources are also sources of health financing, and they are more applicable to LMICs, and seldom related to Canada as shown in Table 4.1. In Nigeria, the external resources for health as a percentage of total health expenditure decreased from 16.2% in 2000 to 6.7% in 2014, whereas in Ghana external resources increased from 14.8% in 2000 to 17.7% in 2010 and dropped to 15.4% in 2014. These findings show that Nigeria received higher amount of external aid than Ghana in 2000, while Ghana received greater external financial assistance than Nigeria from 2010 to 2014 to support its health development. Thus, Odeyemi and Nixon (2013) stated that the latest support from the International Finance Corporation (IFC) could facilitate better development potential to health financing in Nigeria. Over the years, the World Bank is the largest sole source of external funding for health, following are UN agencies (UNICEF, WHO, and others), and lastly are the private agencies with the least contributions. In order to implement the World Development Report (WDR) policy recommendations in LMICs, the World Bank suggested the need to double

the donor aid and health allocations to governments in SSA (World Bank, 1993). According to Owoh (1996), there are implications for relying on foreign aid as a main source of health financing. Firstly, there is implication concerning the allocation of official development assistance (ODA) - which is knotted to creating employments in donor countries. Looking at the government of Canada for example, ODA is a “vital instrument” to attain wealth and security, and to project the culture of Canada in overseas. It is not a tool to address the type of global poverty that causes health issues in Africa. Further, the Canadian Foreign Policy Report (1994) affirmed that the percentage of aid allocated to SSA decreases and fluctuates over the years as Canada and most northern donor countries reduced their support to ODA. When ODA declines, Owoh (1996) thought that reliance on foreign aid to seal the gap of health services for the poor is unreliable. Again, the reduction in external aid to Nigeria and Ghana from 2000 to 2014 could agree with the observation by WHO (2012) and WHO (2014) that for each dollar they receive in form of health aid, some low income country governments reduce their health expenditure from their domestic resources. An evidence by the 2010 *African Financing Scorecard* also corroborated that the reduction in health expenditure in SSAs could be probably due to the global fund and global alliance for vaccines and immunisation (GAVI) funds effect (Africa Public Health Information, 2010).

Finally, data for health expenditure per capital (US\$) indicate that Canada spent \$2100 in 2000 which increased to \$5348 in 2010, and then decreased to \$5292 in 2014, different level of increment is evident in per capita spending on health for Nigeria, rising from \$17 in 2000 to \$118 in 2014. Likewise Canada, Ghana’s health expenditure per capita (US\$) increased from \$12 in 2000 to \$71 in 2010 and fallen to \$58 in 2014 which differ from what obtains in Nigeria. This result implies there was a stronger and an impressive health expenditure per capital in Canada than

Nigeria and Ghana during this period, and this reveals the potential for further growth in Nigeria and Ghana economies. These findings also substantiate the assertion by OECD (2013) that Canada is one of the six OECD countries with the highest per capita spending on health. The analysis and interpretation of data will now proceed to the final conclusion.

Chapter 5

5.0 Summary and Conclusions

Health financing is significant in closing disparity gaps within an economy as “the first wealth of a nation is its health” (Olakunde, 2012). The WHO posits that a good health financing system raises adequate funds for health, and it provides incentives for the effectiveness of health providers and users. Money is crucial in health care, but it is not a necessary condition for efficient and equitable well-being. Hence, money can be converted into equitable health care with appropriate financing methods and involvement of human capital. Internationally, there is a large connection between economic development and health expenditure, and specifically with government health spending. Thus health expenditure either as a share of GDP, per capita, and government spending increase as national income increases. Globally, governments of nations prioritise health in their budgets differently, and their health financing policies might affect equitable delivery of health care. Also, the concerns about LMICs not getting access to quality healthcare, and the huge gaps in access to health services prompted governments, development agencies and civil society organizations to request for effective strategy to enhance health equity. Again, health care access is often identified as a goal for health care policy, and it is based on three dimensions of availability, affordability, and acceptability.

Moreover, health financing is one of the six pillars of a health system, and it involves the basic functions of revenue collection, pooling of resources, and purchasing services. Furthermore, health financing models are categorized as either direct or indirect. In the case of direct provision, the financing and provision of health care is integrated and managed by the same organization. This model is applicable to most developing countries. Indirect provision on the contrary is when organizations that finances the health care are separated from the organizations that provides it. This model have been adopted by the UK and the US. Similarly, health financing in any country

can be categorized as public and private. Public financing includes tax revenue and social health insurance while private sources of funds include private health insurance schemes, user fee/OOP, employer financed services, charitable donations, community self-help and fund raising.

According to CIHI, health care in Canada is financed by both the public sector and the private sector. The public sector consist of the federal, provincial/territorial, and municipal governments and social security funds. Private-sector spending comprise OOP by individuals and private insurance coverage. Higher percentage of total health financing in Canada emanates from public sources while the percentage for non-public sources is lower. In contrast to many nations, Canada's health care funding is almost entirely through taxes. The provinces and territories manage the larger part of the public-sector health budget in Canada while the federal government finance the other part through transfers of cash and taxation.

In Nigeria, there are two sources of revenue for financing the health sector. The pooled sources are collected from budgetary allocation, direct and indirect taxation, and donor funding, and the un-pooled sources are from OOPs. Despite these health financing options, the funds are still inequitably distributed across the health system in Nigeria (Lawanson and Olaniyan, 2013). The financing gaps in the health sectors across Africa due to low priority given to health budgets prompted the countries to be dedicated to the Abuja Declaration. Then, the Abuja summit in 2001 agreed that African governments should commit 15% of their annual budgets to their health sectors. This target remains to be met in Nigeria, while the government of Ghana 10.6% total expenditure is closer to the Abuja target of 15%. Moreover, some scholars believed that Africa countries should move beyond the Abuja Declaration to a higher level of '15 % plus' by expanding both per capita investment in health, and SDH.

One of the important reasons for the creation of the NHIS in Nigeria is the decreasing funding of health care. Similarly, the NHIS in Ghana was established to improve access to healthcare services after the failure of numerous health financing mechanisms. Also, Ghana's NHIS scheme has been relatively successful than NHIS in Nigeria because more than half of the population had been covered by 2010. Ghana is one of the few countries in SSA spending a quite high percentage of its GDP on health. As at 2013, Ghana's total expenditure on health as a percentage of its GDP was higher than in Nigeria. Despite the disparity in their total health expenditure as a percentage of GDP, Nigeria and Ghana are both making positive progress that suggests a growing capacity to their health care funding and delivery.

In the context of neoliberalism, it is argued that the post-colonial experience in the SSA led to the development of free enterprise, and the adoption of neoliberalism. It is generally acknowledged that OOP payments are associated with most welfare losses to individual homes. The predominance of these payments in many countries has risen from the neo-liberal ideologies that depend on borrowing from international donor organizations. Also, the advocates of free market economy in Canada supported serious cuts to health care and tax increment to manage the increasing expenses of public health care. Continuous investment and reforming of health care systems in Canada and SSA countries was suggested to address neoliberalism in these continents to improve people welfare.

Moreover, in making comparison of health financing in the developed and developing nations, research findings indicate that the total health expenditure as a percentage of GDP for each year from 2000 to 2014 for both Nigeria and Ghana is less than half of each year in Canada. Also, for the same period, public health expenditure as a percentage of total health expenditure shows a large difference between Canada, and LMICs of Nigeria and Ghana. In addition, the

government of Ghana is stronger than Nigeria in terms of public health care funding from 2000 to 2014. Generally, the public health financing in Canada is larger than in both Ghana and Nigeria. The governments of Nigeria and Ghana allocate small percentages of their annual national budgets to health, while the government of Canada allocated a higher percentage than these countries. From the global health financing perspective, this indicates the presence of inequality in government health expenditure in HICs and LMICs.

Furthermore, research evidence shows that the percentage of private expenditure that emanates from OOP sources in Nigeria and Ghana are higher than that of Canada from 2000 to 2014. The paper review ascertains that Ghana received greater external financial aid for health development than Nigeria. Lastly, the analysis suggests a stronger health expenditure per capital in Canada than Nigeria and Ghana.

There are many *barriers* to the attainment of health financing objectives. Uzochukwu et al. (2015) itemised these barriers in Nigeria to include: deficient political commitment to health with resultant poor health financing; gaps in financing health care at all tiers of government; lack of a health policy on how funds are to be allocated and spent in the health sector; non-utilisation of other sources of health financing; and lack of cooperation between the stakeholders and development partners to finance health and their inability to agree with governments' policy thrust has led to unproductive use of scarce resources. As a result, Owoh (1996) said that divergent priorities often occur between international donors and domestic institutions; and there could be failure on the part of an external agency to support and reinforce existing health care systems. Again, foreign aid to finance health care goes beyond the health sector to include wider concerns of autonomy (Owoh, 1996). The philosophical commitment of the World Bank to a neoliberal standpoint destabilizes the capacity of the public health sector to organize the essential package of

health care, or adjust self-financing by the poor (Owoh, 1996). The analysis identified the abovementioned barriers, and the following *suggestions* are desirable to achieve the health financing goals.

Hsiao & Shaw (2007) suggest that countries should reform their health care financing systems to alleviating their underfunding of health care, prevent people from impoverishment by health expenses and improve their well-being. Also, the World Health Assembly passed a policy resolution for the WHO, recommending that LMICs adopt SHI as the health care financing strategy (WHO, 2005). Again, Hsiao (2007) argued that SHI mobilizes additional funds for health care; it can target public funds more effectively to the poor in comparison to tax-funded public health services for all. It can improve insured people's access to care by using the capacity of private-sector providers. It is worth mentioning that some LMICs such as Nigeria and Ghana have already initiated and practices SHI as a reform strategy. The WHO also recommends an improved health financing in LMICs such as Nigeria and Ghana if these countries could raise enough funds in a rightful, effective and viable manner; reduce financial obstructions through affordable access and efficient pooling; and use resources wisely and efficiently (WHO, 2010).

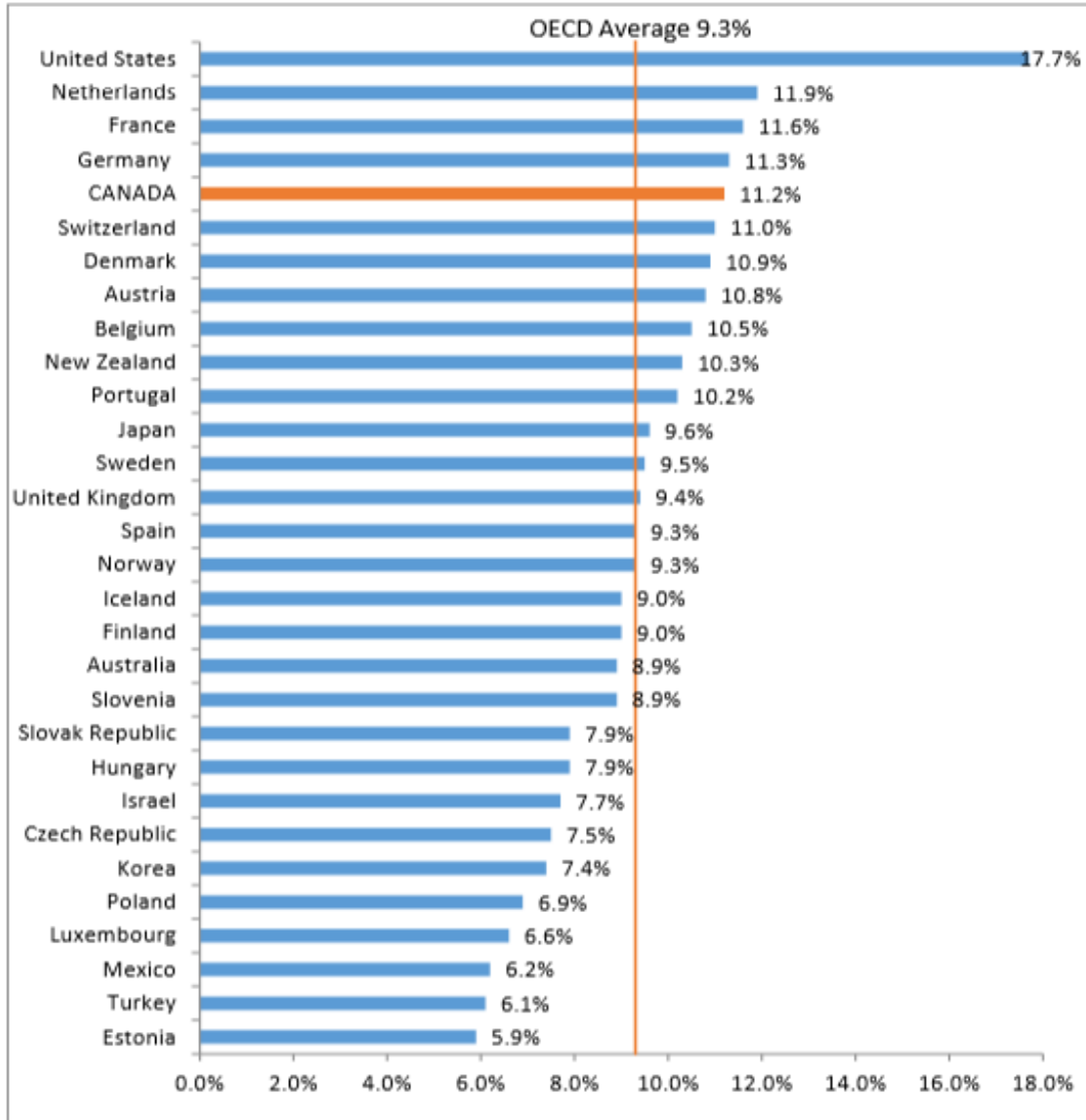
Uzochukwu et al. (2015) suggested that OOPs should be replaced with more equitable methods of financing; policies on health financing should be clearly stated; governments should give higher priority to health in their budget allocations; innovative ways of mobilizing funds and financing health should be explored – adequate funds can be obtained through “sin taxes” on products that pose risks to health such as alcohol, tobacco, and unhealthy foods. Other sources of innovative funds in Nigeria include levies on mobile phone call rates (due to huge number of mobile phone customers), and taxes from the lucrative sectors of the economy like banking, oil and gas (Uzochukwu et al., 2015). Donors should be able to improve on their global obligations

for ODA and to provide more long-term aid flows in Nigeria. Similarly, Owoh (1996) mentioned that the health and civil society organizations and some concerned SSA governments should reappraise foreign aid and non-governmental organization (NGO) funding. Additionally, raising the total government revenues will convert into more money for health (Uzochukwu et al., 2015). Health care in Canada is a good example of social transfer to fight inequalities. Their progressive tax rate system makes that the rich pay for the poor. This implies that Canadian families with the lowest income pays lower tax and health care insurance than a high income Canadian households (McGraw and Robichaud, 2016, p.77). “Deciding how best to finance a health care system thus encompasses a variety of policy choices about what is worth paying for, for whom, and by whom” (Emery and Kneebone, 2013). Global health play a central role in foreign policy (Bliss, 2010), and in the past, key global health decisions were taken exclusively by the Europe and North America powers. But, now power blocs from the Global South provides support on health issues (Sridhar et al., 2013). It is therefore important that the Global North and South work together to strengthening health financing schemes.

In conclusion, a good healthcare financing strategies should enable utilization of resources for healthcare; achieve equity and efficiency in use of healthcare spending; ensure affordable and quality healthcare; guarantee sufficient provision of essential healthcare goods and services (Palmer et al., 2004); and ensure prudent spending of money in order to achieve sustainable development. This assertion by Palmer et al. is appropriate for governments of every country to adopt for proper policies in health finance and enhanced health care delivery.

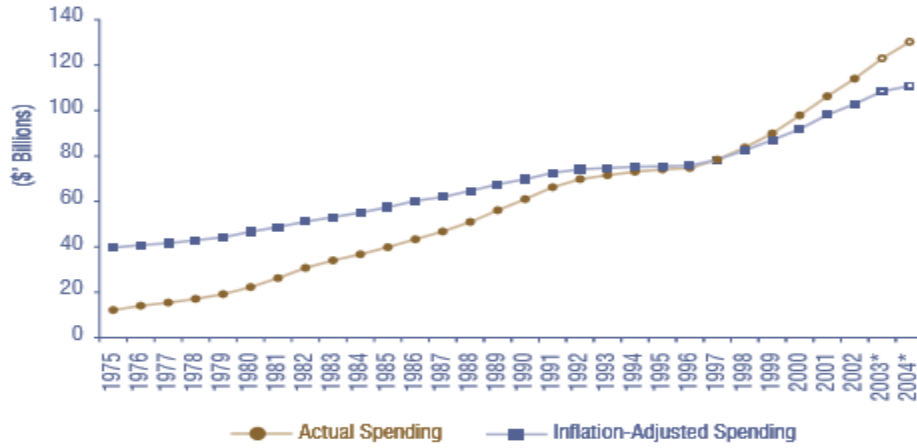
Appendices

Appendix 1: Total health care expenditure as a percentage of GDP, 30 OECD Countries



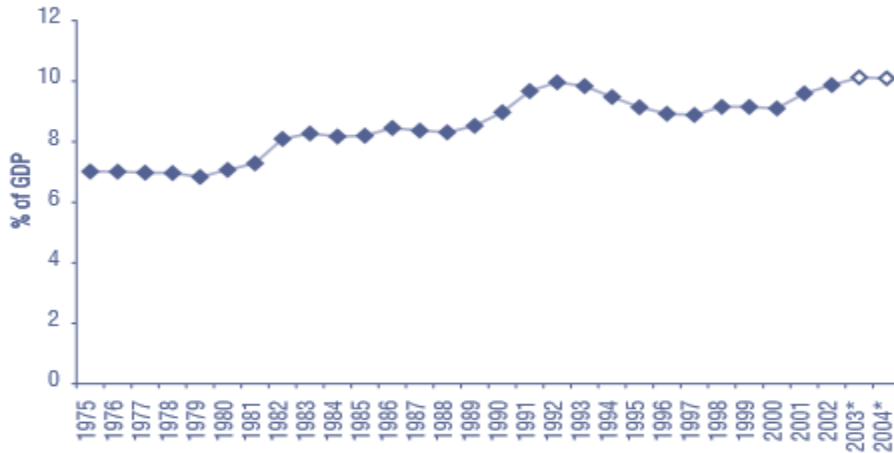
Source: National Health Expenditure Trends, 1975 to 2013/OECD Health Data 2013.

Appendix 2: Total health spending (\$ Billions)



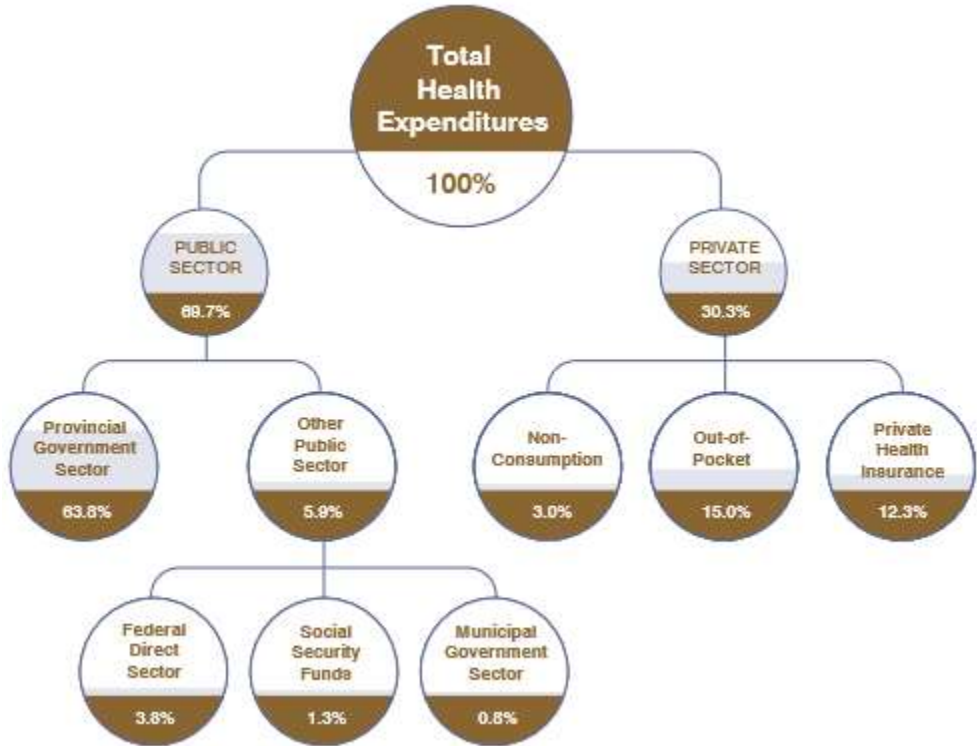
Note: Data for 2003 and 2004 are forecasts. Source: National Health Expenditure Database, CIHI, 2005.

Appendix 3: Total health spending as a proportion of GDP



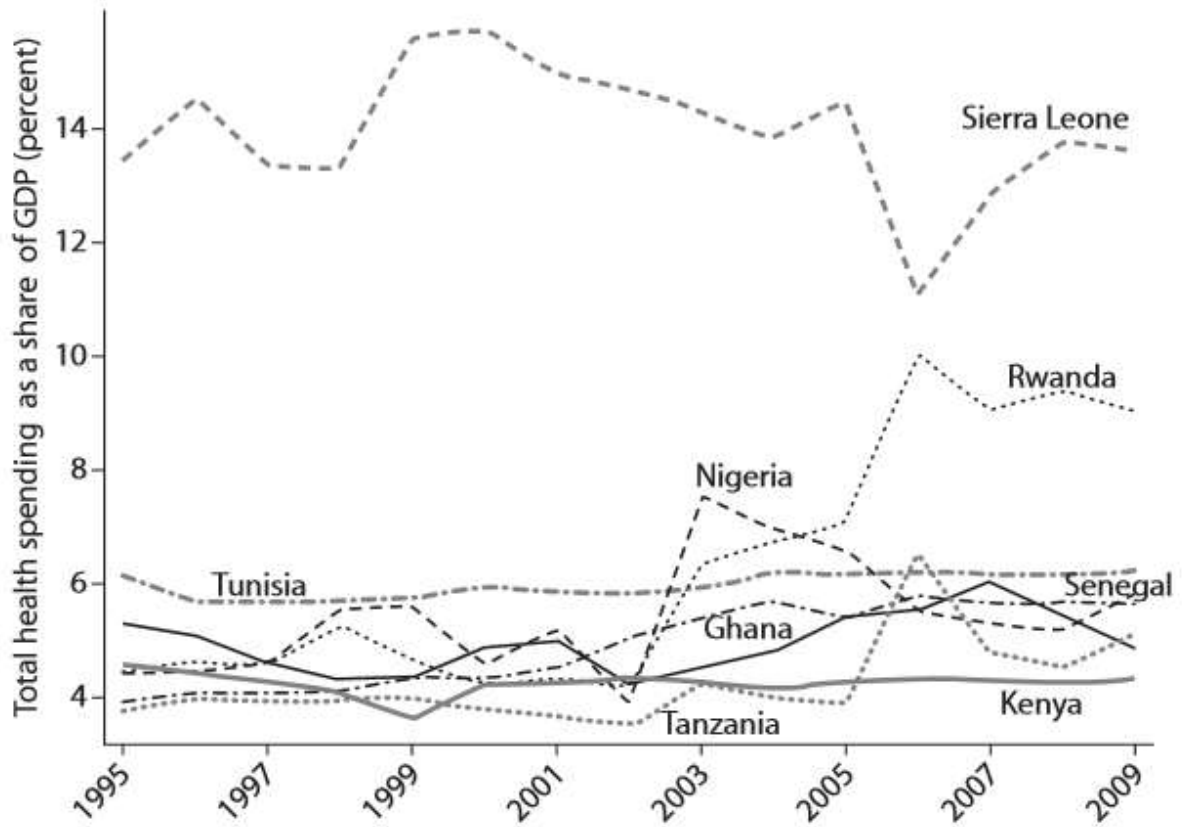
Note: Data for 2003 and 2004 are forecasts. Source: National Health Expenditure Database, CIHI, 2005.

Appendix 4: Who spends what in Canada?



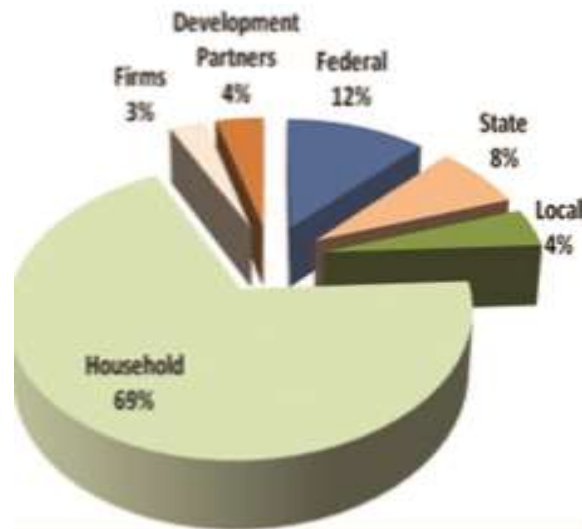
Note: Data are for 2002. Source: National Health Expenditure Database, CIHI, 2005.

Appendix 5: Total spending on health as percent of GDP in Nigeria, Ghana and selected African comparators, 1995-2009.



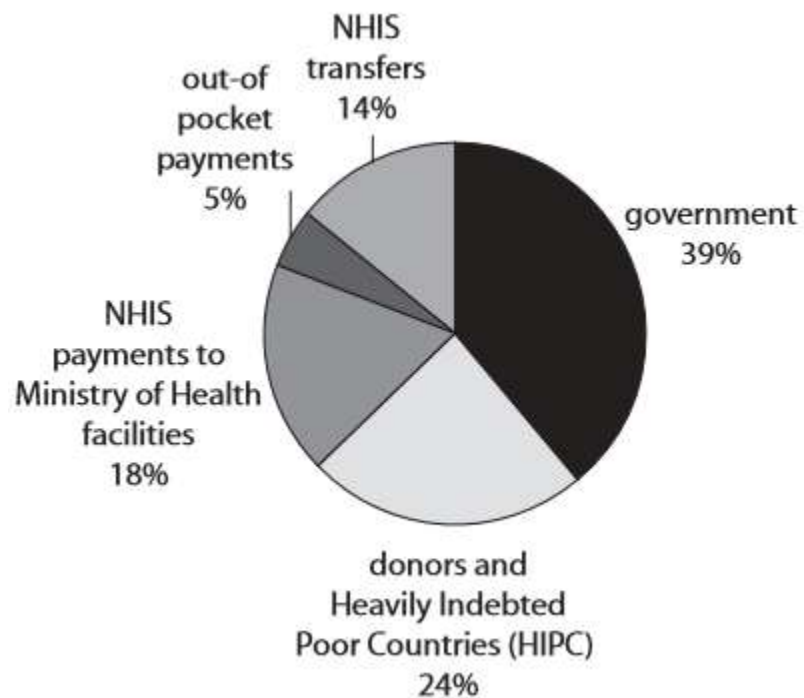
Source: WHO (2011).

Appendix 6: Health funding sources in Nigeria



Source: NHA 2003-2005 In Uzochukwu, et al. (2015)

Appendix 7: Sources of Ghana Ministry of Health Revenues, 2009



Source: Ministry of Health 2011

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