**HEALTH CARE FINANING**

There is continuous rise in the need for financial resources to fund health in the world though resources to achieve same have witness decline overtime, Nigeria is inclusive. However for the avoidance of global recession health care financing had become a major focus though health cost is on the rise due population explosion, increased aged population, increased in diseases, technology driven treatment, administrative costs etc.

Health care financing can broadly divided into two; Public (direct government finance, social insurance scheme) and Private (user fees, private health insurance, donations etc). However it can be grouped into five (5) categories; Direct Government financing, Out-Pocket expenses, Community financing, Health insurance and Donors (foreign aid). According to WHO 2003 expenditure on health by percentage in categories was 33%, 18%, 25%, 20% and 4% respectively, which actually varies yearly.

**Direct Financing** is mainly from government periodic allocation from government revenue. It is the largest widespread source of funding worldwide. They sometimes allocate a particular tax to the financing of the sector. For example in several countries in the Americas or Asia, lotteries have organized to benefit social welfare programme. These methods had been grossly inadequate globally particularly in developing countries. The World Health Organization (WHO) expects each nation to allocate about 15% of budgetary allocation on health, Nigeria like many developing economies had not fulfill this. This due to the economic condition, structural adjustments, spending on other sectors of the economy such as defense though little infrastructure is also seen.

**User Financing** (UF) is non as the Out-pocket expenses of patients or citizens. Patients are charged for services rendered to them, which take variety of forms and varies according to item of treatment. Items may include laboratory test, drugs, procedures etc. it may also be a uniform or bulk charged with the exception of the poor, children or total exemption of some folks; sometimes another scale is given to citizens whose means to pay are assumed lesser. However a link is established between service provisions, financial responsibility, willingness to contribute to cost of health programmes. The user financing aids control of health care services through the imposition of financial disincentive to consumers (when you pay for something a value is attached as compared to when you don’t pay!). When payments are not in effect, attention to cosr by consumers to services provided are limited. UF also galvanizes the referral system, people who are not from lower levels are made to pay more in some climes. However, UF had been a source of largest reduction in health services among the poor; causing people to advocate for equity. However, if the service is available, affordable and accessible more people are catered for rather free health care which is grossly unfunded. Some arguments exist against UF such as collection management, inappropriateness of fees, limiting utilization rates.

UF becomes more successful where; prices are phased not sudden, accountability by the provider, local management of resources (decentralized), quality of service, global competitiveness. Various definition exist between health charge and population such as Contributive Capacity (amount each HH can spend on health at a period; range between 2.5-6.5%), Financial capacity (available cash by HH in very moment cash is needed for medical treatment) and Institutional relationship (particular HH or Community may some relationship health provider).

**Community Financing (CF)** is the community support for health services which is mostly in developing countries either financially, materially or humanly. However people have been grossly unfaithful to contribute to the health service they receive. CF has been advocated due to increased spending of HH from the private sector, attract unexploited resources (labour, land or donations), cooperation of community due to help provided hence maintenance, a mechanism to mobilize contributions.

CF includes full payment or preferential rates for health facilities i.e. unified payment system, voluntary community insurance scheme, giving of cash in gift, kind or land, payment or creation and utilization of community capitalization schemes for health promotion.

**Health Insurance** is a system in which prospective consumers of care make payment to the third party in form of insurance schemes. This may be voluntary or compulsory. Government Agencies, profit making organizations, non –profit(cooperative or benevolent societies) organizations can operate schemes. The operators may employ particular health care provider or own a facility (direct method) or contract same to either public or private providers. Its core advantage of the schemes is that it takes of unpredictable future health expenses to payments that can be budgeted for, which are then collected into a pool that can be drawn upon demand.

**Foreign Aid** are quiet important financiers of health care especially Africa where government are unable to meet the health needs cause of revenue shortfall. Such donations are mostly from development oriented organizations such as bilateral agencies, multilateral organizations and banks (UNICEF, WHO, UNDP,EEC,USAID, World Bank). The donations are targeted towards a central authority in the recipient country such as Ministry of Finance or National Planning or routed through NGOs or agencies of government. The aids are usually have the potential for mobilizing people and strengthen self reliance. Aids play invaluable roles in public expenditure in developing countries though with negative effects. This may include emphasis on vertical programmers, sustainability problem, programme priority is determined by donors, funding progarmme nay be out of proportion to total health needs, coordination of programmes by funding external agencies most is poor.

**Voluntary Contributions** are usually from individuals or groups within the country usually they are philanthropists making kind donations in buildings, equipments, food etc. However some religious group may also fall into these category and non-profit organizations in the health care delivery sector. Private involvement may include also salaried medical physicians who engage in private practice, chemist shops/ pharmacies, private for profit clinics or hospitals, traditional practitioners or quacks, medical services run for employees by private or quasi firms.

Basically health care options are country specific, though government cannot alone bear the total cost of health care. Hence other options of health care financing are becoming continuously visible, though they also come with their shortcomings and bottlenecks.