



COMMENTARY

Crises and challenges in the Nigerian health sector

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I have chosen to comment on the crises and challenges in the Nigerian health system with the intention of drawing our attention to the obvious, and in so doing, initiate and promote a dialogue that can help us in resolving those crises for the betterment of the health of the Nigerian people.

The Oxford Advanced Learner's Dictionary defines crisis as 'a time of great danger, difficulty or uncertainty when problems must be solved or important decisions must be made' and challenge as 'a difficult task that tests ability and skill.' There are indeed great difficulties and uncertainties facing the Nigerian health system. However, these difficulties are not insurmountable provided we are ready to brace up and display our abilities and skills in facing the challenges posed by these difficulties.

With a population of about 130 million people, the country accounts for a quarter of the population of Africa and 47% of the population of West Africa. The country's landmass of 923,768 m² accounts for about 3% of the African continental mass and therefore has one of the highest population densities on the continent. About 40% of the country's population resides in urban areas with these areas growing at the rate of 4.8% annually. The overall population growth rate for the country is estimated at 2.8% annually. Providing health services to this large population is by itself, a major challenge.

The Nigerian people have always had access to some form of health services delivered by traditional healers and herbal practitioners in the different parts of the country. However, what is now known as the orthodox/formal Nigerian health care delivery system was first introduced as a

service for the British Army detachment located in the country during the colonial era.

With the integration of the British Army with the Colonial Government in Nigeria, the government gradually extended health services to the local people working in the civil service and their relatives and then to the local population living close to government stations. One such health station which eventually became what is now known as the General Hospital, Lagos was established in 1893.

Various religious bodies and private organizations have also been very active in the evolution of health services in the country. In fact the first true hospital in Nigeria was established about 1859 by the Reverend Father Coquard of the Catholic Church in Abeokuta and is known today as the Sacred Hearts Hospital. The establishment and growth of these various hospitals did not follow any explicitly formulated national health plans.

The first attempt at national planning for the delivery of health services was the Walter-Harkness Ten-year plan of 1946 which identified major health problems facing the country to include malaria and provided schemes and strategies to combat the problems. The full implementation of this plan was aborted by the introduction of self government in some parts of the country from 1951. The different Regional Governments then instituted their different health plans to cover their respective areas of jurisdiction.

From independence in 1960, health policies were enunciated either in the National Development plans or as government decisions on specific health problems. The first two National Health Plans implemented between 1960 and 1974 concentrated on the provision of curative services. In the early 70's, efforts were geared towards capital development such that about 76% of health budget was expended in this area.

The third National Development Plan of 1975-80 for example attempted to deal with issues such as health manpower development and the provision of health facilities through the Basic Health Services Scheme. The Scheme aimed at the provision of health care infrastructure through the construction of comprehensive health centres. The ambition was to increase the number of comprehensive health centres from 250 to 1650 and the number of primary health clinics from 1600 to 7200 in five years. About 29% of the budget during this plan period was allocated to basic health and preventive services. Note must; however, be taken of the massive capital development planned in this subsector which was likely to reduce the proportion of operational funds. Nevertheless, this subsectoral allocation was recognition of the importance of preventive services. This period also witnessed the rapid expansion of the number of federally managed teaching hospitals for the training of different categories of health workers, particularly doctors, nurses, midwives and technicians. Schools of Health Technology were also established for the production of intermediate level manpower for community health.

The fourth Health Plan (1981-1985) identified the same health problems facing the population at the beginning of the third health plan thus suggesting that most of the problems remained unresolved. The fifth National Development Plan 1987 – 1991 coincided with the period of the adoption of the primary health care strategy and the explicit formulation of a National Health Policy in 1988. With effect from 1990 – 1992, the concept of 3-year National Rolling Plans was introduced. The vigorous pursuit of the primary health care strategy during this period led to gains in the health sector such as increased immunization coverage and the adoption of family planning methods.

In 1995 a National Health Summit was held to review the National Health Policy and develop a plan for its implementation. The revised National Health Policy was published in 1996 and continued to recognize Primary Health care as the cornerstone of the national health care delivery system.

The National Health Policy formulated in 1988 and reviewed in 1996 committed the three levels of government and the people of the country to intensive action to attain the goal of health for all citizens. Specifically, the goal was stated as the attainment of a level of health that will permit all Nigerians to lead socially, and economically productive lives at the highest possible level. The implication of this policy declaration is the recognition of the need for action by all levels of government as well as by all Nigerians.

In allocating responsibilities, the National Health Policy puts the Local Government which is the closest administrative level to the people, as the implementing level for primary health care, while both the state and federal levels are expected to provide support both technically and financially. Furthermore, State Governments are expected to be responsible for secondary health care facilities while the Federal Government is expected to provide tertiary health facilities. All the levels of care are expected to be interlinked and constitute an integral part of a single health system.

A recurring issue to which the policy attaches great importance is the need to provide appropriate mechanisms for involving the communities in the planning and implementation of services affecting their lives. Today, communities are only tokenly involved in the planning, implementation and evaluation of health programmes rather than as partners and stakeholders.

Given the level of investments in health in the country as will be presented later, the health outcomes reported for the country are rather disappointing. With all the levels of government spending on the aggregate about 5% of the Federation Account on health and thus meeting the WHO recommended minimum of 5%, it is obvious that there is a problem of inefficient use of resources. The key issue under this concern will therefore be to see how best more mileage can be extracted from existing levels of expenditure.

Table 1: Global comparison of score and ranking of Dale

Country	DALE (years)	DALE ranking
Sierra Leone	25.9	191
Liberia	34.0	181
Nigeria	38.3	163
South Africa	39.8	160
Ghana	45.5	149
USA	70.0	24
UK	71.7	14
Sweden	73.0	4

Source: World Health Report 2000: Improving Health Systems Performance WHO Geneva

A recognized threat to the health of the population is increasing incidence of poverty and worsening social conditions in the presence of a rapidly growing population. The fall in living standards and the relative scarcity of resources have negatively impacted on the delivery of and access to health services by the people. Using an index, Disability Adjusted Life Expectancy (DALE) that adjusts life expectancy for disability, the WHO ranked Nigeria in the 163rd position out of 191 countries. The DALE index attempts to capture population health in a broad way that takes account of the probability of survival as well as the quality of the survival.

Other health related data show that about 70% of

Table 2: Basic economic and health indicators for selected countries, 1998

Country	GNP per capital US	Life expectancy at birth (years)	Infant mortality rate per 1000
Mozambique	200	41	115
Nigeria	300	50	78
Kenya	350	50	64
Comoros	370	60	71
Cape Verde	1,060	67	44
Egypt	1250	70	71
Algeria	1570	70	40

Source: African Development Report 2000, African Development Bank

Nigerians live below the poverty line. Poverty remains a single most important determinant of health as it contributes significantly to increased exposure to disease-causing agents and also prevents access to health care services once disease has occurred.

Available data suggest that in general, the more the wealth of a country, the better the indices of health status of its citizenry. This fact then raises the concern for the linkages between poverty and ill-health and the need to alleviate poverty as a strategy for improved health.

The linkage between poverty and ill-health are however, bi-directional. Ill-health is a major contributor to individual and community poverty. The ill are unable to contribute maximally to the economic and social development of the communities in which they live. Despite this decreased productivity they must also require resources for their care. Ill-health is a major pauperizing factor. The cost of illness therefore must be computed to include not only the cost of treatment, but also the "cost" of opportunities for production forgone. Investing in health should therefore make sound economic sense as part of that investment if properly applied would save costs that could be incurred due to illness.

One critical issue therefore is the need for proper awareness among policy makers of the role of health in overall development. This awareness should rightfully lead to improved investment in health.

Some common explanations for the circumstances of the poor include the poverty of their nutrition and environment. Poor nutrition makes the body's resistance to be weak and thus increases the susceptibility to all kinds of diseases. Unhygienic environment, including poor housing conditions and overcrowding increases their exposure to disease causing agents. In the circumstances of their decreased resistance to disease and increased exposure to disease causing agents, the poor are further disadvantaged by difficult access to health services.

The circumstances of the poor and the National Health Policy imperative of promoting social justice and national security through health must be key determinants in the adoption of any strategies for resource mobilization and allocation.

Due to persistent neglect over the years, the Nigerian Health System virtually collapsed and is only now a five-year old possibility of attracting actions aimed at its resuscitation since the advent of democratic government in 1999. The mobilization, allocation and judicious utilization of resources can dramatically lead to improvements in health services delivery and the health status of Nigerians. The use of the word "resource" in this context has been to include human, material and financial resources. What may be critical is whether the system will be allowed to go through a transparent democratization of the decision-making process.

The tertiary and secondary levels of the health service consume a disproportionate share of public health expenditure whereas most of the conditions that afflict the majority of Nigerians can be handled at the primary health care level. This allocative inefficiency may mean that common conditions will either not receive treatment or will receive treatment at unnecessary high costs. High costs of treatment arise when highly skilled personnel are deployed to manage simple conditions that could otherwise have been managed by lower level staff.

The other issue affecting the rational use of resources is the poor management of resources. Poor managerial practices such as non-competitive bidding, bureaucratic bottlenecks, inadequate job description and assignment, staff indiscipline etc hamper the efficient functioning of the system.

Enough attention is yet to be given to strategies that will tap the advantages of better efficiency in the private sector through contractual arrangements for the provision of services to meet public health needs.

Other sectors significantly impact on health and adequate efforts need to be made to tap into the resources in those sectors in a way to maximally advance public health. Ministries of Rural Development, Water Resources and Works are involved in the construction of boreholes, wells and dams and these resources can be harnessed to advance the cause of public health.

One major impediment to health development in Nigeria remains the weakness of political commitment to the objectives of the National Health Policy. Thus while the government declares its acceptance of primary health care as the strategy to achieve health for all Nigerians, it fails to fully implement the basic principles of this strategy. Mechanisms for regular policy monitoring and evaluation have not been whole-heartedly activated.

Furthermore, the imposition of externally conceived and designed structures on local communities without adequate considerations for how such local communities will sustain such structures is antithetical to the concept of primary health care. Primary health care can not be successfully implemented from the federal level. Although the support of that level is critical, primary health care must still be implemented by the local governments with all assistance being channelled through local levels to permit sustainable development.

There is further evidence that the problems of poor health status and inadequate delivery of quality health services to the people are not all due to inadequate allocation of resources to health but are also due to glaring allocational inefficiencies within the health sectors.

Consideration of health care financing in Nigeria must be guided by the imperatives of the National Health Policy and the primary health care strategy adopted for achieving the goal of health for all Nigerians. Topmost among these imperatives are the issues of cost-effectiveness, quality, equity and relevance.

Thus in addressing inequity, public funds must be targeted at the financing of primary and preventive care. Within the primary health care sector, funds must be used to operationalise the system rather than construct facilities that may not be able to provide drugs and other consumables whose disappearance from health facilities in the past has been partly responsible for the desertion of these facilities by patients. Preventive and primary care is cost-effective and provides the opportunity for stretching public funds to cover more people.

Within the health sector, health workers need managerial skills to better manage resources and get more mileage from available resources. Local managerial structures need to be activated to

promote community ownership of services; transparency and accountability. Without ensuring capacity for the management of resources, the impact of allocated resources will remain diminished.

Poor management combines with problems of finance to cause chronic shortages of appropriate drugs in public health facilities. One study has shown that only 42% of public health facilities have common drugs on a continuous basis. In Nigeria as in many other developing countries, the availability of drugs is a frequent determinant of health facility utilization. When health facilities run out of commonly used drugs, patients' attendance drops dramatically.

While perennial drug shortage is the norm in public health facilities, private-for-profit health facilities do not often record drug stock-outs as they are able to replenish stocks from costs settled by patients, most patients who attend these facilities are however, middle to upper income members of the population and this raises serious equity issues.

Inefficiency and waste have also contributed to the problem of drug supply in the country. Non-efficacious and even dangerous fake and expired drugs are often procured into the country and sold to the public. There were fears at some time that up to 70% of drugs in circulation in the country were either fake or expired. In recent times the National Food and Drug Control Agency (NAFDAC) has intensified efforts to enforce regulations guiding the importation of drugs. Some country sources of fake drugs and the outlets in Nigeria have been identified and fake drugs worth over N80 million were confiscated and destroyed on one occasion.

Other issues of poor management resulting in wastage of resources include the poor selection of drugs that do not adequately consider cost-effective alternatives; poor quantification of needs resulting either in expensive retail purchase or expiration on the shelf of excess stocks; non-use of competitive bidding processes of awards for drug supply contracts and the accompanying over inflation of costs; poor storage practices not following the first-to-expire-first-to-use (FEFU) policy; and the irrational prescription where only one or two of such drugs are prescribed where only one or two of such drugs would have been adequate.

The Bamako Initiative was initiated by a conference of African Ministers of Health in 1987 as a way to combating the problems of drug shortages and managerial insufficiency within the health system. A key strategy of the initiative is to make drug supply in health facilities self-financing so that drug stock-outs will be banished and the confidence of patients re-established in the system. Unfortunately, the implementation of this initiative has not been backed by political will at all levels. In many local

Table3: Estimated current public sector expenditure on health, year 2000

Level	As % of total budget (%)	As % of Federation Account (%)	(Estimated population 120m) Actual amount(billion)	per capita (N)
Federal	2.92	1.45	₦ 20.4452	170.4
State	10	2.45	₦ 34.4452	287.9
LGA	10	2	₦ 28.2	235
Total		5.9	₦ 83.19	693.2

State and LGA expenditures are estimates only. It is not always that funds in the Federation Account have been fully shared although the situation may improve with democratic governance

governments, local committees that were to overlook the drug-revolving fund schemes were not operational and local government chairman unilaterally diverted the funds in the scheme into other projects. Even when federal funds were provided through the Petroleum Trust Funds, the strategic error was committed of not re-vitalizing the local managerial structures (the primary health care committees) before the supply of the seed stock. Faint attempts were made to resuscitate the village and district development committees only after the seed stocks had been supplied. If the committees had been established earlier, they could have contributed to the processes of needs assessment to ensure relevance as well as participate in general management of the scheme.

Recurrent expenditure has repeatedly taken well over half of the funds spent in the public health sector. Unfortunately, however up to 90% of the recurrent expenditure has often gone into the payment of staff emoluments thus leaving very little for the operation of services and maintenance of equipment. This may explain the situation where even in hospitals with highly qualified personnel; drugs and other consumables are often in short supply. The irregular availability of drugs and consumables has been a major reason for the underutilization of health facilities.

While statistics are showing dramatic increases in absolute volume of Naira budgeted for and expended on health, the impact of the expenditure over the years have been minimal due to a combination of factors. Firstly it must be noted that several projects under capital expenditure required a lot of foreign material inputs. In concrete terms therefore, the regular and unrestrained devaluation of the Naira only meant that there were actual decreases in the expenditures when considered in the dollar equivalent. Secondly, a significant proportion of the recurrent expenditure is used to service personnel costs, thus leaving little for drugs supplies and system maintenance. The little left for drugs and consumables suffers additional reduction in purchasing capability as a result of the progressive devaluation of the Naira earlier referred to – a large proportion of pharmaceuticals used in the country or their raw materials are imported and paid

for in hard currency. A third group of factors that appear to diminish the impact of allocated financial resources would be poor management practices that result in wastage of resource e.g planning of services without adequate justifying evidence; non-competitive bidding and contract inflation; non-definition of jobs, targets and objectives against which key health managers are assessed, commended and sanctioned; and non-involvement of beneficiary communities in decision-making on programmes and services.

In the light of available statistics, lack of physical access cannot be said to be responsible for the gross under-utilization of health facilities. Rather, we must look critically at issues such as the functionality and appropriateness of managerial structures, funding, the technical and managerial competences of health workers, the mobilization and involvement of communities in health management, and the political will and commitments of governments if serious answers are to be found for the existing “**heavy disease burden-poor service utilization**” situation. Often, inefficiencies in the funding mechanisms such as the introduction of user’s fees for services whose quality have not been secured, coupled with a weak referral system has succeeded in keeping these facilities grossly under-utilised.

The way forward

Household poverty is an incapacitating factor in Nigeria with an increasing proportion of the population falling below the poverty line. Paradoxically, the country is blessed with abundant natural resources but wealth in the country has been unfairly distributed. Compounding this situation is that households spend between 25-40% of their income annually on health. Yet ill-health remains a major constraint to increased household income in the absence of a social security system. Illness therefore has the potential of further pushing households into worsening poverty.

The second consideration arises immediately from the first and is about the policy options available to government to promote equity and a redistribution of wealth, of which two are relevant here:

- Increasing minimum income through pay rise and other poverty alleviation strategies as well as reducing personal taxes for those whose income are below a certain level.
- Increasing public expenditure on health and reducing individual and household expenditure on health.

The third strategic consideration in the mobilization or resources for health is the issue of management of resources to promote cost efficiency and better outcomes for deployed inputs. Excessive centralization of resources and decision-making has often resulted in resource leakages and inappropriate interventions and wastages.

Furthermore, the supposed managers of public health systems often lack the skills to work with communities for health development; and to assess, analyse and design health services within the context of community development.

The fourth strategic imperative for successful resource mobilization and management in the country is the need to dramatically improve the data base for informed decision-making. Often information is not available on existing resources, and their location and deployment. This has resulted in the unnecessary duplication of efforts and wastage of resources. The deficiency in the data bases also contribute to the ineffective matching of resources to populations such that there is a maldistribution of all types of resources.

Fifthly, the changes that will be required to move the Nigerian Health System forward can only be effective when coupled with some other contextual changes such as increased accountability and

transparency in governance, civil service reforms. These and other considerations should inform the direction and scope for resources mobilization for health in Nigeria.

The Federal Minister of Health has embarked on health sector reforms as a priority but all States of the Federation must be similarly persuaded to reform their health sectors since they control the vast majority of Secondary health care facilities and possibly have more leverage with Local Government Councils which control the primary health centres, than the Federal Government. We stand on the threshold of history and it depends on us whether we will be bold enough to face the challenges and resolve the crises in the Nigerian Health Sector.

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