POLICY BRIEF

Effect of COVID-19 on Catastrophic Medical Spending and Forgone Care in Nigeria

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The context/background

Nigeria is faced with high reliance on out-of-pocket (OOP) medical spending as a means of financing the health system. These have posed a greater financial burden on households, thereby limiting their utilization of medical facilities (household forgoing medical care) and worsening of public health status (Ichoku, 2005). The worst case scenario was during COVID-19 pandemic which disrupted the source of livelihood of many Nigerians, exposing the vulnerabilities in the country's healthcare system where most households rely on OOP medical spending.

The problem

According to World Health Organization (WHO, 2005; 2010; 2017), countries need to fund their health systems through general revenues or premium contributions of social health insurance, complemented with government revenues, to achieve UHC and financial protection. However, government funding for health in Nigeria remains generally inadequate and many households still suffer financial hardship resulting from high OOP medical spending (Edeh, 2022). OOP medical spending in Nigeria is still up to 75%, which is well above the WHO recommended 15-20% for the achievement of financial protection (World Bank, World Development Indicator (WDI), 2021). This excess reliance on OOP spending for medical bills tempts households to forgo medical care, deepens unequal access to quality health care and exposes Nigeria households to incurring catastrophic health expenditure (CHE) (Amos et al., 2016). The COVID-19 pandemic may have worsened the situation, since it led to decline in household income. Hence, our study estimates the effect of COVID-19 on catastrophic medical spending and forgone medical care in Nigeria.

Research results (analysis)

The research objectives were achieved using descriptive statistics and panel logit model. The data used is drawn from the 2018/2019 (wave 4) of the nationally representative Nigerian general household surveys (NGHS 2018/19), panel and the Nigerian COVID-19 national panel phone survey (COVID-19 NLPS). Our findings:

- CHE incidence in the pre-COVID 2019 period is still quite high, not just at the national level but across regions and geopolitical zones of Nigeria. It is found to be 41% at the national level. In the rural region and northern zone, the incidence levels are 45% and 48% respectively. These are higher than the level, 35% found in the urban region and southern zone in the country.

- In terms of forgone care in the COVID period, 13% of the households experienced forgone care in wave 1 when the COVID restriction was in full effect. However, this level slightly declined to 12% in wave 2 when the lock-down measure was partially lifted. In terms of forgone care for different reasons (financial, fear of contracting COVID, medical supplies and other reasons), we found that the levels of forgone care due to financial barrier (lack of money for medical care) is relatively higher. Specifically, at the full effect of the lockdown measure, we see that 11% of households needing care did not have access to care due to financial reasons. Further, the COVID reasons (fear of contracting COVID-19 when seeking care) uncovers 2%. The supply reasons (health facilities being full or closed, or insufficient staff or supplies) reveals 2% while other reasons revealed only 1.7% but observed only when the legal restrictions were partially reduced.

- We found that COVID legal restriction reduces the probability of incurring CHE but increases the probability of forgone care. The COVID legal restriction significantly reduces the likelihood of incurring CHE by 0.02%. However, it significantly increases the probability of households forgoing care by 0.03%. This result is expected, since the COVID lockdown measure prevented many households from accessing their works – leading to some loss in jobs and income. Loss in income leads to a corresponding decline in medical spending and in turn a possible reduction in probability of households incurring CHE (Abor and Abor 2020). However, this result imply households forgoing health care (Tandon et al., 2020), which is in line with the argument that households not able to afford health care services do not incur CHE, but forgoes health care (Pradhan and Prescott, 2002).

- We also found that belonging to the richest income group is associated with 0.44% less likelihood of incurring CHE, whereas belonging to the second poorest income group is associated with only 0.13% less likelihood of experiencing CHE. More so, belonging to the richest income group significantly reduces the probability of forgoing care by 0.05%, unlike belonging to the second poorest income group that significantly increases the probability of forgoing care by 0.04%. This confirms that households in the highest income quintile (the richest) are more likely to experience a reduction in CHE and forgone care, relative to households belonging to the lowest income quintile (the poorest).

- Our results uncover that having health insurance reduces the probability of households incurring CHE and forgoing care. In specific terms being insured significantly reduces the likelihood of the household incurring CHE by 0.12%, relative to having no insurance. Similarly, being insured significantly reduces the likelihood of the household forgoing care by 0.02%, relative to not being insured.

Implication for policy makers

In line with the findings, the study recommends:

- There is need for a better policy design to tackle the effect of the COVID-19 on medical spending and guard the welfare of the households against such pandemic in the future.

- Boosting general revenues to fund public health services adequately is important to ensure effective coverage with quality health care services for all within and outside the pandemic periods.

- Public policy health efforts, in terms of increasing the depth of health insurance will ensure effective coverage and access to quality health care services for the poor households to cushion the effect of COVID on medical spending within and outside the pandemic periods.

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