

3. The Nigerian Health System

3.1 Nigeria's Health System Performance

The effectiveness of a country's health care delivery system is central in meeting its health goals. This chapter reviews some aspects of the Nigerian health care system with respect to the development and operational implementation of the integrated maternal, newborn and child health strategy. The performance of Nigeria's health care system was seriously undermined by the nearly two decades of military rule. For example, between 1985 and 1993 per capita investment in health had stagnated at about \$1.00 per person compared to the international recommended level of \$34 per person.²⁹

More worrisome was the overall dismal performance of Nigeria's health care system, especially when compared with other less endowed African countries. For example, in 2005, Uganda allocated 11% of its total budget to health care, while Nigeria, in 2006, budgeted just 5.6%. Despite its high percentage of HIV+ citizens, Uganda was ranked 149 out of 191 countries and came 39 steps ahead of Nigeria³⁰ at 187/191 in the *World Health Report 2000*.

Nigeria's low level of expenditure on health care per capita seems to preclude that it will fall short of meeting MDGs 4 and 5. The effective implementation of the IMNCH strategy will require a much greater commitment from all levels of Nigeria's health care system. It is expected that the on-going

Health Sector Reform Programme³¹ (HSRP), and the passage of the National Health Bill before the National Assembly will enable Nigeria to successfully revamp its primary health care system and implement the Integrated Maternal, Newborn and Child Health (IMNCH) strategy and move closer to achieving MDGs 4 and 5.

3.2 Organization and Management of Nigeria's Health Care System

The national health system is, in principle, decentralized into a three-tier structure with responsibilities at the federal, state and local government levels. Currently, all three tiers are involved, to some extent, in all the major health system functions; stewardship, financing and service provision.

3.2.1 The federal level

More specifically, the Federal Ministry of Health (FMOH) is responsible for policy and technical support to the overall health system, inter-national relations on health matters, the national health management information system and the provision of health services through the tertiary and teaching hospitals and national laboratories.

3.2.2 The state level

The state ministries of health (SMOH) are responsible for secondary hospitals and for the regulation and technical support for primary health care services.

²⁹ Nigeria Federal Ministry of Health. (2004) *Health Sector Reform Programme (HSRP): Strategic Thrust and Plan of Action. 2004-2007*. Abuja, Nigeria: Federal Ministry of Health 2004, 7.

³⁰ World Health Organization. *The World Health Report, 2000*. (Geneva, WHO: 2000).

³¹The HSRP is the FMOH-led fundamental realignment/ transformation of the organization, management and financing of the Nigeria health care system driven by its new bold vision and anchored within the wider regeneration of Nigeria as encapsulated in NEEDS.

Table 3.1. Health specific Debt Relief Fund (DRF) appropriation breakdown (2006)

Allocation(₦b)	Initiative	Activity	Executing MDA
5.5	Immunization Programme	Examples include: Procurement of vaccines for routine immunization through UNICEF	NPI
8.45	□7.850 Primary Health Care	Examples include: Construction and equipping of 200 new PHC centres and the rehab of 150 old PHC	NPHCDA
	□0.645 Maternal & Child	Examples include: capacity building for doctors and nurses and procurement of drugs, equipments and supplies for MNCH	CDPA FMOH
1.38	Roll Back Malaria	Examples include: Insecticide treated bednets (ITNs) and drugs	FMOH
0.51	Tuberculosis / Leprosy Control	Examples include: Anti-tuberculosis treatment using the directly observed treatment short course (DOTS) therapy	Nat'l TB & Leprosy referred to Teaching Hospital, Zaria
4.75	HIV/AIDS	Examples include: Anti-retro viral (ARV) drugs, test kits, training workshop	FMOH
0.21	Tracking the implementation of MDG policies and plans	Examples include: Procurement and distribution of software for tracking, monitoring and evaluation of the implementation and health millennium development goals	FMOH
0.21	M & E	Examples include: Monitoring & Evaluation	Presidency
21 billion			

Source: Federal Ministry of Health, Nigeria. Department of Planning, Research and Statistics.

3.2.3 The local government level

Primary health care is the responsibility of the local government where health services are organized through the ward.³² Each local government is subdivided into 7-15 wards.

³² Technically the equivalent of districts in other countries are known as local government areas in Nigeria. However a typical local government in Nigeria may have a population in the range of 1-2 million people (some much more) compared to the wider international understanding of district which generally has population in the range of 150 -200,000. The ward health system aligns operationally more

While the organization of the health sector seems well coordinated, the practical workings of the system is not as seamless as depicted here. There is often a duplication and confusion of roles and responsibilities among the different tiers of government. The implications of this are weaknesses in coordinating and tracking performance and bench marking.

3.2.4 The community level

The community is probably the most important link in health care delivery. It forms the support structure for the implementation of primary health care services. To this end, the

1988 National Health Policy included the creation of primary health care (PHC) management and technical committees at local government level, ward development committees and community/village development committees at the ward and community levels. In most cases, these committees have been established, however, the majority are not functioning very well. For instance, a survey of 202 local governments (spread across the six geopolitical zones) in 2001³³ indicated that 89% had PHC management committees, of which only 27% were functional—having met at least once in the last three months before the visit. Similarly, 75% of the local governments had formed PHC technical committees and 44% had met at least once in the last 3 months before the visit.

3.25 Agencies/Parastatals/Departments

Within the FMOH and SMOH, the proliferation of the departments and agencies has often outlived the policies that set them up, because as policies change it is common to create new units without reflecting on the moribund departments/agencies that still exist. It is, therefore, not surprising that there are operational challenges and conflicts in the inter-departmental/agency working relationships. In the implementation of the IMNCH strategy therefore, an important goal will be to improve the effective collaboration across departments, agencies and line ministries based on a shared vision.

The activities of the Federal Ministry of Health, parastatals/agencies, state ministries of health and all interested stakeholders are coordinated through the

National Council on Health. Similarly, in each state, the State Council on Health is expected to bring together the state ministry of health and the local government health authorities. Profit and non-profit private health institutions are also regulated by the appropriate government agency.

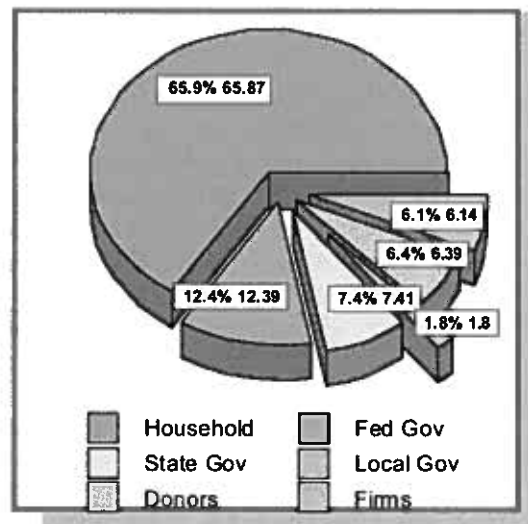


Figure 3.1 Sources of Health Financing, 2002. Source: Soyibo, Draft National Health Account, 2004.

3.3 Who Pays for Health Care?

Recent work on the national health account estimation (1998 -2002) reveals that the bulk of health funding is borne by households, making out-of-pocket payment for health care regressive.³⁴

Household expenditure as a proportion of the total health expenditure (THE) varied between the least value of 60.35% recorded in 2000 and the highest value of 69.21% in 1999 with a mean of 64.59% over the period.³⁵ This

with this international understanding and thus forms the basis for the policy change.

³³ J.O. Adeniyi, J Ejembi, CL Igbinosun, P. Muhammed, et. al, *Report of the National Health Care Needs Assessment Survey* (National Primary Health Care Development Agency, Abuja, 2001).

³⁴ Meaning whether you are rich or poor, the amount you pay for health care is the same, which makes payment for health care in Nigeria highly inequitable

³⁵ A. Soyibo, 2004 National Health Accounts of Nigeria, 1998-2002. Draft report presented to the World Health Organization, Geneva.

has massive implications for access and scaling-up maternal and child health services across the country. It is noteworthy that the federal budgetary component of health expenditure has increased from the 1999 ₦16 billion (1.7% of the federal budget) to ₦63.2 billion (6.4%) of the 2002 budgeted expenditures.³⁶ The federal figure for 2006 was about ₦102 billion (5.6% of the budget proposal), representing a 40% increase in actual revenue, but a decrease in the percentage of the budget allocated to health. The health appropriations in 2006 also included the deployment of ₦21 billion from the Debt Relief Fund (DRF) towards the achievement of health-related MDGs from the debt relief gains (see table 3.1 above). Nevertheless, the budgetary allocation for health is still below the 15% signed by the Nigerian government in the Abuja Declaration (2001).

Health expenditure as a proportion of the GDP was lowest in 2000 at 4.39%, and the highest in 1998 at 5.45%, with an average THE/GDP ratio of 4.78%. This does not compare favourably with average ratios of 7.2% of THE/GDP for the Eastern and Southern Africa National Health Account (NHA) network.³⁷ In fact many resource-poor countries of the subregion performed better than Nigeria as regards total health expenditure as a ratio of GDP. Among these are: Rwanda, 5.0%; Kenya, 5.3%; Zambia, 6.2%; Tanzania, 6.8%; Malawi, 7.2% and South Africa, 7.5%.³⁸

³⁶ Data culled from Research Department Central Bank of Nigeria, Abuja. As cited in O Idogho, A Ogundipe. (Action Aid Nigeria) (2004): Reproductive Health/HIV/AIDS Policy Environment in Nigeria - Challenges and Opportunities. Abuja, Nigeria. ActionAid Nigeria 2004.

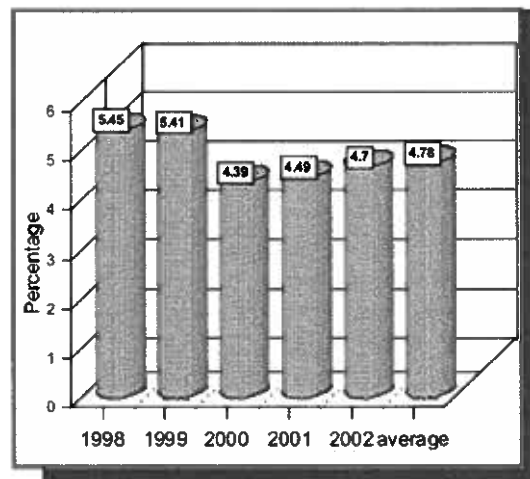
³⁷ Naboyonga and Munguti, 2001.

³⁸ Ibid

3.3.1 How is the health budget allocated?

The bulk of government's resources come from oil revenue into the Federation Account, which is shared among the federal, state and local government, according to an allocation formula. Transfers from the Federation Account to the state and local governments are not 'earmarked', that is, each state and local government decides how they spend the funds that are allocated to them. In addition, they are not required to provide budget and expenditure reports to the federal government. This means that federal government does not have any significant influence on funds allocated for secondary and primary health services (except those funded through special agencies and programmes). This lack of accountability in health expenditure is clearly an area that needs to be addressed if the national strategy and framework for IMNCH is to have the desired impact.

Figure 2.1. Total health expenditure as ratio of GDP



Source: National Health Accounts of Nigeria, 1998-2002. Final Report, WHO, 2005, p.4

This scenario is replicated in the control that state governments have over the primary health care services, as the local government, similarly, allocates its resources with little influence from the state. Statutorily, however, the state government *could* exercise a stricter supervisory role as the constitution sees the

local government as integral component of the state. This loose budgetary arrangement, combined with poor coordination between the levels of government, has limited level of integration in the health system. Personnel costs account for about 60% of the budget (2006 appropriations).

Presently, however, there is a draft Fiscal Responsibility Bill (FRB) at the National Assembly which when passed, will create the framework within which Nigeria's economic policy will be managed. The Bill seeks to compel all tiers of government to adhere to principles of sound public expenditure management. It prescribes rules of fiscal responsibility and transparency and also sets rules for financial and asset management and financial reporting. In addition to this, it also prescribes clear rules for timely financial reporting including wide publication of fiscal affairs of government

3.3.2 The National Health Insurance Scheme

The government's answer to financing health care is the National Health Insurance Scheme (NHIS) which was first mooted in 1978. The implementation of NHIS started in 2005, focusing initially on public sector employees. The potential for this scheme to improve access for the poor and the informal sector is dependent on how quickly it can build up a sizeable number of contributors. Health consumers predominantly have to pay at the point of service delivery. While the cost of health care for those in formal employment may be free/subsidized as a component of their remuneration packages. However, the majority of the poor must make-out-of-pocket payment at service delivery point (SDP). This limits access for the vast majority of people who need health care the most. The high cost of medical treatment is one of the most commonly cited constraints in accessing health services.

The National Health Bill when passed into law, will enhance the financing of health care, especially at PHC level, while the NHIS will support secondary and tertiary health payment systems.

Even though donor support for the health sector has increased in the last 5 years with the advent of democracy, it represents a tiny contribution compared to countries like Malawi,³⁹ where the donor component of health financing is reported to be more than 60% of the total budget.

The challenges of financing are further complicated by the limited information available on health budgets of the states and LGAs.

Though the federal, state and local governments retain overall responsibility for funding health services at their respective levels, there are agencies both at the federal and state levels which fund programmes across the different levels. There are also Hospital Management Boards owned by the federal and state governments that fund and manage tertiary and secondary level facilities, respectively.

Fluctuations in public funding, poor management, political interference and poor coordination between the state and local governments limit the effectiveness of federal programmes, such as National Programme on Immunization (NPI). Even when programmes are well-supported, they often contribute to fragmentation and duplication, with different programmes operating in the same local government under different administrative and reporting arrangements—all making different demands on the same health staff.

3.4 Human Resources

The main categories of human resources in the health care system are doctors, nurses, midwives, public health nurses and the community health workers (community health officers, community health extension workers and health assistants, *see table 3.2*).

Government health workers are paid by the level of government responsible for their employment. That means the federal

³⁹ *National Health Account, Malawi.*

government funds tertiary hospitals, the state governments look after secondary hospitals, and the local government authorities takes care of the PHC facility staff. However, there are a few exceptions, in some states, health professionals working in PHC facilities may be employed by the state government, while some skilled health staff employed by the federal parastatals or vertical programmes may also work at the secondary and primary levels.

There are also categories of health workers at the community level who work

Table 3.2. Categories of registered health workers in Nigeria (2005)

Staff category	Number	No. of health workers /100,000 population
Doctor	39210	30
Nurse	124626	100
Midwife	88,796	68
Dentist	2,773	2
Pharmacist	12,072	11
Medical Lab Scientist	3,059	3
Community Health practitioner	117,568	93
Physiotherapist	769	0.62
Radiographer	519	0.42
Health Record Officer	820	0.66
Nutritionist	2000	0.3

Source: Federal Ministry of Health.

Note: This table shows categories of health workers in Nigeria based on registration, but does not reflect the current status of human health resources across the country.

Voluntarily, however, programmes in which these workers are paid a stipend to offset travel expenses and other costs are much more effective.

In 1997, 95,000 nurses and 70,000 midwives were included in the Nigerian Medical Registry.⁴⁰ There are more doctors per capita in the South than in the North, however, there are no large regional

disparities in number of nurses. Most doctors and nurses work in secondary and tertiary level hospitals or in private practices.

Of the 26,361 doctors practicing in the country, 88% work in hospitals, and of these the majority, 74%, work in private hospitals. Only 12% of the practicing doctors, however, work at the PHC level either in private or public facilities.⁴¹ Out of 2000 registered nutritionists, only 97 are currently employed in the health sector.⁴² This is a unique feature of Nigeria's health system rarely seen in other countries, and is one of the reasons the maternal mortality rate is so high in the rural areas.

It appears that better working and living conditions, as well as higher remuneration draw skilled health personnel to urban areas and the private sector. In the rural areas, the irregular payment of staff salaries was described as the reason why many health workers have a second source of income. The insufficient medical supplies and equipment, and the lack of opportunities for training and advancement are the common reasons given for poor performance at the PHC level.

3.5 Drug Supply Management

Drug procurement in the public sector is decentralised and fragmented. Most state drug stores are generally well-organized, but do not fulfil any central procurement function as this is done directly by individual hospitals and local government authorities. Drug supply is especially inadequate at the PHC level. Part of the reason is that when resources are available to local governments, salaries are the first priority, and there is often little left for other recurrent expenditures, eg, drugs.

For instance, a survey by FMOH in 2002 found that 64% of the PHC facilities visited had not received any drugs from the

⁴⁰ National Population Commission and UNICEF, 2001.

⁴¹ Dare, et al, 2003.

⁴² Nutrition Society of Nigeria, July 2007.

government in the past two years, and that staff were purchasing and selling medicines privately.⁴³

In 2001, out of the 674 facilities visited in 202 local governments, 46% had less than half of the essential drugs; 54% had experienced out-of-stock in the preceding three months. Tertiary and secondary hospitals in general have more reliable drug supplies compared to PHC facilities, probably due to better funding and better management. However, their supplies are not always sufficient to meet the needs of their patients.

A revolving drug fund was widely established (with support from donors) as an integral part of the PHC implementation in the 1990s to ensure an uninterrupted supply of essential drugs. The federal government also made a major contribution to the scheme in 1997 through the Petroleum Trust Fund to ensure that the revolving drug scheme would have nationwide coverage. Unfortunately by 1999, poor management and political interference led to the discontinuation of the fund. The collapse of the revolving drug scheme became a *fait accompli* because of the insistence of the state and local governments that the proceeds from the sales of drugs be centralized. This has weakened accountability and control, and has allowed the funds to be used for purposes other than to replenish the supply of drugs. Even when the proceeds were retained by the facility, the funds were often used to meet other needs, like staff remuneration.

3.5.1 Drug supply through the private pharmacies

There are numerous registered pharmacists and patent medicine dealers who provide drugs to the public health sector through their retail outlets. Although patent medicine dealers are not permitted by regulation to fill prescriptions, in practice, this is hardly enforced.

3.6 Health Service Delivery System

Health services are provided through the various hospitals and clinics owned by federal, state and local governments. The local government is responsible for primary health care, which includes comprehensive health centres, primary health care centres, health clinics and health posts. A comprehensive health centre should have at least three doctors and offer both PHC services and a limited number of secondary clinical services. There should be at least one comprehensive health centre per local government area.

Within each ward, there should be at least one Basic Essential Obstetric and Neonatal Care Centre (BEONC) staffed by medical officers or NYSC doctors (where available); 2 midwives, 2 community health officers (CHOs) with nursing/midwifery background; senior and junior community health extension workers, laboratory and pharmacy technicians, offering basic preventive and curative services.

At the community level, health clinics or health posts should be served by community health extension workers (CHEWs) and Junior CHEWs who are expected to work in the community 80% of the time, and 20% in the health facility.

Secondary level services are provided by general hospitals and are the responsibility of the states. Tertiary and secondary health facilities should have appropriate mix of health manpower as prescribed by the human resource policy.

Overall, the number of PHC facilities indicate reasonable availability with less regional disparities than is the case with hospitals. According to the FMOH, in 2000, there were over 13,000 public sector PHC facilities and almost 7000 private PHC facilities. Although the population/PHC facility ratios are higher in the northeast, northwest and south-south (as in secondary facilities), the disparities are not as marked. More importantly, there are relatively more public sector PHC facilities in the North compared to the South, so if one compares only public sector PHC facilities, population to

⁴³ FMOH and WHO, 2002.

facility ratios are better in the North than the South.

The 1999 NDHS indicated that 71% of households in Nigeria were within 5 km of a PHC facility. The distribution of PHC facilities is better in urban areas (80%) compared to rural (65%). The overall population to facility ratio of around 5,500 is reasonable. Unfortunately, many of these clinics are not functioning. They are poorly equipped and lack essential supplies and qualified staff.⁴⁴

In 2000, there were an estimated 54 tertiary and specialist hospitals in Nigeria, with a population to facility ratio of 2.1 million. There are 855 public sector secondary facilities with a better than standard population to facility ratio of around 135,000 (compared to 500,000 standard). In addition to this, there are a large number of privately operated hospitals bringing the reported total number of secondary facilities to 3,002. However, the overall average is deceptive as there are marked regional disparities with fewer hospitals in the North. Population /facility ratios are under 50,000 in the North-Central and southern zones, but over 150,000 in North-West and North-East zones. This is due to the large number of private secondary hospitals that exist in the southern states. Overall, private hospitals accounted for 72% of the secondary health care centres, but constituted only 5% in the North-East and 24% in the North-West zones, compared to 90% in the South-East and over 80% in South-West zones. It is instructive to note that the North has fewer public secondary health facilities.⁴⁵

3.7 Health Management Information System

A national health management information

⁴⁴ Integrated Child Survival and Development Strategy document, 2005.

⁴⁵ Nigeria: Country Status Report, 2005, WHO.

system, which was established in the 1990s, has been significantly revised to ensure that standard forms are available for both public and private health care. Information thus generated by the health system is designed to flow upwards from the community (collected by Junior Community Health Extension Workers) through the local government and the state ministries of health to the Federal Ministry of Health.

3.8 Health Sector Reform Programme (HSRP)

The HSRP is the government's response to dealing with the outlined organizational, systemic and financial challenges facing the national health system.⁴⁶ The comprehensive reform is structured along seven strategic thrusts:⁴⁷

- i. Improving the stewardship role of government
- ii. Strengthening the nation health system and its management
- iii. Reduction of the disease burden
- iv. Improving availability of health resources and their management
- v. Improving access to quality health service
- vi. Improving consumer awareness and community involvement
- vii. Promoting effective partnership, collaboration and coordination

In addition, many of the professional regulatory bodies have been reconstituted. For example, the Medical and Dental Council

⁴⁶ H. Van Rensburg, A. Fourie, E. Pretorius (1992) Ch 1. Health care systems; a framework for analysis, comparison and evaluation. Adapted in: O. Idogho, (2006) Analytical Review of Nigeria's Health Sector Reform Programme. An Evidenced-Based Health Systems: Report to the Program Support Unit (Canadian International Development Agency (CIDA) Nigeri., Abuja, Nigeria).

⁴⁷ Nigeria Federal Ministry of Health. (2004) *Health Sector Reform Programme: Strategic Thrust and Plan of Action. 2004 – 2007*. Abuja, Nigeria: Federal Ministry of Health 2004, 7.

Malpractices Tribunal is functioning again. These professional bodies are empowered to ensure that high standards are maintained in the health professions.

- The areas which cut across all the aspects of the programme are:
- Health management information system
- Communication strategy for health sector reform advocacy
- Health sector reform monitoring and evaluation

3.8.1 Improving the organization and coordination of the system

3.8.1.1 The National Health Bill and institutional reforms within the FMOH

A National Health Bill has been drafted and is in the process of being passed. When the bill is passed into law it will provide a framework for the development and management of the Nigerian health system. It will provide minimum standards for health service delivery across the country. The Bill, in addition to defining clear roles and responsibilities for the three tiers of government, provides for the creation of a Primary Health Care Development Fund. The Bill makes explicit pronouncements on how the funds are to be utilized.

The National Health Bill proposes a direct funding line for primary health care. This fund will be channelled from the NPHCDA through state primary health care boards for distribution to local government health authorities on the basis of annual budgets and performance reports. This is designed to liberate health service delivery from the 'politics of the tiers of government' and the perennial problem of underfunding.

Structural reforms within the FMOH are also on-going. Elements of the reforms include the streamlining of various parastatals and departments. In addition, the roles and mandates of the various departments and agencies are being refined. The establishment of a National Tertiary Hospital Services Commission has been

proposed to provide the leadership and urgency needed to improve health service delivery. It is also proposed that the National Tertiary Hospital Services Commission will be responsible for the administration of tertiary and specialized secondary hospitals, while the Department of Hospital Services will focus on policy development. The Commission will work closely with the state hospital management boards to regulate both public and private service delivery points at the state level.

The National Health Insurance Scheme (NHIS) has been restructured to function more effectively as a regulatory body and to include the formal (public and organized private sector) and informal sector (community and rural areas).

3.8.2 Financing the National Primary Health Care Development Fund

The NPHCD Fund will be funded from revenue raised from taxes on alcohol, tobacco and road traffic insurance schemes, value-added tax and other existing taxes at the federal level.

The state and local governments will have a defined statutory contribution, which will be deducted at source and paid into the account. Monies from the fund will be used to finance the provision of a basic minimum package of health services in primary health care facilities, which includes:

- ✓ Purchase of essential drugs for primary health care.
- ✓ Provision and maintenance of facilities, equipment and transport for primary healthcare.
- ✓ Payment of salaries for primary health care personnel in the local government.

3.8.3 Distance to the health care centre

Reducing the distance health consumers travel to the health service delivery point is another objective of the Health Sector Reform Programme. The health consumer not only bears the cost of the health service, but also transport cost to facility.

In addition to financial factors, the three critical factors that determine access to health

care are:

- Distance to the health care facility
- Perceived quality of the care
- Type and severity of the illness.⁴⁸

The National Primary Health Care Development Agency is building and equipping an additional 200 PHC centres across the country to improve consumer access and provide quality health care. The Debt Relief Fund (DRF) is being used to fund this activity, in addition to other ancillary activities aimed at achieving the health-related MDGs in Nigeria (*see table 3.1*).

⁴⁸ FMOH and WHO 2002; World Bank, 1996. *Nigeria: Poverty in the midst of plenty. The challenge of growth with inclusion*. World Bank Poverty Assessment Report No. 14733 – UNI, 1996.