Payment Patterns in Nigeria's Public Facilities: Unexpected costs and implications for health-seeking behaviour in Nigeria

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Executive Summary

Adequate health financing is a critical element of any strong healthcare system. In Sub-Saharan Africa, financing and payment models for primary, secondary, and tertiary health care can be significant tools for improving issues of access, quality, and equity in care delivery. While much effort is made to understand the financing approaches that may be optimal for health systems at large, little is known about financing mechanisms that may work best considering the dominance of out-of-pocket payment and, more importantly, the impact that unexpected, informal costs for care may have on health-seeking behaviour. The abolition of user fees for public health facilities has become increasingly popular in many low-income countries, with results from numerous studies noting an increase in access and utilization for the poorest populations. However, abolishing user fees often does not remove the cost of many goods and services related to a care episode. Though some patients may pay no initial fees for a basic service such as an initial consultation, there are often treatment-related costs that are unknown to the patient.

Even with health insurance or under "free" social schemes, evidence suggests that many patients in Nigeria's public health facilities still pay a significant amount of care-related costs. The discrepancy between the expected free cost of care at public facilities and the actual cost of treatment often means that poorer patients pay as they are able to gather funds. Abolition of user fees and fee exemptions may not effectively protect access to health services among the poor. The majority of fee removal and exemption mechanisms have not meant an end to the existence of informal fees and other care-related costs. A better understanding is needed of the existence of fee removal mechanisms, whether they are able to increase access for the poor, or if other supplemental mechanisms may be necessary.

In Nigeria's health system, a better understanding is needed on the impact that unexpected costs have on health seeking behaviour. Of note, patients' health-seeking choices between

public vs. private facilities is influenced by their ex-ante perception of public vs. private facilities' cost, quality, and accessibility. Lowered or abolished user fees at public facilities tend to increase utilization because patients believe the full cost of care is lowered. However, evidence points to care-related costs being passed off to the patient in other ways and at various points in a care episode. Since little is known about the impact that payment expectations and patterns have on health seeking behaviour, the ideal user fee payment structure and appropriate ways of financing it are also poorly understood.

In this country case study, we explore patterns in user fees at public hospitals and its potential relationship to utilization, investigate the phenomena of unexpected antenatal and delivery costs and payment patterns specific to Lagos' public hospitals, and examine the relationship between unexpected costs and patients' attendance of public facilities in 11 local government areas within Lagos state.

Results from the findings of this study show that majority of respondents pay a lower out-of-pocket fee to access ANC services in public health facilities. However, they incur unexpected/extra cost amounting to over 300% to access additional services (i.e. blood test and scans) from private independent providers. In addition, there is the presence of information asymmetry as health workers have access to information on policies related to costing and quality of services that patients do not have access to. Lastly, the occurrence of unexpected/extra cost influences the desire of respondents to utilize ANC services.

List of Abbreviations

ANC – Antenatal Care

LGAs – Local Government Areas

NDHS - Nigeria Demographic and Health Survey

OOP - Out-of-Pocket

List of Figures and Tables

Table of Content

1. Background

Many low- and middle-income countries face inadequate government financing for health, causing a heavy reliance on out-of-pocket payments (OOP) to cover costs [1]. Health in Africa policymakers and health financing stakeholders have noted that user fees are a significant obstacle to accessing care [2]. In recent years, more and more African governments have been considering and implementing the removal or phased implementation of user fees as a way to increase the accessibility of basic healthcare goods and services [3] [4]. Countries such as Mali, Niger, South Africa, and Uganda have done away with user fees completely in public facilities. Early evidence supports the idea that removal of user fees is indeed effective for improving access to healthcare, particularly for the poor [5] [6].

Although the removal of user fees seems to, on the surface, increase utilization, on-ground anecdotal evidence suggests that abolition of user fees does not completely eliminate all the costs associated with a care episode [7]. Rapid surveys conducted in Bangladesh indicated that the average level of informal fees each patient experienced was twelve times the amount they expected to incur under official payments [8]. Survey research in Ghana pointed to the idea that due to higher user fees for some services coupled with increased travel costs, routine services cost more in hospitals than in their respective health centers [9]. Notably, the survey also found that costs to the user other than fees for routine services often took up more than 50 percent of total care costs for patients in Uganda, and that the service fees charged informally by midwives were higher than the charges seen at public health centers and even as high as those charged in formal hospital settings. These studies reflect the problem where patients believe user fees in public facilities are abolished or lowered, but may in fact be informally paying up to or more than is charged at most private facilities.

Across Africa, fees have been seen to have a negative effect on the population's use of maternal and antenatal care services. Such fees are out-of-pocket payments for expenses such as facility charge, doctor or midwife charge, antenatal drugs, and the likes; and these reduce health-seeking behaviour of expectant mothers. As expected, there is often a decrease in the utilization of antenatal care services following the introduction of incremental changes in user fees in most African countries, and an increase in cases where abolition of maternal and antenatal care user fees have been implemented. Studies in Zimbabwe, Tanzania, and Ghana have shown that the introduction of user fees or user charges have led to declines in the utilization of antenatal care in public health facilities [10] [11].

In Nigeria, user fees in public facilities have not been universally abolished. As is the case in many countries in Sub-Saharan Africa, Nigeria's health care system is supported by a network of donors, partners, and not-for-profits that frequently provide assistance to different parties within the health system. Many of the programs being implemented by donors and partner agencies have collaborated with local, state, and federal governments to provide free basic health care goods and services to various segments of the population. These instances of basic goods and services at no cost are typically centered on primary care provision, such as malaria, typhoid, vaccinations, and standard maternal and child care.

However, in many instances of free care, where user fees have been abolished for at least a segment of the population, a significant amount of often unexpected out-of-pocket payments are made by patients to receive treatment. Many policymakers do not account for these "hidden" or unexpected OOPs when assessing the impact of abolishing user fees. The removal of user fees together with these additional OOPs bring with them a number of issues for health financing, including (a) overcrowding of public health facilities, which drives marginally wealthier patients to the private sector; (b) dispersed out-of-pocket payment, which extends the

time from initial consultation to the end of a care/treatment episode; and (c) private out-of-pocket funds being inefficiently used on non-direct care costs.

Peculiar to public health facilities is the overcrowding issue, and this is because the removal of user fees and OOPs policies are especially aimed at improving health-seeking behaviour of poor patients who frequent such already limited public facilities. As their behaviours are further incentivized by the abolition of user fees, their visit frequencies also receive a boost and result to overcrowding. Consequently, with the resultant increase in waiting time and drop in quality of delivery services, wealthier counterparts are pushed to patronise the private sector's health facilities.

Although free care exists for certain populace, a high level of demand for health care services by different socio-economic groups -a characteristic of developing countries- necessitates dispersion in out-of-pockets payments. Where possible, the available and quality resources are allocated to patients who are willing and able to pay high out-of-pocket fees for the services, leaving the poor to grapple for what is left with the little funds they may have. In essence, the willingness and ability to pay is strongly correlated with the limited amount of time it will take to receive health services. A care episode time period is extended for poor patients who pay little OOPs as priorities are given to more socio-economic advantaged patients.

This country case study aims to explore payment patterns, their relationship to health-seeking behaviour, and potential implications for health financing. Specifically, this case study aims to create for health stakeholders a better understanding of unexpected costs and payment patterns in terms of their relation to patients' health-seeking behaviour at public facilities.

1.1 Objectives

Government and donor programs focused on the removal of upfront user fees often fail to account for the embedded costs of care delivery. Anecdotal evidence and qualitative data from

patient satisfaction surveys point to the idea that while patients may believe they are receiving care free of charge at many public facilities, the costs of care-related transportation, supplies, and drugs are often borne by the user and/or family members. For low socio-economic status patients, these costs often cannot be paid at once in one large bulk payment. Poor patients often have to break up the costs of a single care episode, and spread it out over multiple visits to the hospital or clinic. Particularly for poor patients, large bulk payments at one time are often unaffordable. For this reason, many public and private providers allow patients to pay at various points in time for their care.

On one hand, this dispersed payment structure makes even the most inexpensive treatments more affordable on any given day for poorer patients. On the other, it expands the cost of care by forcing multiple rounds of transportation costs and expenses for minor supplies. Most potentially crippling for health outcomes, dispersed payments extend the time from initial consultation to the end of a care episode with final treatment. Lastly, in terms of health financing, dispersed payments create inefficiencies in the use of health-related funds by increasing time and money spent on transportation as opposed to actual health care needs.

Objective 1: Report national patterns in user fees for antenatal care and delivery at public and their potential relationship to utilization.

Objective 2: Investigate the phenomena of unexpected/informal fees and payment patterns specific to antenatal and delivery care in Lagos' public hospitals.

Objective 3: Assess evidence of the relationship between patients' payment expectations and their attendance of public facilities in 3 Local Government Areas of Lagos state.

2. Overview of Antenatal Care In Nigeria

According to the Nigeria Demographic and Health Survey (NDHS) in 2013, Nigeria has one of the lowest proportions of pregnant women that attend antenatal care (ANC) services, with only 60.9% of women of child bearing age receiving ANC from a trained skilled ANC provider (i.e., midwife, auxiliary nurse, nurse, or doctor) in the five years preceding the survey. Following WHO recommended minimum of four or more visit, this proportion further reduces to 51.1.%. This is far below the recommended target of 90% attendance[1] and requires mitigating circumstances to address this poor ANC attendance given the high maternal mortality rate in Nigeria.

Various studies have investigated the factors affecting ANC utilization on national, regional and state levels in Nigeria. Factors such as distance to health facilities, insufficient number of ANC providers, socio-demographic and health knowledge factors amongst others have been identified. However, the relationship between household income level and ANC utilization remains a pertinent issue. Given the high level of poverty in Nigeria, the cost of accessing ANC services could pose as barriers to its utilization, particularly to the most vulnerable

Although, Nigeria does not have a general free antenatal care (ANC) policy for all pregnant women in the country. However, some States Governments (Lagos, Anambra, Kano and Ondo) had sponsored free antenatal care policy. The policies did not take the same form in these states, for example, in Kano and Anambra state, full exemptions were provided for all pregnant and postpartum women, whereas Ondo state had an only partial exemption for some services in the

[1] https://apps.who.int/iris/bitstream/handle/10665/259947/WHO-RHR-18.02-eng.pdf?sequence=1

government hospitals. However, women still report barreirs such as poor knowledge of service, economic barriers (indirect cost and transportation cost), geographical barrier, drug stock outs, poor referral system, no means of transportation during labour, religious and cultural beliefs, women's low status in the society, poor quality of service, in ANC utilization.

Review of existing literature, shows limited or almost non-existence literature on the policies of user fees and payment pattern for ANC in Nigeria. Although a few newspaper publication reports on patient's opinion on the cost of accessing ANC, to the best of our knowledge this study fills an existing gap in literature by providing an analysis of the pattern of user fees and unexpected cost in ANC utilization.

3. Methods

This study made use of both existing large-scale national panel survey data from a vetted and reliable data source, as well as first-hand qualitative and quantitative data from a small sample of facilities within Lagos state. This study's first assessment question centers on the patterns of between user fees for antenatal and delivery services and utilization of public health facilities. User fees are measured using the cost of registration for patient visits for antenatal and delivery care services at health care facilities. Utilization of public and private facilities is measured by the reported proportions of respondents using public, private, non-governmental, or faith-based facilities.

3.1 Existing Dataset

To meet Objective 1 of analysing national patterns in user fees for ANC and delivery and their potential relationship to utilization, existing mass data for this study will be garnered from the 2013 Nigeria Demographic and Health Survey (NDHS) [11]. The sample was nationally representative and population-based. The 2013 NDHS was implemented by the Nigerian Population Commission with support from many development partners including the United Kingdom Department for International Development, the United States Agency for International Development, and the United Nations Populations Fund.

The 2013 NDHS survey was carried out through a stratified three-stage cluster sampling, consisting of 904 clusters – 372 and 532 in urban and rural areas, respectively. A representative sample of 40680 households (16740 in urban areas and 23940 in rural areas) was selected for the survey. A comprehensive report on the sampling procedures, settings, questionnaires and the design of the 2013 NDHS has previously been published

We chose the NDHS dataset due to the large scope and depth of information that it provides. Individual and household characteristics are captured in the NDHS, with items such as educational attainment, languages spoken, martial status, gender, and education included. More

relevant to our aims for this study, the NDHS also captures information on healthcare services utilization and access. Our specific variables of interest centre around the health questions on the timings and quality of ANC.

3.2 Additional Data

3.2.1 Patient Exit Interviews

To gather the required data and information on patient informal and formal fees, facility data, key informant interviews, and patient exit interviews was conducted in 11[2] local government areas (LGAs) in Lagos state. A total of 250 pregnant women in approximately 15 total facilities across the 11 LGAs were examined. Patient interviews for this study were designed to capture the subjective expressions of patients' experiences on unexpected payments, the amount and timing of payments, and their experiences of accessing public based on cost perceptions.

The Interview questions were composed of both open and closed ended questions. These questions explored the demographic characteristics of the patients, the potential unexpected costs that they encountered, and health seeking behaviour such as alternative care options in relation to their immediate care episode. Specifically, patients were asked in-depth questions about any unexpected costs they experienced and their payment for the precise service they are receiving. These questions determined which wealth quintile of patients paid how much for which services.

Patient payments will be measured in two ways through interviews. First, patients were asked open ended questions that aimed at eliciting the general cost of care they paid, and their perspective of the appropriateness of the cost. This allowed patients to have the opportunity to explain their payment structure in their own words. Studies on interview and survey data in

[2] Ikorodu, Ikeja, Oshodi-Isolo, Alimosho, Shomolu, Ifako-Ijaye, Kosofe, Epe, Lagos Island, Apapa

settings where multiple cultures and ethnicities coexist have shown that there is often a mismatch between the intended meaning of questions and participants' understanding of what that question means. To diminish such mismatches from developing in this study, beginning interviews will open-ended questions will allow the patient to describe in their own words the actions and phenomena that are taking place, with little room for misunderstanding or misinterpretation from the interviewer. Secondly, a 2-point likert scale will be used to indicate the lowest and highest satisfaction patients have with upfront or dispersed payments, and how that impacted their desire to access antenatal care.

3.2.2 Key Informant Interviews

The following staff members at each selected facility were interviewed assuring as much privacy as possible: head administrative manager; head/senior midwife or nurse/midwife responsible for maternal health services; and head registration clerk. A total of 20 staff members where interviewed, at least 2 from each LGA surveyed. The aim was to collect the information below:

• Knowledge about monetary amount of formal user fees and official fee collection practices;

• Knowledge about official fee waiver criteria and the eligibility determination process;

• Patterns and practices of formal and informal fee collection, including who collects fees, from which types of clients, at what points in the delivery of services, for what types of products and services, and monetary amount of fees; and

• Opinions about the appropriateness of formal and informal fee collection practices and the impact of informal fees and other costs on access to and utilization of services and health outcomes

4. Analysis of Results

Majority of our respondents belong to the 26-35 age group. 47.4% of women reported their highest level of education to be the secondary school level with one third of the respondents either earing below the minimum wage or unemployed. The highest proportion of respondents earn less than N50000 (approximately US$120/month). In this study only 10% of the respondents belonged to lower class and a meagre 1.61% belonged to the lower middle class. Approximately 61% of respondents reported family size ranging from 3-5 and 21.3% reside in Ikeja LGA.

Table 1: Socio-demographic characteristics of the respondents

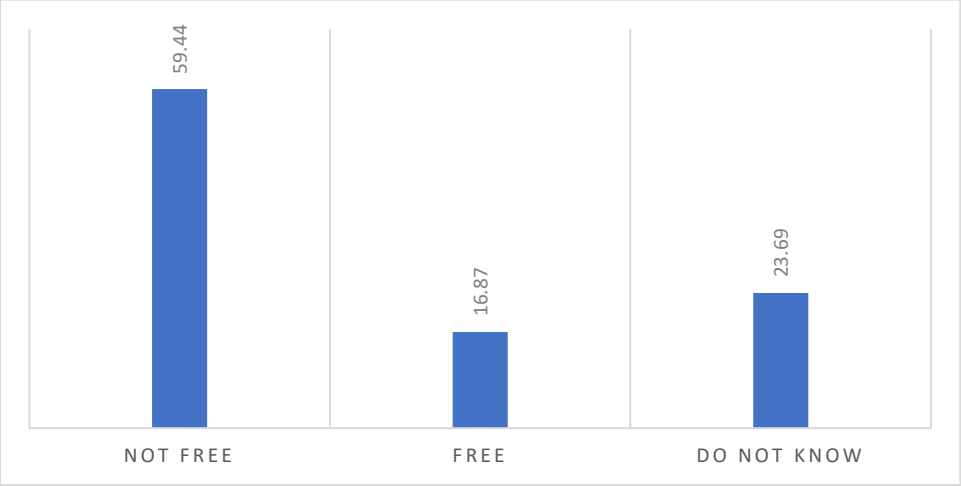
Socio demographic variables (n=250)	Frequency (%)
Ages (years)	
<18	6(2.4)
18-25	67(26.8)
26-35	140(56)
36-50	35(14)
>50	2(0.8)
Respondent's education	
No education	18(7.2)
Primary	20(8)
Secondary	118(47.2)
Tertiary	94(37.6)
Income Level (Naira)	
Unemployed	44(17.27)
<18,000	30(12.05)
18,000-50,000	79(31.73)
51,000-100,000	67(26.91)
100,000-200,000	26(10.44)
201,000-400,000	4(1.61)
Marital Status	
Not Willing to Disclose	28(11.24)

Single	14(5.62)
Married	207(83.13)
Household Size	
<3	48(19.28)
3-5	152(61.04)
6-8	35(14.06)
>8	14(5.62)
Area of Residence	
Ikorodu	42(16.87)
Surulere	20(8.03)
Ikeja	53(21.29)
Oshodi-Isolo	27(10.84)
Alimosho	24(9.64)
Shomolu	18(7.23)
Ifako-Ijaye	5(2.01)
Kosofe	7(2.81)
Epe	2(0.80)
Lagos Island	43(17.27)
Apapa	8(3.21)

4.1 Pattern of user fees for antenatal care and delivery at public hospitals: patients

To analyse the patterns of user fees for antenatal care, we asked respondents about their knowledge on the cost of antenatal care in their LGA.

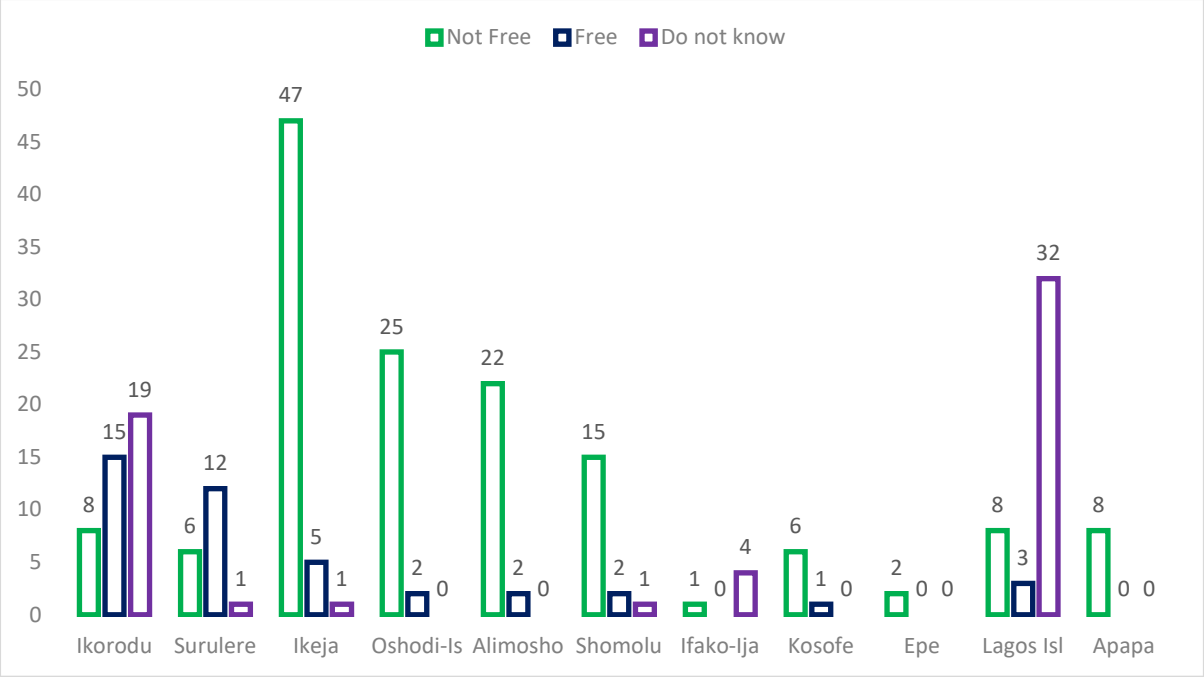
Figure 1: Knowledge on the cost of antenatal care



Source: Authors' Compilation

Majority (59.44%) of respondents report that antenatal care is not free, while 16.87% state that antenatal care is not free, 23.69% state that they do not know the cost of antenatal care (see figure 1). Analysing based on LGA shows that antenatal care services is not free in most LGA (see figure 2) and lack of information on antenatal cost is a major concern in Ikorodu, Lagos-Island and Ifako-Ija LGAs.

Figure 2: Knowledge on the cost of antenatal care by LGA

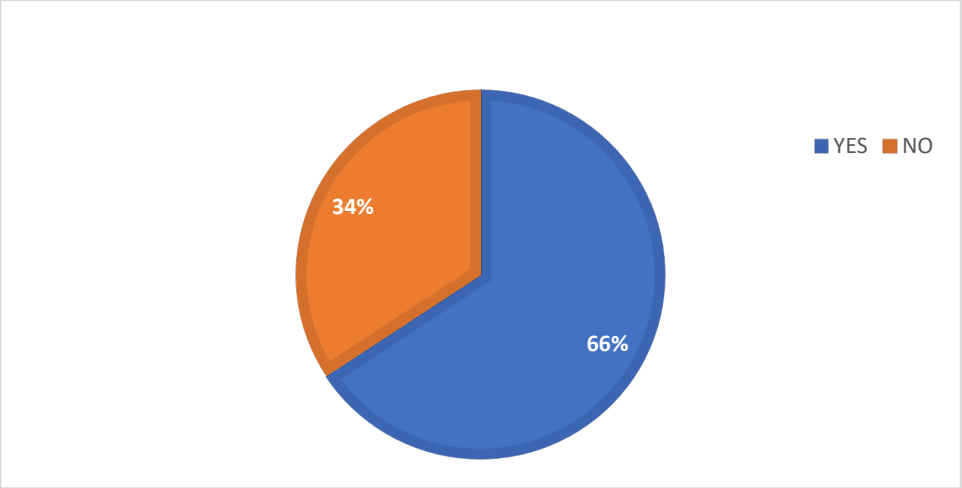


Source: Authors' Compilation

Going further, this study examines patterns of user fees by asking respondents about the cost of registration for ANC utilization.. Analysis of results from survey data shows that more than half (66%) of our respondents paid registration fees to access ANC services in various public health facilitates (see figure 3). However, the price and services offered varied across LGAs. The cost of registration ranged from a low as N1000 to N35000 (see figure 4). Majority (42.5%) of respondents paid registration fee costing below N5000. The cost of registration for about one third of respondents ranged between N5000-N10000. 15% of respondents paid above

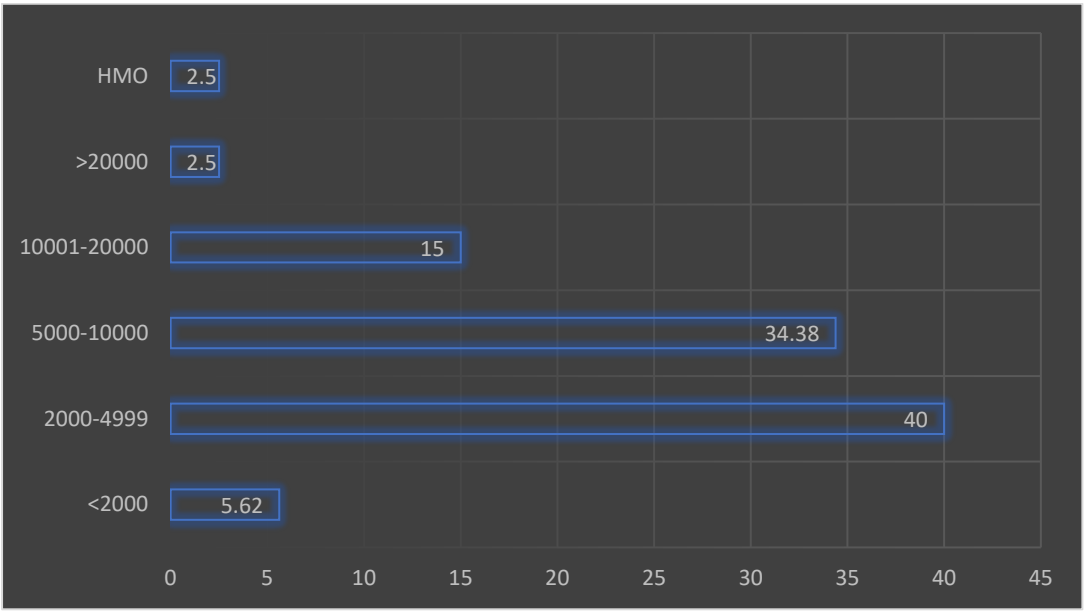
N10,000 but below N20,000 with and meagre 2.5% incurring more than N20000 to cover registration for ANC utilization.

Figure 3: % of respondents who paid registration fees



Source: Authors' Compilation

Figure 4: Cost of Registration for Antenatal Care Utilization

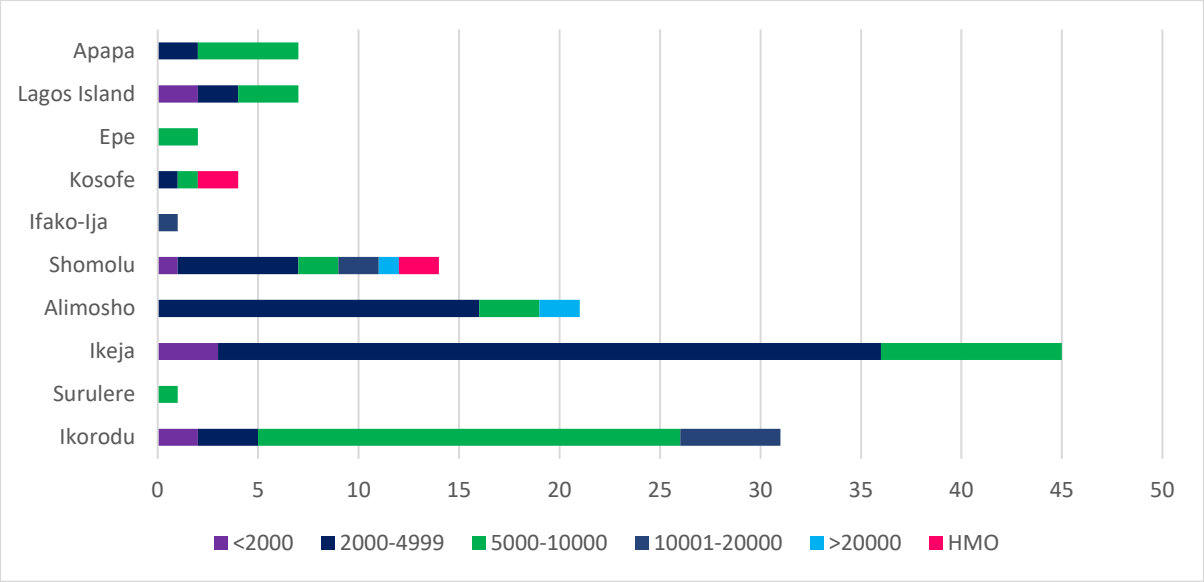


Source: Authors' Compilation

A further analysis of the cost of registration for ANC services disaggregating based on LGA area (see figure 5) shows that the average cost of registration in most LGA sampled is below N5000. However, in LGAs such as Ikorodu, Apapa, and Lagos-Island the cost of registration

is higher and ranges between N5000-N10000. In addition Ikorodu, Alimosho and Shomolu report registration fees higher than N10000.

Figure 5: Cost of Registration for Antenatal Care Utilization by LGA

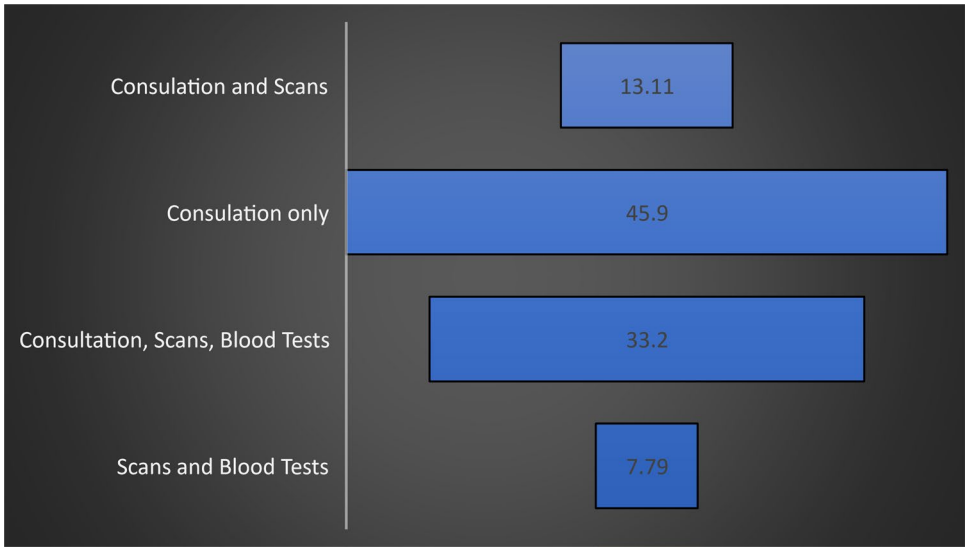


Source: Authors' Compilation

From our survey data, four major antenatal care packages are reported: (i) consultation only (i.e. receiving medical advice from a qualified medical practitioner), (ii) consultation and scan, (iii) consultation, scan and blood test (i.e. complete package), and (iv) scan and blood test. Discussions with respondent reveal that services offered by each public health facilities is dependent on the facilities and man-power available. For instance, for health facilities without laboratories and ultrasound scan machines, patients are offered consultation only and are required to conduct blood test and scan by independent providers.

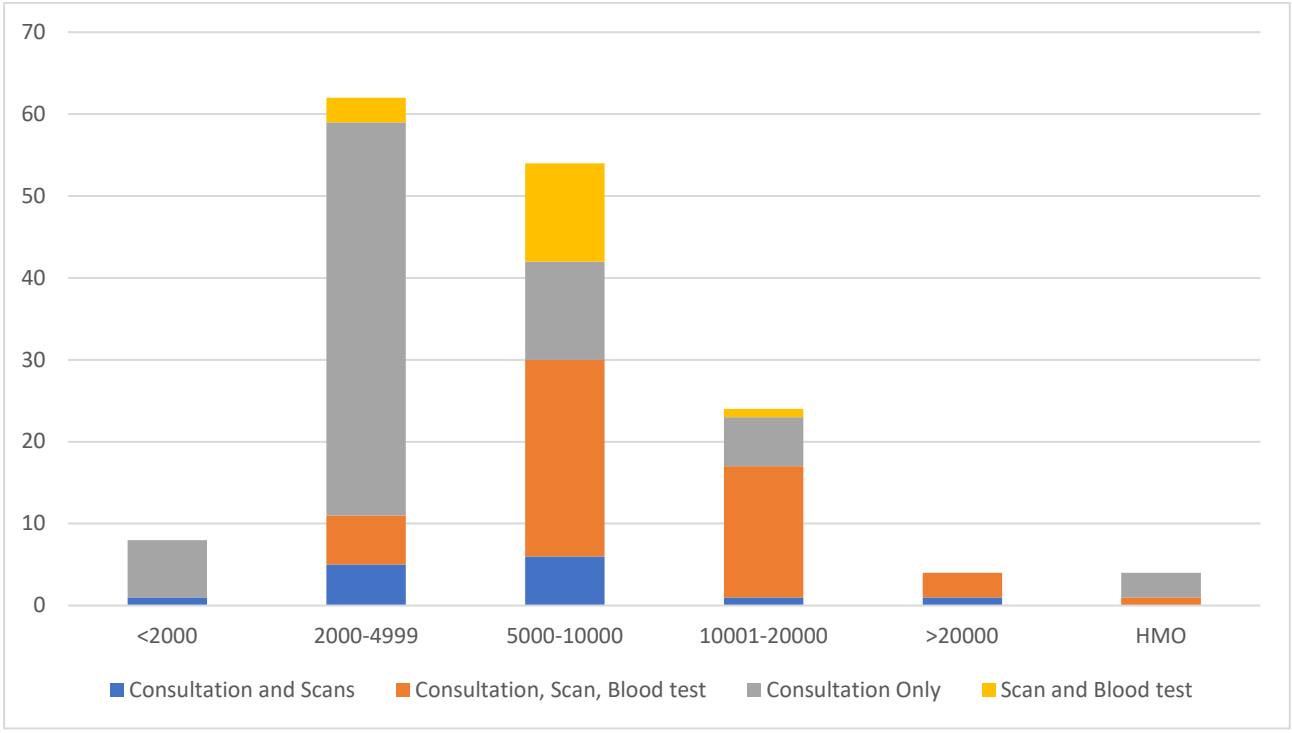
Figure 6 shows that consultation only is the most common antenatal package offered by public health facilities in Lagos state. 33% of public health facilities offer the complete package of consultations, scans and blood test with 13.11% offering consultation and scans only. The least provided package is the combination of scans and bloods test supporting the claims of patients that most public health facilities lack the infrastructure and man-power for offer this services.

Figure 6: Antenatal Care Package: Patient



Source: Authors' Compilation

Figure 7: Antenatal Care Package by Registration Fee

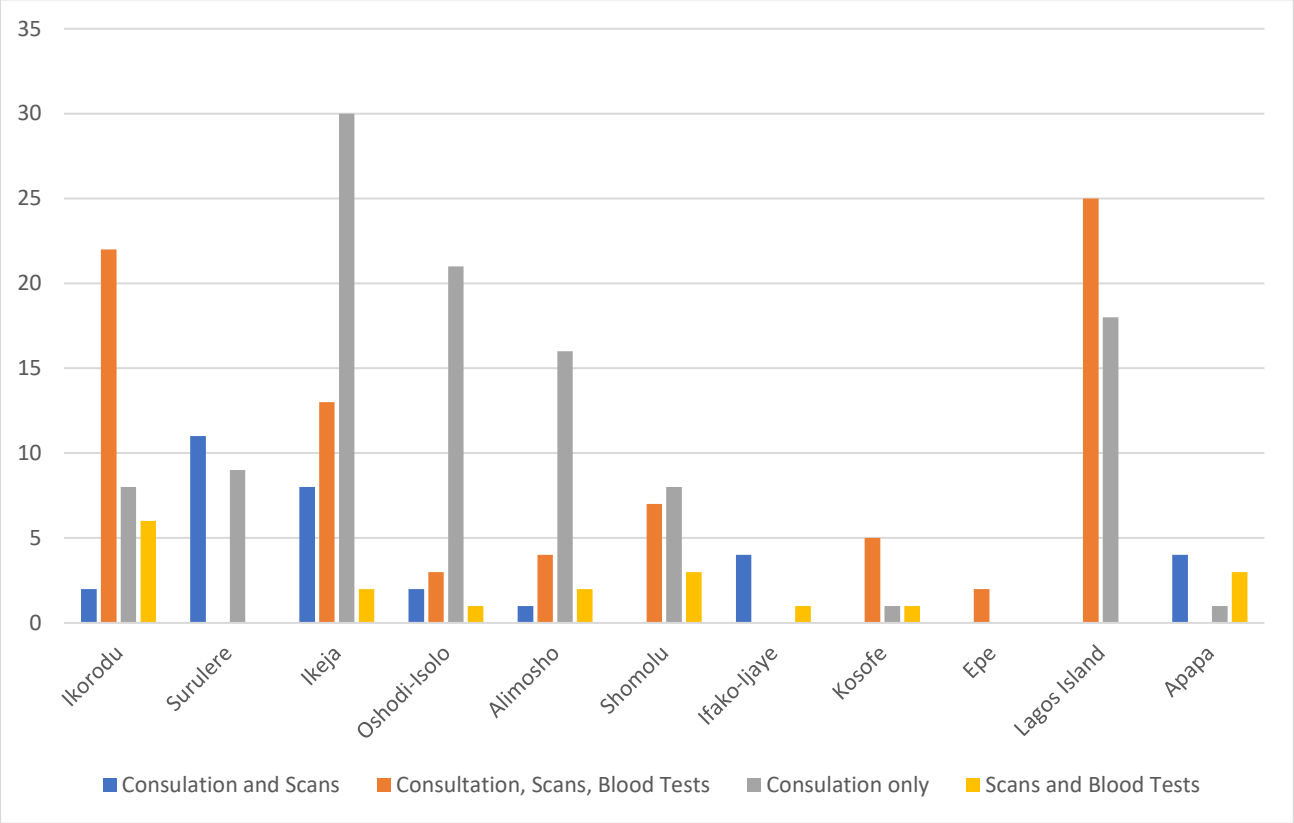


Source: Authors' Compilation

Figure 7 shows that the amount paid for registration determines the antenatal care package respondents are offered by public health care facilities. Respondents who paid higher amounts were offered the complete package (i.e. consultation, blood test and scan) while those who paid less were offered a lesser package (i.e. consultation only).

Further analysis by LGA(see figure 8) shows that in LGAs where registration fees cost less that N5000, the most common antenatal care package offered is the consultation only package (i.e. Ikeja, Alimosho, Shomolu). However, in Ikorodu, Apapa and Lagos Island with higher registration cost, respondents are offered more comprehensive package for ANC.

Figure 8: Antenatal Care Package by LGA

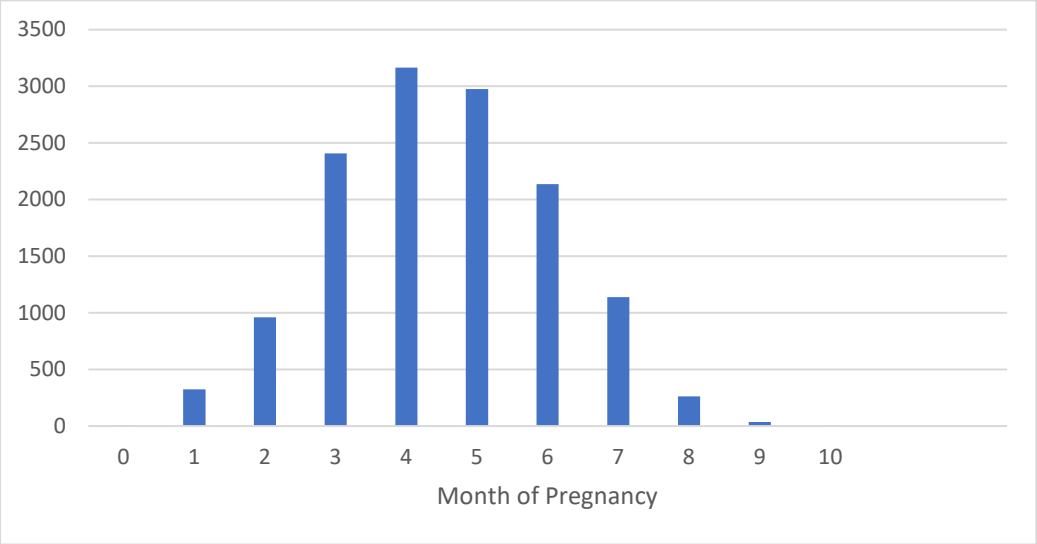


Source: Authors' Compilation

4.2 Patterns in user fees and their potential relationship to utilization.

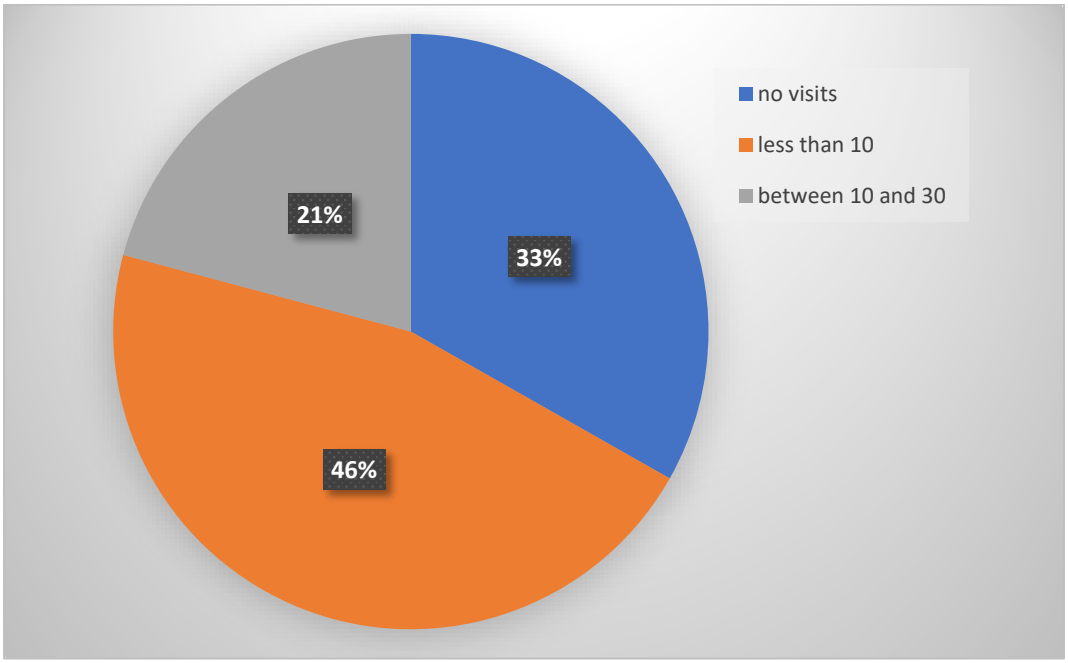
To analyse ANC utilization, data from NDHS is used. Figure 9 shows that majority of pregnant women made their first visit for antennal care in their fourth month of pregnancy, with less than 10% of the respondents made antenatal in the first two months of pregnancy. Majority (46%) of women surveyed in the NDHS made less than 10 ANC visits, while 33% made no visit at all.

Figure 9: Timing of Antenatal Care Visit (First Visit)



Source: NDHS 2013 Survey

Figure 10: No of Antenatal Care Visits

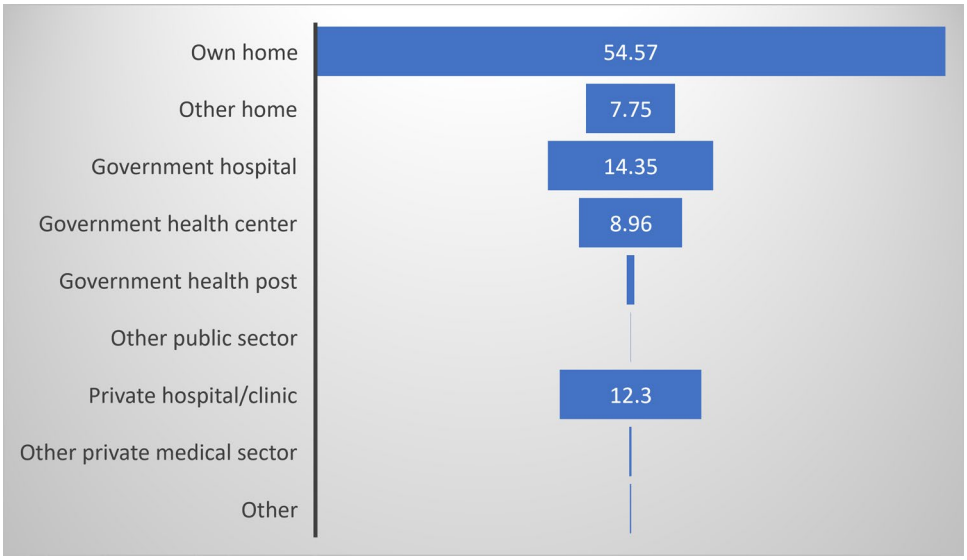


Source: NDHS 2013 Survey

Given that to confirm the viability and nature of care required during the episode of antenatal care, more procedures (i.e. blood test, scans) are required more at the beginning of the care episode than towards the end. This could explain the low attendance during the first two months and last two months of pregnancy (see figure 9). In addition, figure 11 shows that majority

(54.57%) of women surveyed report their homes at the place of delivery, while 14.35% and 8.36% report government hospitals and government health centre respectively.

Figure 11: Place of Delivery

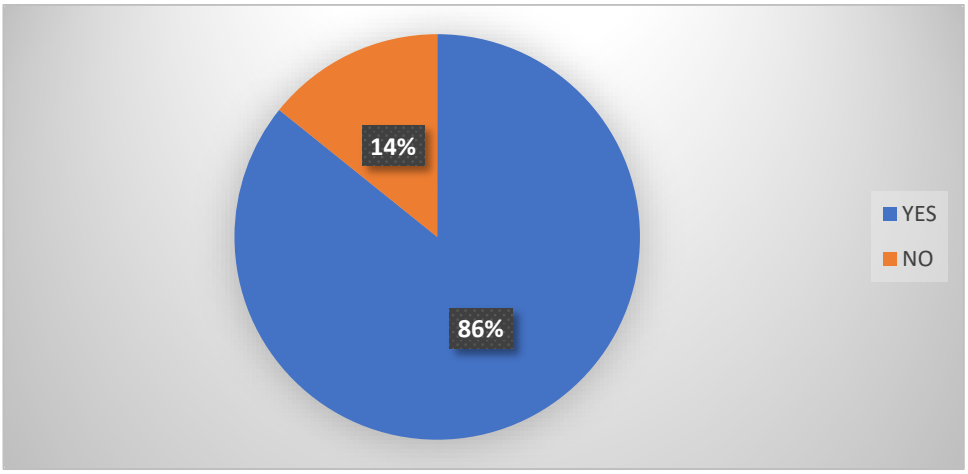


Source: NDHS 2013 Survey

4.3 Patterns for Unexpected/Informal Fees for Antenatal Care Utilization

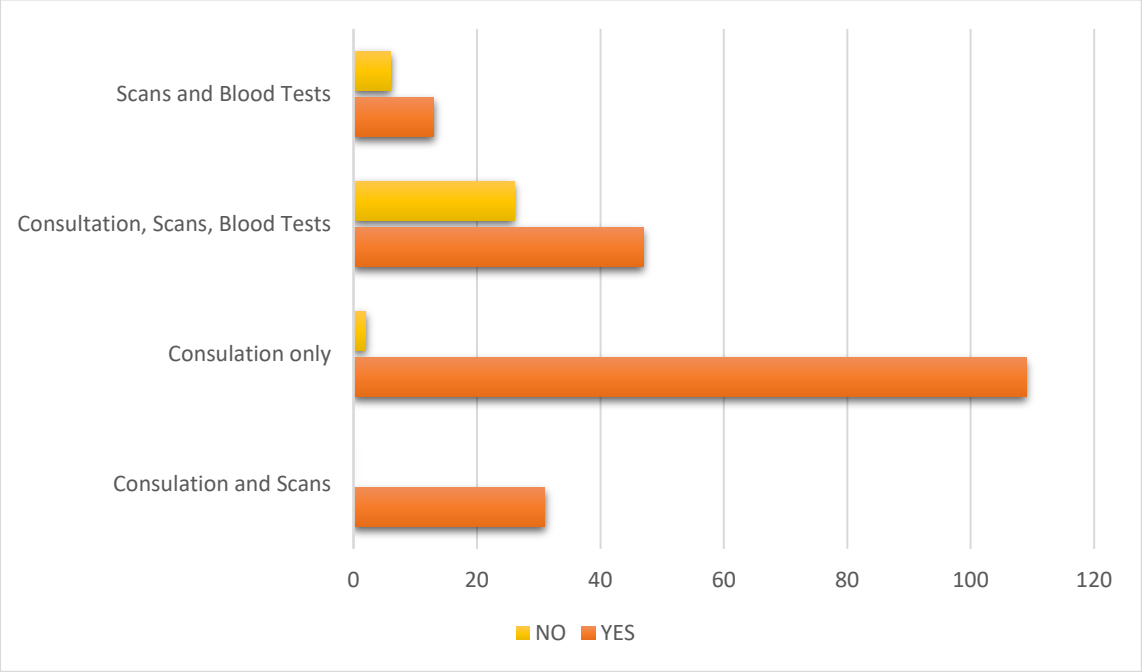
To analyse the patterns of unexpected or informal fees through the episode of care, respondents were asked if they have incurred any extra cost in accessing ANC services. Figure 12 shows that 86% of respondents have incurred extra cost aside the initial registration fee paid above.

Figure 12: % of respondents who paid extra fees



Source: Authors' Compilation

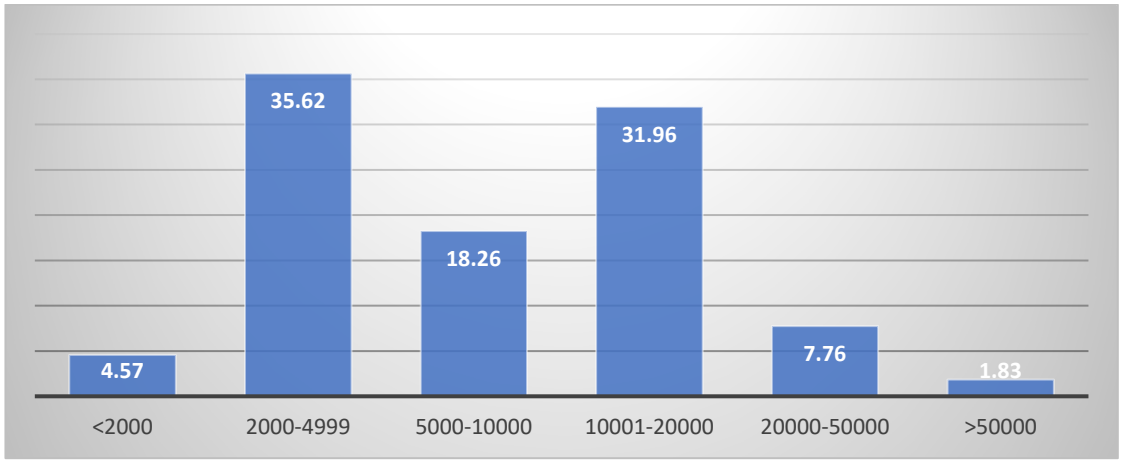
Figure 13: % of respondents who paid extra fees by antenatal package



Source: Authors' Compilation

Figure 13 shows that respondents who received consultation services only are the highest proportion of respondents that incur extra cost in the episode of care while the majority of respondents who do not have to incur extra fees are recipients of the complete package. This implies that respondents who are subscribed to consultation only have to incur extra cost in accessing additional services for blood test and scan from independent providers.

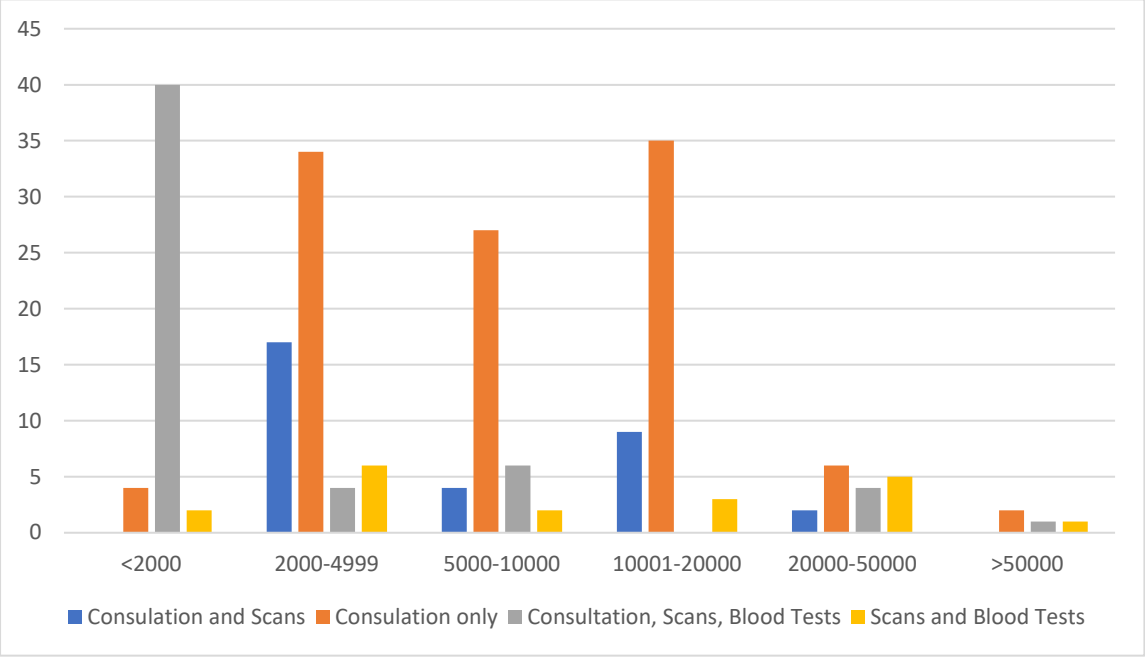
Figure 14: Cost of extra fees



Source: Authors' Compilation

Majority (35.62%) of respondents incurred less than N5000 as extra cost in their episode of care with 31.96% incurring extra cost between N10000 and N20000. Survey report shows that pregnant women who have been informed about the need for caesarean section (CS) are required to pay of booking fee of N50,000.

Figure 15: Cost of extra fees by antenatal package

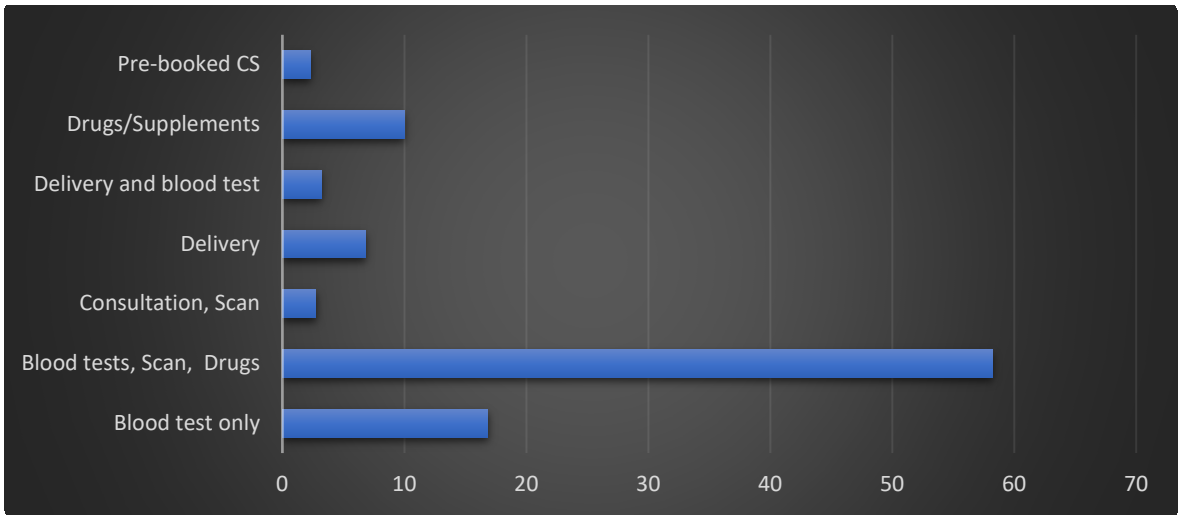


Source: Authors' Compilation

Figure 15 shows that respondents who paid less that N5000 as registration fee providing them access to only consultation services have to incur extra cost amounting to N20000. This implies that the total cost of ANC utilization for majority of respondent summed up to N25000. This implies that pregnant women that access public health facilities have to incur more than 300 percent of the initial cost of ANC as extra/unexpected cost. However, if public health facilities are equipped with the appropriate facilities and man-power, even where ANC services are not free, respondents would have been required to pay only 40% of the extra cost incurred in the episode of care.

Figure 16 shows that most respondents who incurred extra cost spent it on undertaking blood tests, scans and drugs/supplements. This services are provided by independent providers mostly private institutions who do not provide subsidized cost.

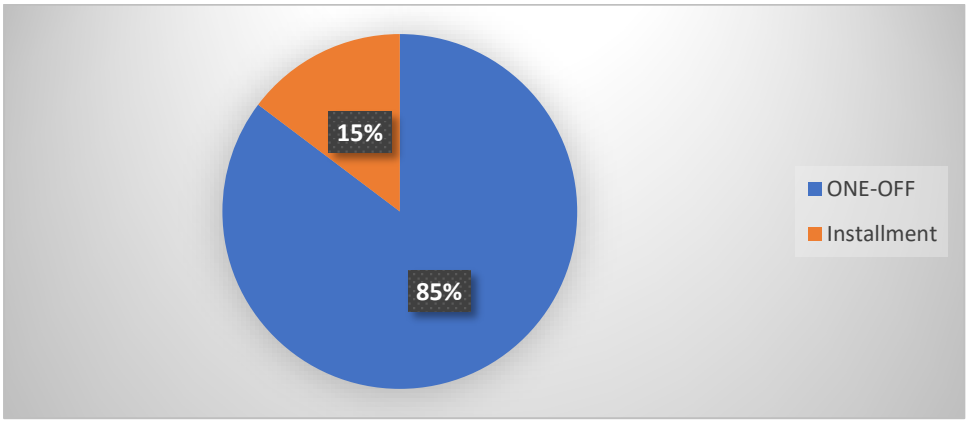
Figure 16: Extra Fees Package: Patient



Source: Authors' Compilation

Major respondents report that most private facilities who provide this additional services do not provide facilities for payments in instalment (see figure 17). 85% of respondents stated that there were required to pay the extra cost as one-off payments by sourcing for funds from relatives, loans etc., while 15% who were not able to raise the funds were offered payments in instalments.

Figure 17: Payment Pattern of Extra Fees

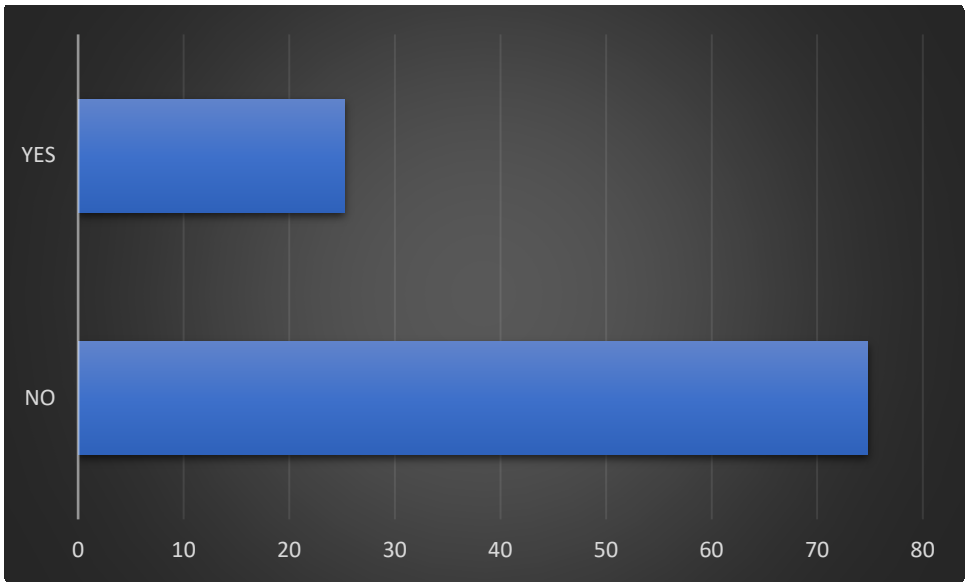


Source: Authors' Compilation

4.4 Relationship between patients' payment expectations and their attendance

This study further accessed the effect of the extra cost respondents had to incurr on the their desire to access ANC services. Overall, the results show that majority (74%) of respondents state that the extra cost did not affect their desire to access care. Upon further interrogation of this findings, respondents report that although the cost is high, they had to incur it for their own benefits.

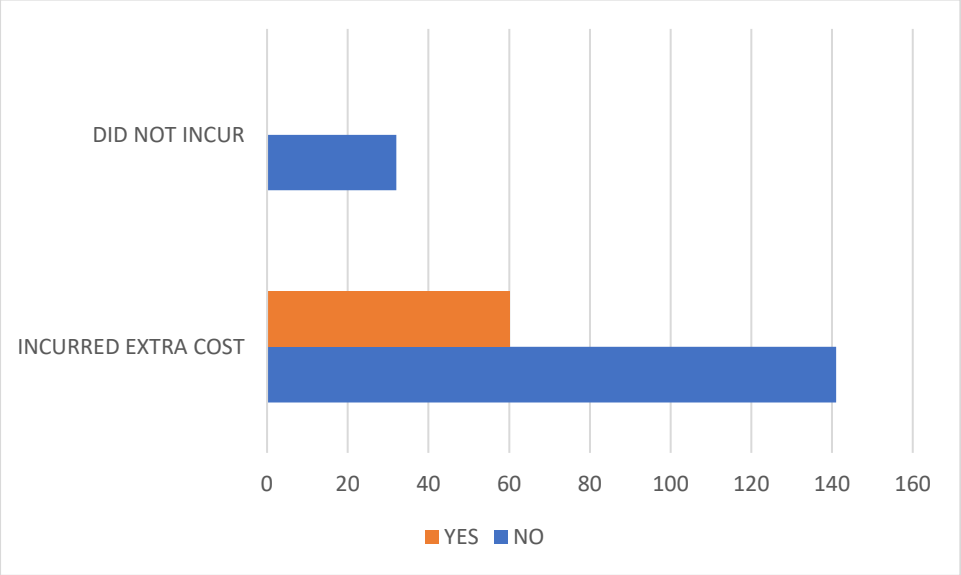
Figure 18: Effect of extra fees on respondents' desire to access care



Source: Authors' Compilation

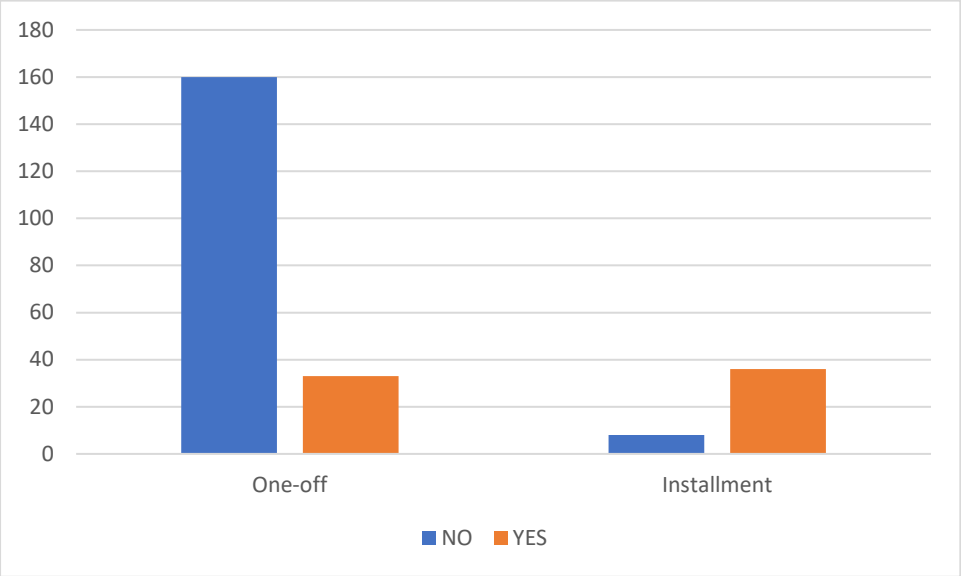
However, when the results are disaggregated by those who incurred extra cost or not more than 50% of respondents who incurred extra cost report that incurring extra cost had an effect on their desire to access care (see figure 19). All the respondents who did not incur extra cost reported that their desire to utilize ANC services was not affected at all. In addition when disaggregated by the payment pattern of extra cost paid in instalments or one-off, the result shows that majority of respondents who could not meet the one-off payment and paid in instalments reported that the extra cost had an effect on their desire to utilize ANC services (see figure 20).

Figure 19: Effect of extra fees on respondents' desire to access care by extra cost incurred



Source: Authors' Compilation

Figure 20: Effect of extra fees on respondents" desire to access care by payment pattern

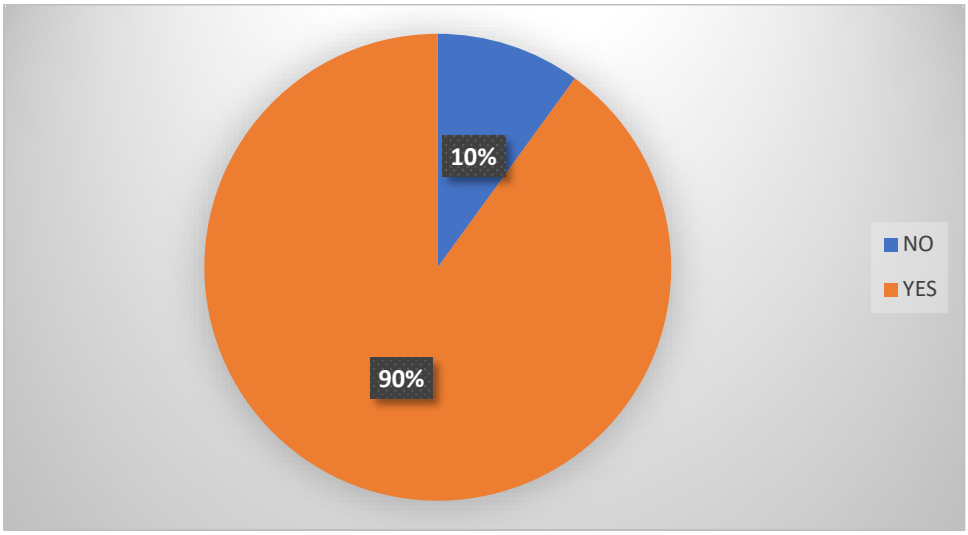


Source: Authors' Compilation

4.5 Pattern of user fees for antenatal care and delivery at public hospitals: Staff

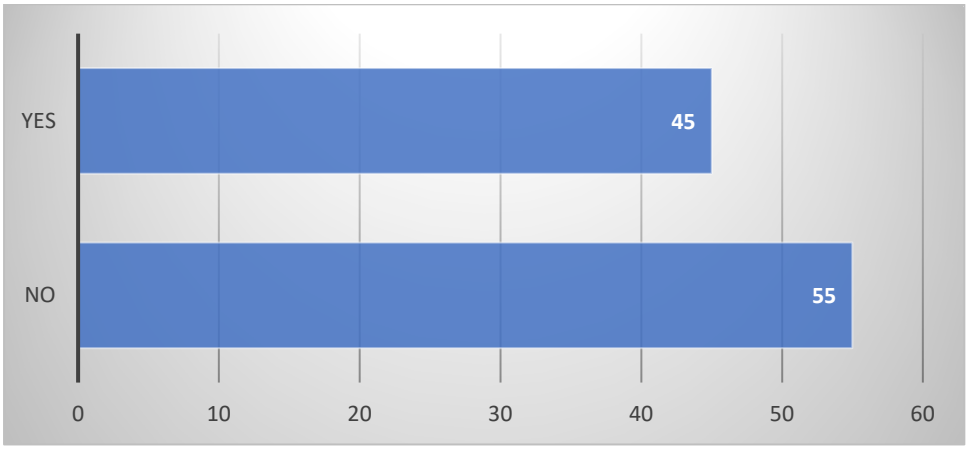
From the survey results 90% of health workers surveyed report that patients are required to pay registration fees for ANC utilization in their facility (see figure 21). In addition some health workers further state that this registration fees are meant for opening cards and not for payment for the services offered

Figure 21: Is registration fee charged in your facility



Source: Authors' Compilation

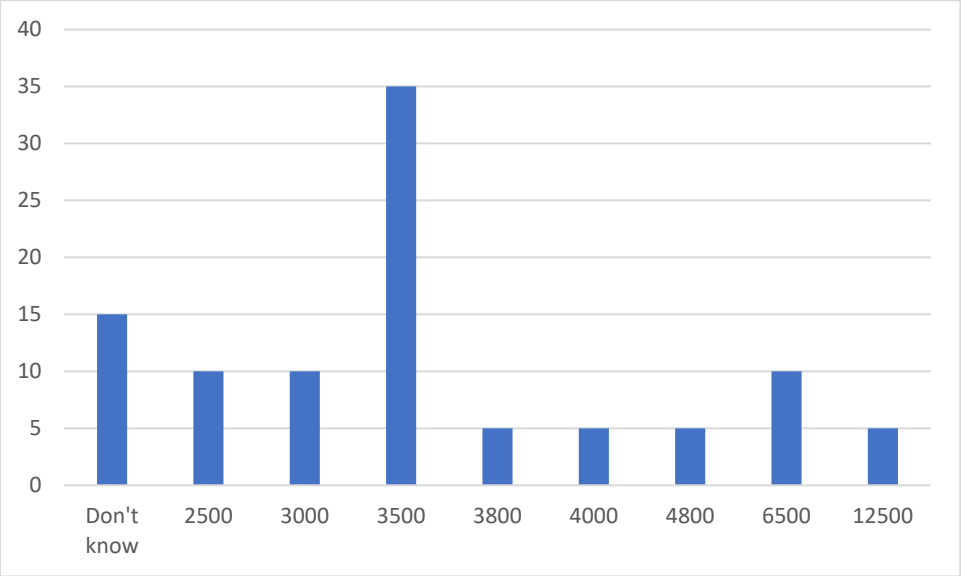
Figure 22: Are patients required to pay for antenatal care services



Source: Authors' Compilation

The study further asked if patients are required to pay for accessing ANC services, 55% report that patients are not required to be (i.e. ANC service is free), while 45% report that ANC services is not free. This is wide disparity from 16.67% of patients reporting access to free ANC service reported in figure 1. This further confirms the possibility of information asymmetry which implies that patients do not have access to appropriate information on the health policy provided by the government and could be exploited by health care providers in various public health facilities.

Figure 23: Cost of antenatal care in your facility



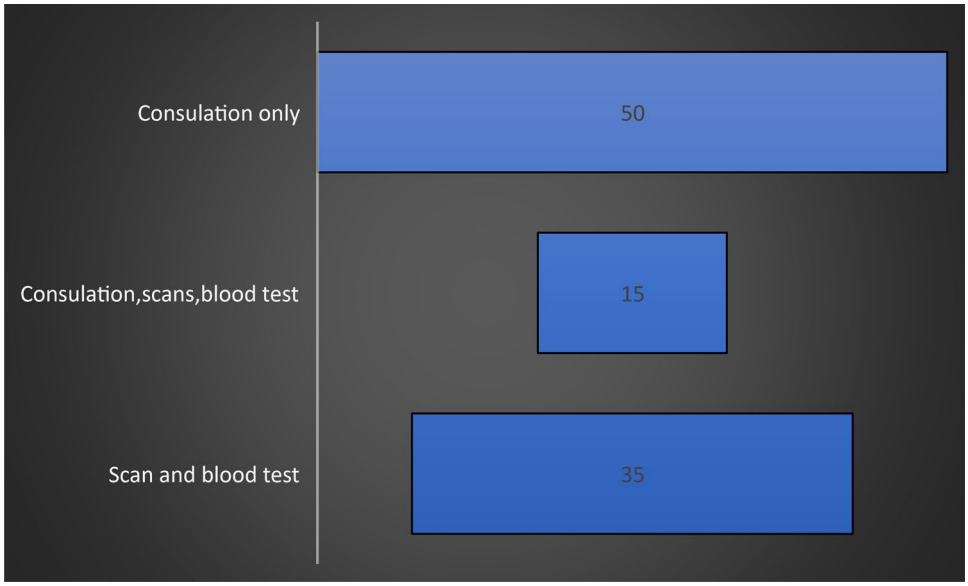
Source: Authors' Compilation

Figure 23 reports the cost of ANC services, the results report a wide disparity in the cost of ANC services by various public health care services. While a combined majority (55%) of health care workers report that patients are required to pay N3500 or less to access antenatal care services; 15% report that ANC cost range between N6500 and as high as N12500 in some facilities.

Similar to patient the results from patients interview, figure 24 report consultation services as the most popular ANC package offered by public health facilities according to health workers. We report a synergy between the ANC cost and package reported by health workers in public

health facilities. Majority of health workers report that most patients pay less that N5000 granting them access to only consultation services as seen in earlier analysis of patients interview.

Figure 24: Antenatal Care Package: Staff

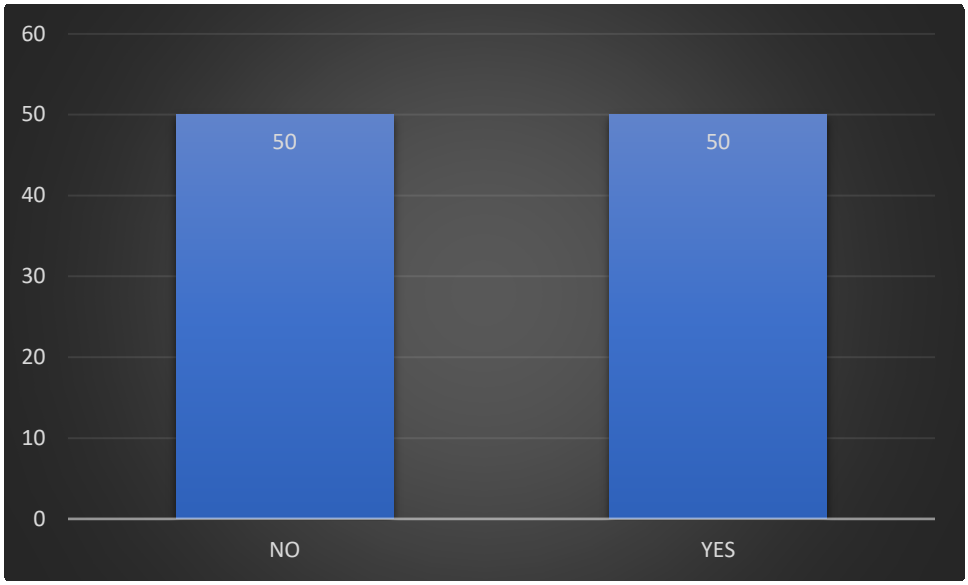


Source: Authors' Compilation

Figure 25 shows that 50% of health care workers state that patients have ended their episode of ANC as a result of unexpected/extra cost they have to incur by outsourcing services not rendered by public health facilities. In addition, health workers that the unexpected/extra cost are incurred majorly (65%) for undertaking blood test and scan, while 35% is spent on blood test only.

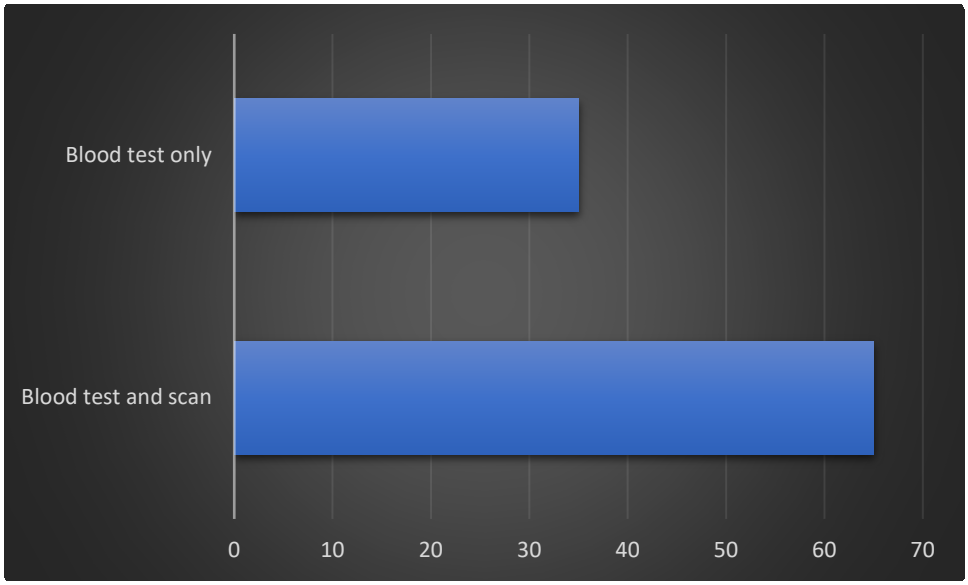
In summary, there is the presence of information asymmetry in the delivery of ANC services. Patients are not fully aware of the cost and services they are entitled to base on stipulated heath care policy. Given that most public health facilities do not have the required infrastructure and man-power, pregnant women are forced to outsource these services from independent private providers.

Figure 25: Patients exist ANC due to unexpected cost



Source: Authors' Compilation

Figure 26: Extra Fees Package: Staff



Source: Authors' Compilation

5. Conclusion and Policy Recommendations

This country case study, explored patterns in user fees at public hospitals and health centers and its potential relationship to utilization, investigated the phenomena of unexpected antenatal and delivery costs and payment patterns specific to Lagos' public hospitals, and examined the relationship between unexpected costs and patients' attendance of public facilities in 11 local government areas within Lagos state.

On the patterns of user fees at public hospital and health centers, survey results show the presence of lack of information and information asymmetry on government policy on the cost and status of ANC services available in public heath facilities. This is supported by the limited or the almost non-existence of literature of Nigeria's government policy for ANC. This is indeed worrisome given the high level of maternal mortality rate in Nigeria. Therefore, the first step the government needs to take is to put together a policy framework on the status and cost of ANC available in each state and LGA.

Following the lack of uniformity in available information, respondents (pregnant women) report varying cost of for accessing ANC services. While majority of respondents (42%) report registration fee costing below N5000; the cost of registration for about one third of respondents ranged between N5000-N10000. 15% of respondents paid above N10,000 but below N20,000 with and meagre 2.5% incurring more than N20000 to cover registration for ANC utilization.

However, further analysis shows that respondents who pay below N5000 are offered only consultation services and have to be up to 300% above the registration cost to access additional services from private independent providers. Thereby at the end of the episode of ANC, a patient might have spent up to N25000 to access ANC services. The fundamental reason for this is that most public health centers do not have well equipped laboratories and ultrasound scan machine to carryout blood test and scan.

The lack of adequate facilities in public hospitals and health centre is increasing the cost of ANC by almost 300%. Given the level of poverty in Nigeria and the low wealth index of households, the utilization of ANC will remain low as the vulnerable – "the poorest of the poor" who account for the highest proportion in Nigeria's population cannot afford ANC. Therefore, it is imperative that Nigeria needs to take a more proactive step towards improving ANC utilization by ensuring that public health facilities are equipped with adequate and sufficient infrastructure and man-power.

Analysis of results from this survey, infers that Nigeria could experience a further decline in ANC utilization as respondents report that incurring unexpected/extra cost in their care episode reduces their desire to utilize ANC. To avoid this occurrence, an alternative policy for government given the reality of budget constraint will be partnering with private laboratories or ultra-scan centers to provide these services at subsidized rates for pregnant that provide proof of registration in a public hospital or public health centers. Implementing this would result in significant deduction in the cost of ANC utilization and could lead to improved utilization in the long run.

Lastly, there is need for a comprehensive monitoring and evaluation framework by government officials on the quality of ANC services offered to patients. Observation from our survey shows that patients are not offered equal and uniform services. The socio-economic (mainly financial status) happens to be a major determination of the nature of service patients receive from health care providers. Therefore, it is required that government officials provide a framework for monitoring and evaluating the quality of ANC services patients receive in their episode of care. In addition, health workers report an break in communication between the lower and higher management levels as well as misappropriation of funds budgeted for equipping health facilitates with adequate infrastructure.

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APPENDIX

1. Questionnaire for Pregnant Women

QUESTIONNAIRE

Dear Participant,

The Centre for the Study of the Economies of Africa (CSEA) is currently conducting research to explore the patterns in user fees at public hospitals and its potential relationship to utilization in Nigeria. Specifically, we are investigating the phenomena of unexpected antenatal and delivery costs and payment patterns specific to Lagos public hospitals, and examining the relationship between unexpected costs and patients' attendance of public facilities.

Thanks for your cooperation.

Name of Interviewer		Date of data collection	/ /

Pregnant Women

(4 pages)

1	**How far is your household from this health facility in kilometers?**
2	**What was your primary mode of transportation today?** This should be for a one-way trip.
3	**Do you know the cost of antenatal care in public hospitals?**
4	**How much did it cost in Naira for you/the patient to travel to the health facility today?** This should be the total one-way cost incurred for both the caregiver and the patient to come to the facility.

5	**Was a registration/ consultation/ doctor fee charged?**
6	**How much was paid in Naira for this?**
7	**Do you have any insurance or HMO package?**
8	**Is the cost for antenatal care covered in your package?**
9	**What does your antenatal package include?** **1. Consultation** **2 Scans** **3 Blood tests** **4 Delivery packages** **5 Others, please specify below**
10	**Have you incurred any additional expenses in the course of care?**

11	**If YES. How much additional expense have you incurred so far?**
12	**What was the additional cost incurred for?**
13	**Where you able to make the payment one-off or in installment?**
14	**If payments in installments, how many payment instances were made?**
14	**Has this unexpected cost affected your desire to access care?**

Section 2: Background Details/Demographics

Gender:	Female ☐		
Age:	Below 18 ☐ 18 – 25 ☐ 26 – 35 ☐	36 – 50 ☐ Above 50 ☐	
Highest Educational Level:	No education ☐ Primary school ☐	Secondary school ☐ Tertiary ☐	
Marital Status:	Single ☐ Married ☐	How many dependants? ……	
What is your income level per month?	Less than 18k ☐ 18k – 50k ☐	51k – 100k ☐ 100k – 200k ☐	201k – 400k ☐ Above 400k ☐
Household size:	Less than 3 ☐ 3-5 ☐	6-8 ☐ Above 8 ☐	

2. Questionnaire for stakeholders (i.e. health service providers)

STAFF QUESTIONNAIRE

Dear Participant,

CSEA is currently conducting research to explore the patterns in user fees at public and private hospitals and its potential relationship to utilization in Nigeria. Specifically, we are investigating the phenomena of unexpected antenatal and delivery costs and payment patterns specific to Lagos public hospitals, and examining the relationship between unexpected costs and patients' attendance of public vs. private facilities.

Thanks for your cooperation.

Name of Interviewer		Date of data collection	/ /2019

Hospital Staff Questionnaire

(2 pages)

1	**Do uninsured patients pay to open a card with this facility?**
2	**Do uninsured patients pay for a consultation?**
3	**Are pregnant women offered a package?**
4	**What is the cost of antenatal package ANC package?**
5	**What is the cost of individual visits, as opposed to the full package?**
6	**What goods and services are provided with a package?**

7	**Do patients have to pay in full, before using the package?**
8	**If patients do not pay in full, when do they make payments?**
9	**Have patients left the facility due to the unexpected expenses?**
10	**What are some of these unexpected costs related to ANC?**