IMPROVING HEALTH SYSTEMS IN NIGERIA

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ABSTRACT

Nigeria, with a population of 140 million people accounting for 47% of the population of West Africa, has a moral responsibility to lead the continent towards achieving the Millennium Development Goals (MDGs). Yet its health system is ranked 187th of 191 WHO member states. Lending credence to this ranking are health indices such as an infant mortality rate of 101 per 1000; maternal mortality rates ranging from 500 per 100,000 in the South West to 800 per 100,000 in the North East, perinatal mortality rate of 48 per 1000 and child mortality rate of 205 per 1000.

There is thus an urgent need to foster effective collaboration and partnership with all relevant stakeholders to improve the health systems in Nigeria.

This paper explores challenges and possible solutions relating to health systems strengthening in Nigeria including health policies, governance, organization and financing of health services, health workforce production and health service delivery.

KEYWORDS:- Goals, Stakeholders, Health System, Health Service, Organization

INTRODUCTION

International collaboration in health initially focused on providing aid to needy countries during epidemics and other crises. Collaboration has widened to include the sharing of knowledge and mutual support to achieve global targets in the health sector. In the area of disease control, the eradication of smallpox was a unique example of the value of coordinated action by all countries of the world.

The past century has been characterized by major advances in biomedical sciences providing many varied opportunities for health promotion, disease prevention, treatment and rehabilitation. The phenomenal growth of science has fuelled increasing expectations on the part of individuals and communities; and it has led to increasing complexity in planning and managing health services as well as rising costs. These challenges have brought the design and operation of health systems to the front of national and international debate.

Health systems, aimed at meeting these challenges, are evolving in the context of local needs and opportunities as well as being constrained by limited resources. Hence there is great diversity in

the format of health systems, showing variation from country to country and also changing over time.

Nigeria, with a population of 140 million people accounting for 47% of the population of West Africa, has a moral responsibility to lead the continent towards achieving the Millennium Development Goals (MDGs). Yet its health system is ranked 187th of 191 WHO member states (WHO, 2000). Lending credence to this ranking are health indices such as an infant mortality rate of 101 per 1000; maternal mortality rates ranging from 500 per 100,000 in the South West to 800 per 100,000 in the North East (Partnership for Maternal, Newborn and Child Health, 2006), perinatal mortality rate of 48 per 1000 and child mortality rate of 205 per 1000 (UNICEF State of the World's children, 2006).

Since a health system is designed to respond to the needs of its population, it is therefore a major failing of the system when effective and affordable interventions do not reach the population who would benefit from them the most. Poor utilization rates and unfavorable health indices in Nigeria are attributable to identified challenges to the organization, financing, provision and delivery of health care services. Thus improvement in health indices or achievement of the millennium development goals in Nigeria will be difficult unless there is a concerted effort to restructure the Nigerian health care system.

LITERATURE REVIEW

HISTORY OF NIGERIA'S HEALTH CARE SYSTEM

In colonial times, the government health program served three constituencies:

- Europeans – civil servants, traders
- Nigerian civil servants
- General public

Special services were provided for expatriate Europeans. Where there were relatively large concentration of expatriates, it was possible to provide exclusive services for them e.g. the European Hospital in Lagos (later renamed 'Creek' hospital in 1947). In the general health facilities, Nigerian civil servants were accorded priority access. The geographical distribution of government health services was uneven. Hospitals and other health institutions were strategically located in cities and towns that served as administrative and military centers of the colonial government. Few services were provided in other areas; they provided no public services in some large townships that did not have government offices. Christian and faith-based missions played a major role in bringing health services to under-served populations. The medical missions also cared for victims of leprosy and other marginalized groups. With the

encouragement of the World Health Organization, a new movement arose aimed at providing basic health services to communities at the grassroots level. The Nigerian Health Policy, written in 1984 and adopted in 1988, signaled a new approach to the development of Nigeria's health system. It prescribed a health system based on the primary health care approach.

More recently, on consultation with stake holders, the health policy has been updated and the Federal Ministry of Health has issued more detailed statements on some specific issues – human resources, etc. The philosophical and theoretical basis of the Nigerian health system has been firmly laid. The current challenge is to translate these ideas into concrete action.

WHAT IS A HEALTH SYSTEM?

A system can simply be defined as **"**A group of interdependent items that interact regularly to perform a task". The essence of a system is the interaction of items in order to achieve a defined goal. Thus, a health system is not merely a collection of discrete services each being delivered without specific relationship to the other elements of health care. A health system is defined in the National Health Policy as comprising all organizations, structures, institutions and resources needed to provide all Nigerians with qualitative, effective, efficient, available, accessible and affordable health services in a manner that is equitable and meets their needs.

The challenge in developing a health system is to organize the various elements for health promotion, specific disease prevention, diagnosis and treatment of ailments and rehabilitation. The required inputs include biomedical interventions as well as contributions from other disciplines and sectors.

Factors accounting for the poor ranking of the Nigerian Health Systems include the following:

- Fragmentation of the health system with poor coordination between the primary, secondary and tertiary levels.
- Weak and ineffective referral systems resulting in overburdened secondary and tertiary health facilities.
- Inappropriate orientation of available services.
- Duplication of health activities with resultant wastage of resources.
- Low level of financial risk protection for the population who live in poverty.
- Gross under-utilization of public health facilities.
- Lack of formal integration of the private sector and weak partnerships between public and private sectors.
- Lack of health information/data for planning purposes.

HEALTH AND POLICY FRAMEWORKS IN NIGERIA

Health systems provide health services through a range of activities designed to improve or maintain health. These services are delivered in the context of guidelines, policies, legislation and laws with the specific goal of optimizing inputs to produce health. Policy achieves the objective of defining a vision and setting goals for the future; which in turn helps to establish benchmarks for the short and medium term. Health policies also outline priorities, roles and responsibilities for stakeholders in health. Despite the obvious benefits, African countries are at various stages of development in terms of policies and regulatory frameworks. Some countries appear to have issued very few national health policy statements while, though policies exist, there is lack of implementation in other countries.

The current Nigerian constitution fails to clearly delineate responsibilities for different tiers of government, leaving all tiers involved in funding and provision of healthcare at their discretion. Without this constitutional definition of roles, there is a near complete absence of effective linkages and referrals. This is especially apparent with the poor funding and organization of healthcare at Local Government level where two-thirds of Nigerians ought to receive care. To address these problems, the proposed National Health Bill defines the National Health System and outlines roles and responsibilities of Federal, State, and Local Governments in the health system. It also creates the National Primary Health Care Fund to ensure joint funding of Primary Health Care by all tiers of government.

Policy oversight and regulatory activities is a responsibility of health authorities. It covers the development of regulatory guidelines or rules to govern the operations of actors in the health system, as well as efforts to ensure compliance. To augment government oversight, professional bodies also exist to conduct training, accreditation, and certification and of health professionals.

In most African countries, there seems to be an abundance of policies and regulatory guidelines within which to operate but government capacity to implement such policies or carry out regulatory responsibilities is hampered by lack of funds and commitment. Since independence, Nigeria has adopted five successive national and 24 sectoral health policies; some of which have been incorporated into various national development plans, the last of which was adopted in the 1988 National Health Policy.

The Constitution of the Federal Republic of Nigeria (1999) is another policy instrument but it does not clearly specify the roles expected of Local Government Areas (LGAs), State and Federal Governments in the national health care delivery system. This creates loopholes and gaps in service delivery since the LGAs are the main implementing agents of primary health care.

Although health is not in the Concurrent List of the 1999 Constitution of the Federal Republic of Nigeria, however, in practice, all the tiers of government, the Federal, State, and the Local authorities, engage in different aspects of health care. Specifically, the Federal Government provides tertiary health care; State Governments provide secondary health care; the Local Government provides primary health care. The lack of clarity and specificity in the Constitution makes it possible for all tiers to engage in all the 3 types of health care.

HEALTH IN THE 1999 CONSTITUTION OF THE FEDERAL REPUBLIC OF NIGERIA

The Nigerian government has produced many health sector policies since the country gained political independence in 1960. The first four were outlined in various national development plans that spanned the period between 1960 and 1985. The national health policies prior to 1985 were orientated towards the orthodox approach. The philosophy that guided the policies stemmed from the assumption that the development of the health sector would well depend on the availability of physicians as well as the accessibility of users to secondary and tertiary health care facilities. Consequently, substantial resources were earmarked for, and invested in the training of physicians including the construction and expansion of health care facilities in the four plans that were adopted / approved prior to 1985.

The Government should show commitment to, and appreciate the provisions of the 1999 Constitution, which deals with the fundamental objectives and principles of State policy which though not justifiable, are relevant to health. It provides that the Federal Republic of Nigeria shall be a State based on the principles of democracy and social justice. This includes the security and welfare of the people. It also provides that the State shall ensure *"that health, safety and welfare of all persons in employment are safeguarded and not endangered or abused"*. The constitution clearly states that there will be adequate medical and health facilities for all persons, children, young persons and the aged and that they are protected against any exploitation whatsoever and against moral and material want.

HEALTH AND HEALTH-RELATED LEGISLATION IN NIGERIA

The Legislations relevant to health could be classified as follows:

- Laws relating to health professions
- Laws relating to healthcare institutions, regulatory bodies and institutions implementing health programs
- Laws on drugs and foods
- Health in the context of the criminal code
- Health-related laws on environment
- Health-related laws on industries
- Unclassified others

IMPLICATIONS OF THE CONSTITUTIONAL LACUNA ON THE HEALTH SYSTEM IN NIGERIA

The absence of a clear provision for health in the 1999 Constitution, which can be interpreted as a constitutional lacuna, has the following implications:

- There is no clear definition of responsibilities for different tiers of government.
- All tiers are involved in all aspects of the health system, resulting in ineffectiveness and inefficiency.
- There is inadequate co-ordination and collaboration by different tiers of government.
- There is inadequate funding of the system.
- Effective linkages and referrals are almost absent within the system.

In view of this, the Federal Ministry of Health (FMOH), in collaboration with NASS, proposed a National Health Bill in 2004 with the purpose of providing a frame work for the development and management of a structured health system within the Federal Republic, taking into account the obligations imposed by the constitution and other laws on the Federal, State, and Local Governments with regards to health services; and to provide for matters connected therewith.

GOVERNANCE AND STEWADSHIP OF NIGERIAN HEALTH SYSTEM

Governance and stewardship in the health sector is increasingly being recognized as an important factor in the provision of health services and functioning of health systems. Performance of a health system is more effective when there is strong governance and effective institutions. In fact where low income countries have made progress in improving health outcomes, political commitment has played a major role. Stewardship has been defined as a “function of a government responsible for the welfare of the population and concerned about the trust and legitimacy with which its activities are viewed by the citizenry”.

Government is particularly called on to play the role of a steward, since it makes huge investments in health and also develops many of the policies and laws pertaining to healthcare delivery. The community’s key role in stewardship is evolving, particularly in developing countries. Public consultation which encourages community participation and collective ownership of health resources is part of the policy formulation process in some countries. An important expansion of this approach beyond policy-making to implementation is represented by sector-wide approaches. Strengthening structures of accountability encourages good performance of health systems. So does the introduction of mechanisms to ensure that users have a voice in the local health system and that they can influence priorities. In Burkina Faso for example, participation by community representatives in public primary health clinics has increased the coverage of immunization, the availability of essential drugs, and the percentage of women who

get two or more antenatal visits. In Jigawa state of Nigeria, a community approach to organization of health services which involved the engagement of traditional structures in formal healthcare proved to be a promising health reform strategy.

Health services funded from public sources are obviously the responsibility of government. The challenge for governments in developing countries like Nigeria is to harness the energy of the private and voluntary sectors in achieving better levels of health systems performance. Services financed and provided by the private sector in a developing country may account for as much as 60-70% of health service provision and private spending in health constitutes a large proportion of total health spending in low and middle income countries. In spite of this, policy debates frequently focus on public spending. Policymakers have to find ways to improve stewardship of both public and private spending in order to improve health indices. Regulation of the private sector to ensure that it acts responsibly in the provision of healthcare services is an important part of the government's task as the overall steward or trustee of the health system.

Governments of several states in Nigeria have sought to strengthen healthcare delivery by various reforms, with or without the support of development partners. For example, in Enugu state, improvements in health care delivery was achieved through the development of governance structure, management systems including an information management system and massive capacity development of frontline health workers/administrators on their new roles. In addition, Lagos state located in the South Western part of Nigeria improved its health service delivery through Public-Private Partnership (PPP) and by simplifying the bureaucracy attached to public health systems.

However, there are a number of challenges related to governance and stewardship currently being faced in Nigeria by communities at state level. These challenges include lack of policy direction, inequity in distribution and maintenance of health infrastructure, inappropriate orientation of available services, poor integration of services and poor collaboration between the State and Local Governments on health matters. As a result, poor utilization of public health facilities is reported in most of the States.

The way forward include introduction of district and local health authority management teams, engagement of traditional structures in the formal delivery of healthcare and strengthening of referrals.

ORGANIZATION AND FINANCING OF THE NIGERIAN HEALTH SYSTEM

The most visible function of a health system is the provision of healthcare services, although it is also expected to perform financial protection and stewardship roles. In addition to the provision of qualitative and accessible healthcare services, a health system has the objective of raising, pooling and allocating revenue as a means of providing families and communities with financial protection from the catastrophic cost of ill health. To meet this objective, most high income countries rely heavily on either general taxation or mandated social health insurance contributions. In contrast, low income countries depend far more on out-of-pocket financing

which promotes inequity and limits access for the most vulnerable in the population. In 60% of countries with incomes below $1000 per capita, out-of-pocket spending is the predominant form of health spending whereas only 30% of middle and high income countries depend on this kind of financing (Cassels and Janovsky, 1998). Studies have shown that such inequity in financing mechanisms influences health seeking behavior and can affect the success of basic public health programs such as a malaria prevention program.

In some African countries, including Nigeria, government expenditure on health may have increased over the years but it is still below the statutory recommendation. WHO estimates that a minimum government expenditure of USD34 per person per year will be required to provide an essential package of public health interventions in order to achieve health related MDGs. To this end, Heads of States of African countries made a commitment to allocate at least 15% of their annual budget to the health sector. Only two countries spend over 15% of their budget on health, leaving 44 countries, including Nigeria striving to meet this target.

In Nigeria, the structural adjustment program of the 1980s severely reduced government spending in the social sector and triggered the expansion of other modes of financing such as user fees; indirectly increasing private sector participation in both purchasing and provision of healthcare.

Currently, the major sources of funding for the health sector are private sector expenditure (mainly from household out-of-pocket spending); various employer sponsored health schemes; government health expenditure from Federal, State and Local Governments and the donor community. Out-of-pocket spending (OOPs) is the most common form of health financing averaging 64.5% between 1998 and 2002 and represents a significant financial burden for households. This prevents some people from seeking care and results in financial catastrophe and impoverishment for those who do seek care. Recently, as part of health sector reforms there have been introduced national and community financing schemes as well as an effort to actively promote Public-Private Partnerships (PPP) in order to pool health resources.

ISSUES OF EQUITY

By 1999, about 65% of Nigerians were reported to be living below the poverty line. This figure rose from 27.2% in 1980 thus showing a picture of increasing pauperization of the Nigerian population. In practical terms, the poverty line was drawn at the proportion of Nigerians living on less than one dollar (US$1) a day. The Gini Index which is a measure of the unequal distribution of income (consumption) is one sure pointer that there is disequilibrium in the distribution of the resources of the country and it shows that only about 2% of the Nigerian population control about 55% of the country's resources. This is a major indication for policy instruments to facilitate a socially responsible but orderly redistribution of wealth in the country. This redistribution must have well defined social and developmental objectives.

If the health indices of the country are to improve drastically, appropriate attention must be placed on access to health care in addition to efforts to reduce risk exposure. Health care must be available and accessible on the basis of need. This equity requirement is in the interest of

national development as evidence has shown that a healthy population is more economically productive.

GOVERNMENT STRATEGY FOR FINANCIAL AND FISCAL MANAGEMENT TOWARDS HEALTH DEVELOPMENT IN NIGERIA

The Federal Government of Nigeria has put in place a medium term fiscal strategy, which is expected to serve as an integral part of the economic management reform framework of the Federal Government.

This strategy which cuts across key sectors of the economy, health inclusive, is designed to deliver sustainable economic growth and improve the quality of life of every citizen of Nigeria. Some of the objectives of the Federal Government's fiscal policy for the period which spans 2007- 2009, are to strengthen the national health system; reduce disease burden attributable to priority diseases and health problems such as malaria, tuberculosis, HIV/AIDS, infant and maternal/reproductive related health illnesses; foster effective collaboration and partnership with all stakeholders in the health sector, and strengthen basic and operational research and development.

The strategy of the present administration is to ensure increased involvement/commitment to health at the State and Local Government levels. The Government is committed to mobilizing more funding for the health sector and intends to achieve these through the following initiatives:

- Refurbishing and equipping all Federal Tertiary Health Institutions.
- National AIDS/STI Control Program, including the procurement and distribution of ARV drugs and test kits.
- Roll Back Malaria Program, including the procurement of drugs for malaria case management and Insecticide Treated Nets.
- National Program on Immunization for routine immunization.
- Capacity building and training for 5,000 health workers on Integrated Management of Childhood Illnesses.
- Strengthening of the National Health Insurance Scheme.
- More efficient response to the health needs of the citizenry through improved coordination between the various sectors of the economy to ensure an integrated healthcare delivery.

As part of the effort to strengthen the existing health systems in Nigeria, the Federal Government in 2004, introduced the National Health Insurance Scheme (NHIS) with the objective of ensuring

that every Nigerian worker, and ultimately all Nigerians, have access to a wide range/ choice of health service providers and are not completely paying for health services with their own income. The NHIS is to facilitate pooling of funds for health systems development and also provide financial protection for the insured. At present, it covers the government sector but it will gradually extend to other sectors.

OUT OF POCKET PAYMENT FOR HEALTH SERVICES IN NIGERIA

In Nigeria, more than 80% of all health spending is through out-of-pocket spending (OOPS). As such, most Nigerians who do not have money at the time of illness will not be able to access and use healthcare services.

This applies not only to curative and rehabilitative services but also to health promotion services. Hence, because of the high poverty level in the country, most people are prone to making catastrophic health expenditures, which increases their vulnerability, perpetuates poverty and ill-health. Therefore in Nigeria, financing mechanisms that will increase access and scale-up use of interventions for achieving the MDGs, by proving financial risk protection are needed.

In an effort to cope with the spiraling cost of health care, the Nigerian National Health Policy articulates funding of health sector from budgetary sources, and recognizing additional avenues of revenue such as health insurance schemes and direct financing by employers of labor. The introduction of user fees was arguably in response to the severe problems in financing health services in Nigeria, like in most of sub-Saharan Africa. Government health budgets declined in real terms in response to macroeconomic problems at the time while demand for health services increased, partly because of population growth and successful social mobilization. Consequently, African Heads of State in the Abuja declaration agreed to set a target of 15% of government budgets to be directed to the health sector (OAU, 2001).

Presently, increasing public health expenditures does not automatically translate into better outcomes. Skewed resource allocation and pro-rich benefit incidence have often hindered making a dent in poor health outcomes as the additional public fund spent gets thinly spread on the population segments with the most need subsidies. As a result, with ill-targeted and ill-functioning exemption mechanisms, it is the poor and vulnerable that get trapped in catastrophic OOPS. Without a meaningful safety net, they fall further into chronic poverty (World Bank 2004, Soyibo 2003).

The 2004 National Living Standard Survey (NLSS), a representative sample of above nineteen thousand households in Nigeria, indicates that OOPS on health care is about US$22.5 per capita, which accounts for about 9% of total household expenditures, one of the largest shares in low-income countries across the region and even globally. The survey provides evidence on the impoverishing effect of healthcare payments on households.

On average, 3.9% of households are estimated to spend more than 50% of their total household expenditures on health and 11.6% of households are estimated to spend more on care than 25% of their total expenditures. Therefore, protection against catastrophic health expenditures has to be a priority item on the health care financing agenda (Velenyi, 2005).

Presently, public expenditures funded through general tax revenue in Nigeria account for 20-30% of total health expenditures and private expenditures accounts for 70-80% of the expenditures and the dominant private expenditure is OOPS, which is about US$ 22.5 per capita and accounts for 9% of total household expenditures (Federal Office of Statistics 2004). Half of those who can not access care do not because of its costs.

The dominant reliance on this non-pooled financing instrument and the related absence of risk sharing transfers the largest financing burden on the poor. The clear absence of exemption mechanisms and pre-paid instruments is largely responsible for impoverishing health expenditures. Other financing mechanisms are also used to pay for healthcare, including community-based health insurance; tax based funding of the public sector and the federal civil servants national health insurance scheme, which was started in 2005.

HUMAN RESOURCES FOR HEALTH IN NIGERIA

Human resources are a vital part of the health system. It is widely acknowledged that Africa's insufficient health workforce will continue to be a major constraint in attaining the MDGs. Thus, the capacity to plan, produce and manage human personnel is a determinant factor in human resources development for health. The development of human resources for health (HRH) depends on a number of factors, some of which relate to the overall national situation while others relate to the health sector. Targeting of one or the other of these factors instead of a holistic approach is the source of the many problems confronting the optimal utilization of health resources and the implementation of health policies. African countries have also been reported to have a low density health workforce, compounded by poor skills mix and inadequate investment. This low density of health workforce is severely threatened by high attrition rates underscored by four factors namely insufficient training opportunities, deteriorating health of the workforce, rural/urban imbalance and the "brain drain".

To ensure adequate human resources for health, the four aforementioned factors leading to low density of health workforce needs to be addressed. Nigeria is known to have one of the largest stocks of human resources for health in Africa, 28 doctors and 170 nurses per 100,000 population. This compares with a sub-Saharan average of 15 doctors and 72 nurses per 100,000 population (World Health Report, 2006). Despite this large stock of human resources, there are great disparities in health status and access to health care among the six geo-political zones of the country with indicators generally worse in the North than the South.

The FMOH/Partners for Health Reform plus HRH assessment conducted in April-May 2005 indicated that the major reason for the great disparities in health status and access to health care among different population groups in the country is a critical mal-distribution of health workers. Currently, 70% of health workers are engaged in urban settlements where only an estimated 34% of Nigerians are living. On the other hand, 66% of the populations, living in rural areas, are experiencing crippling shortages (Ogungbekun I et al, 1999).

Furthermore, Nigeria is one of the several major health-staff exporting countries in Africa. For example, 432 nurses legally emigrated to work in Britain between April 2001-March 2002,

compared with 347 between April 2000-March 2001; this is out of a total of about 2000 (legally) emigrating African nurses, a trend that is perceived by the government as a threat to sustainable health care delivery in Africa's most populous country (Raufu A, 2002). Data on Nigerian doctors legally migrating overseas are scarce and unreliable. Nevertheless, hundreds of Nigerian trained doctors continue to migrate annually. Factors attributable to this "brain drain" include minimum standards of health facilities, low salaries compared to what can be obtained in North America, Europe or the Middle East and little incentives.

Thus progress in improving relevant health indices or achieving MDGs will be slow unless the contribution of workforce challenges to weakening health systems is addressed.

STRENGTHENING SERVICE DELIVERY

The primary objective of a health system is to improve people's health and therefore its chief function is to deliver health services.

Health care services are amongst the most basic of all essential services, and their significance cannot be over emphasized. However, health care delivery in Nigeria is faced with the problems of the quality of care and accessibility to care. Health facilities are unable to function well because of poor physical infrastructure such as roads, transportation, electricity, communication and clean water supply. Vehicles are often immobile for lack of repair and maintenance.

Documentary evidence has shown that health service delivery in Nigeria is as low as 30% and other indicators such as waiting times, staff attitude to work and public confidence in the health sector has declined significantly over the years.

Over the last few decades the health sector has witnessed a gradual decline generally and a lack of managerial capacity at all levels of the health system. This has resulted in key resources not being managed well, and consequently, in poor service delivery.

Globally, health services are known to be provided at different levels by different agencies and specialists. Health care provision in Nigeria is a concurrent responsibility of the three tiers of government in the country; these are also supported by organizations and the private individuals who establish and run private medical services.

In summary the major constraint affecting the health care delivery program in Nigeria are; the lack of adequate materials, lack of community ownership, prevalence of inadequately trained staff and inadequate or non-availability of qualitative health care.

Thus, the strategy to achieve a strengthened health care delivery is a comprehensive health care system based on primary health care that is promoting health, preventive, curative and rehabilitative to every citizen of the country.

ENSURING ACCESS TO DRUGS AND ESSENTIAL PHARMACEUTICALS

Shortage or lack of drugs and essential pharmaceuticals in health care is indicative of a serious failure in the system. Drug shortages have been a recurring phenomenon particularly in the public health sector. Even when drugs are available it does not translate to accessibility. Availability is not synonymous to accessibility because of the huge impact of prices in the determination of accessibility to essential medicines.

Access to essential drugs has assumed significance over the years because of increasing difficulty experienced by people in obtaining their medication both within and outside the regular health care structures. In the past 2 decades an even greater concern in the drug sector has been that of the menace posed by fake drugs.

Government is obligated to ensure that health care delivery is without discrimination. This obligation poses great challenges to the government with close to 90% of Nigerians living below the poverty line. High prices of medicines remains one of the greatest obstacles to access and it is of primary concern to the government. The high prices of medicines are a result of several factors. The procurement process particularly often lacks transparency and contributes significantly to the high prices and by extension affordability and quality of the medicines procured. Medicines and pharmaceuticals available have a high cost process and therefore access to them is denied and when quality is compromised, safety cannot be guaranteed.

Baseline assessment of the Nigerian pharmaceutical sector in 2002 showed that only 46% of essential medicines were available in public health facilities. A national survey in Nigeria in 2004 – 2006 showed that the drugs were neither sufficiently available nor were they affordable. Ensuring access to safe drugs and essential pharmaceuticals in Nigeria, therefore, is challenged by inadequate funding by government, lack of a transparent procurement process, and poor availability of medicines. Other challenges are chaotic drug distribution system, irrational drug prescription and use, poor implementation of government policies especially the National Drug Policy, and poverty.

ACHIEVING UNIVERSAL ACCESS TO HEALTH CARE IN NIGERIA

FINANCIAL RISK PROTECTION FOR HEALTH CARE SYSTEMS IN NIGERIA

National health financing systems are generally expected to be pro-poor if health care targets are to be met. Such systems should therefore cover three important dimensions: ensure that contributions to costs of health care are in proportion to different households' ability to pay, protect the poor from financial shocks associated with severe illness, and enhance accessibility of services to the poor. Such systems can only be achieved if the benefit and financing incidences of different health financing mechanisms in operation are available to health care planners. It is

evident that the Nigerian health system, especially its financing is not pro-poor and hence is not geared towards achieving the MDGs.

The Nigerian health system, especially measured against its responsiveness to citizens' expectations and financial protection of everyone, rich and poor (equity) is poor. This is based on the fact that people make high out-of-pocket payments for health care. Hence, a health system encompassing health financing mechanisms that would be equitable and ensure that providers financially protect the poor within different mechanisms used to finance healthcare is needed. In order to ensure financial risk protection for achieving the MDGs, pro-poor financing strategies, as well as other financing strategies that assure financial risk protection for interventions for the reduction of maternal and childhood mortality plus elimination of communicable diseases as public health problems should be developed and implemented immediately in Nigeria.

The options available will include the elimination of out of pocket spending for such interventions and channeling the money to health insurance (community-based and social), scrapping of user fees, increased use of exemptions and deferrals, free provision of some critical services, vouchers and subsidies. These mechanisms are in line with the national health financing policy. A great push for scaled-up implementation of the strategies should be provided, if the Nigerian health system is to become fair and move towards achieving the MDGs.

PUBLIC – PRIVATE PARTNERSHIPS FOR HEALTH SYSTEMS FINANCING

Improving access to health services is a fundamental principle of State as enshrined in the Nigerian Constitution and is in the spirit of solidarity and social justice. Engaging the private sector thus holds the potential for increasing the availability of health services and where the process is properly modulated by the public sector, it should also improve access and affordability *(Nigerian Constitution 1999).*

Properly implemented Public-Private Partnerships hold the potential to combine the strengths of public and private players, and thereby ensure cost efficiency and improved quality of service delivery while also working towards an equitable distribution of healthcare services and the provision of such public goods as are essential to achieving broader health policy goals. Public Private Partnership needs a fertile soil to germinate if health objectives are to be met. At no time must the public sector abandon the driver's seat or else the social goals that the health sector must necessarily pursue will be missed. At the same time enough room must be allowed the investing private sector recoup its investment over a reasonable period of time.

Public-private partnerships provide a path towards more effective service delivery and a means by which the system's present inefficiencies may be mitigated. PPP has been shown to be a fast, effective - and in the short term at least - cheap way of getting new facilities built or new equipment procured.

Non-availability of services serves no equity goals and it is in fact more equitable to partner with private sector funding agencies to provide services that would otherwise have been unavailable. Public sector leverage must in those circumstances, make chargeable fees to be lower than they would have been in the unfettered private sector. The public sector goals of social responsibility

and equity must be in focus while advantage is taken of the management efficiency of the private sector to ensure quality delivery of services.

NATIONAL HEALTH INSURANCE SCHEME

Another emerging paradigm in the Nigerian health systems is the health insurance phenomenon which, if well organized, can offer the best possible solution to the public-private mix issue. Under the National Health Insurance Scheme, budget-holding institutions (HMOs) serving as intermediaries between financing entities and providers, organize and manage the consumption of care under public entitlement. Some HMOs are also offering private insurance outside the National Health Insurance Scheme. Many of the health care providers, particularly the primary providers are private, the fund managers or HMOs are all private while the NHIS (public sector) serves as the regulator. A fundamental difference between medical schemes and commercial health insurance is that health insurance was based on risk-rating leading to cream-skimming and exclusion of the elderly and unhealthy.

The introduction of public – private mix could be feasible without compromising the quality of the service to the public health sector. Such an introduction may require some external regulation and enforcement.

This may be easier to enforce in a not-for-profit environment. A proper mix in the provision of health care services may lead to the strengthening of the public sector that serves everybody. It may prevent the shifting of good physicians and resources from the public sector to a private one that benefits only a few.

IMPROVING HUMAN RESOURCE MANAGEMENT SYSTEMS

In the health sector reform, a major thrust is to improve the availability of health resources (including human resources for health and their management). Improvement of human resource management systems will lead to the formulation of relevant policies and strategies and rationalized training systems for health workers.

In context, the major human resources for health challenges that need to be addressed include the mismatch between the training of professionals and requirements, the massive brain drain from poor developing to rich developed countries, the internal mal-distribution of available staff (rural-urban), the unclear career pathways for health professionals, and the public-private sector dichotomy in the management of health professionals.

The principles under-pinning the human resources for health Policy which include improving access, stewardship and accountability, strengthening public-private partnership for health, improving efficiency and effectiveness in resource mobilization, producing adequate numbers of health workers who are also adequately prepared to respond to health challenges and assuring quality of care should be thoroughly implemented.

IMPROVING SERVICE DELIVERY

Best practices by health care providers are essential in the delivery of quality healthcare. In order to achieve this, health care providers must adhere to Standard Operating Procedures (SOP) at all times. Generally, health care providers must conform to professional standards and codes of ethics, ensuring that health centers/hospitals are furnished with the appropriate quality and quantity of hospital equipments. Adequate staff training and provision of care in a conducive (hygienic and spacious) environment are also essential in the provision of quality healthcare. It is also important that equity must be maintained for healthcare to be affordable to all. In summary, effective healthcare delivery amounts to achieving the health related Millennium Development Goals (MDGs)

High quality patient care can be achieved through a relationship based care taking into consideration patient's satisfaction. Using practical strategies and solutions that improve safety and quality, can lead to patient satisfaction.

ENSURING ACCESS TO ESSENTIAL DRUGs

Availability is the first step in ensuring access. About 75% of essential medicines used in Nigeria are imported, less than 20% are produced locally while the remaining 5% are obtained from foreign donors. Drug availability is also dependent on several other factors like funding, selection, quantification, procurement and rational use. The goals of the revised National Drug Policy which is to ensure the availability of safe, efficacious, and affordable essential medicines as well as the promotion of rational drug use should be vigorously implemented.

Affordability is the second step in ensuring access. A recent survey of prices of medicines in Nigeria showed that Nigerians pay 2 to 64 times the prices of medicines in the international market, yet over 90% of Nigerians are considered poor and live on less than $1 per day. The government should put policies and strategies in place for lowering prices of medicines in order to ensure access.

In addition, creating consumer awareness and promoting community participation will also improve access to drugs.

The public-private partnership (PPP) approach including the NHIS will also help in improving access. The availability of health resources and the proposed national health investment plan will go a long way in improving the funding outlay that can be applied in the procurement of medicines thereby improving access.

CONCLUSION

In order to strengthen health systems in Nigeria, there is a need to build consensus amongst the various stakeholders and other sectors which have direct impact on health so as to ensure significant investment in the sector.

There is also need for division of responsibilities among the three tiers of government – Federal, State and Local Government; entrenching evidence- based approach in policy making and the design of strategies at all levels of the health system; optimizing the effectiveness of human resources for health and establishing monitoring and evaluation as an integral part of the management of services;

Accordingly, effort should be geared toward Public-Private Partnerships, increased technical support by our development partners, and establishment of strong linkages between government-owned health systems and privately run health institutions.

Government at all levels, business organizations and individuals need to play effective roles in health financing. In this way, overall affordability, availability and quality of health services are ensured for the entire populace. It is incumbent upon the government to provide the appropriate policy guidance and direction that will create a conducive environment for sustainable health care delivery to all Nigerians.

With greater transparency in budgeting, prudent management of revenue, and expenditure, more resources would be available for investment in the priority sectors, including health. There is a dire need to ensure that health financing arrangements combine individual responsibility with targeted subsidies in the most effective manner that would make health care services in the country generally efficient accessible, and affordable.

In addition, access to essential medicines which are safe, efficacious and of good quality on a sustainable basis is crucial for the success of the Nigerian health care delivery system. Access to medicines can lead to significant improvements in health outcomes and facilitate realization of the health related components of the Millennium Development Goals (MDGS), as well as considerable reduction of the burden of disease. It is a human right and government has full responsibility of being responsive to this issue. However, government cannot handle this alone and therefore all hands must be on deck to ensure that we remain our "brothers' keepers".

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