

Health Care Financing in Nigeria: Prospects and Challenges

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Abstract

Fifty years after independence, Nigeria is still struggling with the provision of basic health services for its teeming population, now estimated at over 150million. The health care sector is still a labour-intensive handicraft industry, in spite of advances in technology, and health care provision has now become more complicated than in the past. Infant and under-five mortality rates are near the highest in the world, and maternal mortality is extremely high. It has the second largest number of people infected with HIV/AIDS in the world only next to South Africa and in 2008, between 3million and 3.5million people were estimated to be living with HIV/AIDS. Nigeria has the fourth highest number of TB cases in the world, with a 2004 estimate of 293 new cases per 100,000 population and 546 per 100,000 total cases. The reasons for a dysfunctional health system include: gross inadequate infrastructural support, electricity, potable water and diagnostic laboratories, very low per capita health spending, high out-of-pocket expenditure by citizens, and a total absence of a community-based integrated system for disease prevention, surveillance and treatment amongst others. Some strategies to tackle health sector challenges in Nigeria may include improved access to primary healthcare; strategic and purposeful leadership in health delivery services; increasing funding to the health sector; amongst others.

Key words: Health Sector, Health Sector Reforms, Challenges and prospects

1. Introduction

The health sector in any country has been recognized as the primary engine of growth and development. But despite the laudable contributions of the health sector to economic development, the Nigerian health sector has witnessed various turbulence that has negatively revised the progress recorded at various times.

Nearly 15 percent of Nigerian children do not survive to their fifth birthday. Two leading causes of child mortality are malaria (30 percent) and diarrhea (20 percent). Malnutrition contributes to 52 percent of death of children under five. A household survey conducted by the government in 2003-2004 showed that 54.4 percent of the population is poor, with a higher poverty rate in rural area of 63.3 percent (HERFON, 2006). The incidence of poverty in Nigeria is widespread and increasing with some of the worst poverty linked health indicators in Africa. There has been a sharp increase in poverty from 1992 to 1996, with an estimated third of the population living below \$1 per day and nearly two thirds below \$2 per day (FMoH, 2005).

Some of the factors that affect the overall performance of the health system include; inadequate health facilities/structure, poor human resources and management, poor remuneration and motivation, lack of fair and sustainable health care financing, unequal economic and political relations, the neo-liberal economic policies of the Nigerian state, corruption, illiteracy, very low government spending on health, high out-of-pocket expenditure in health and absence of integrated system for disease prevention, surveillance and treatment, inadequate mechanisms for families to access health care, shortage of essential drugs and supplies and inadequate supervision of health care providers are among some of the persistent problems of the health system in Nigeria.

1.1 Problem Statement

In spite of huge government spending, coupled with bilateral and multilateral assistance in the health sector, the patterns

of health status in Nigeria mirror many other Sub-Saharan African nations but are worse than would be expected given Nigeria's GDP per capita. The health system is in shambles, policy somersault and reversals tends to have undermined several reforms in the health sector over the years. Poor human resources and policy management have led to unprecedented brain drain in the health sector as health professionals in search for better conditions of service abroad often vote with their feet in droves (FMoH, 2005). (Federal Ministry of Health).

The Nigerian health system is in comatose, few hospitals with few drugs, inadequate and substandard technology and a lack of infrastructural support, including electricity, water and diagnostic laboratories resulting in misdiagnosis. Medical record keeping is rudimentary and diseases surveillance is very poor. Delivery of health care becomes a personal affair and dependent on ability to pay for basic laboratory and physician services. These have exacerbated the disease burden (FMoH, 2004). Health care financing is worse hit especially in the poor continent where health care faces serious problem of acceptability with out-of-pocket expenditure accounting for over 70% of total private health expenditure is enough to dent the little progress of the health system made. Hence, the increasing out-of-pocket expenditure due to high disease burden on most poverty-stricken households has kept them in the vicious cycle of the poverty trap. Risk pooling in the form of private/commercial health insurance is often lopsided while the much touted social insurance is limited to those in Federal government service (HERFON, 2006).

1.2 Objective of the Study

The provision of accessible and affordable health care services on a sustainable basis in any country, including Nigeria, is an important obligation of government and the fundamental right of the citizens, through direct participation in health delivery system and good legislature on health. The government of Nigeria, through the Federal Ministry of health, has been undertaking this responsibility, but with abysmal result (FMoH, 2005). In economic parlance it is believed that health and education are the two important prerequisites for human capital development, and have been demonstrated to be the basis of individual's economic productivity. Health is the basis for job productivity, the capacity to learn in school, and the capability to grow intellectually, physically and emotionally. As with economic well being of individual households, good health is a critical input into poverty reduction, economic growth and long-term economic development at the scale of whole societies (Sachs et al, 2001).

The broad objective of the study is to assess the challenges of health sector as it is expected to provide an important role in national economic development strategy. Specifically, the study will address the following major issues:-

- (i) The problems confronting the health sector in Nigeria
- (ii) The measures to reverse the trend through reforms
- (iii) The impact of reform on the health sector and the challenges
- (iv) Health care financing for economic development
- (v) Make recommendation on the way forward.

1.3 Organization of the Study

There are seven sections in this study and there are subsections in some of the sections. Section one deals with the general introduction to the topic of research. It is further grouped into subsections. 1.1 is the problem definition, 1.2 explores the objective of the study, and 1.3 contains the organization of the study. Section 2 –Chronicled challenges of the health sector in Nigeria. Section 3 looks into health sector reform process in Nigeria. Section 4 examines to what extent, the health sector reform in Nigeria has helped in addressing the health sector challenges –achievements and gaps. Section 5 appraises the health care financing mechanism in Nigeria. Section 6 compares the status of the health sector with other sectors and its performance so far. Section 7 points the way forward while session 8 provides the references employed in the study.

2. The Challenges

The poor health status of a large percentage of people in sub-Sahara Africa is widely known for years. Over the past decade, however, Africa's health care crisis has received renewed attention because of the greater awareness of the militating factors and a greater understanding of the link between health and economic development (Lowel et al (2010). The major factors that affect the overall contribution of the health system to economic growth and development in Nigeria include inter alia; lack of consumer awareness and participation, inadequate laboratory facilities, lack of basic infrastructure and equipment, poor human resource management, poor remuneration and motivation, lack of fair and sustainable health care financing, Unequal and unjust economic and political relations between Nigeria and advanced

countries, the neo-liberal economic policies of the Nigerian State, Pervasive Corruption, Very low government spending on health, High out-of-pocket expenditure on health, Absence of integrated system for disease prevention, surveillance and treatment.

- (i) Lack of consumer awareness and participation: The majority of consumers are ignorant or unaware of available services and their rights regarding health service delivery mainly because of the absence of a bill of rights for consumers (claim holders) and providers (duty bearers). The role of the family in preventing and managing illness is also underestimated or inadequately supported by government programmes. It is now well known that interventions should be implemented through the health system as well as at the household level. The capacity of families and communities should be developed to increase awareness for meaningful participation in their health care and that of their children.
- (ii) Inadequate laboratory facilities: In many states of Nigeria, most of the laboratories in the primary and secondary health care centers require some infrastructural upgrading to provide a safe, secure and appropriate working environment. Some basic health centre laboratories are better equipped than those in comprehensive health centers and some secondary level hospitals, but equipment was often minimal. Most laboratory staff in secondary facilities were qualified as medical laboratory scientist or technicians, whereas most of those in primary health care facilities were qualified as science laboratory technicians. There is minimal quality control of laboratory test in secondary facilities and none in primary facilities because they lack appropriate professional supervision.
- (iii) Lack of basic infrastructure and equipment: Basic life-saving commodities are in short supply in most low income health systems. This is, in part, a result of resource shortages, but, there are still problems even when substantial increase in funding are available, as in the case of Global Fund to fight AIDS, Tuberculosis and Malaria. Building effective and accountable national procurement and drug management systems is an increasing prominent component of the health system action agenda.

The provision of health services relies on the availability of regular supplies of drugs and equipment, as well as appropriate infrastructure at the facility level. Facilities without safe water and electricity, with non-functioning equipments, and inadequate deliveries of drugs, diagnostic and other supplies are all too common in many states of the country. The Nigerian health system is characterized by inadequate and poorly maintained health facilities, particularly at the PHC level. Poor state of infrastructure such as buildings, equipments, materials, and supplies and inequitable distribution of available facilities is the norm in many places. In some communities, people have to travel over 5 km to access health care because sitting of structures is often based on political expediency rather than perceived need.

The drug system is plagued with 'out-of-stock syndrome'. Fake, substandard, adulterated, and unaffordable drugs are prevalent across the country. Erratic supplies, non-availability of some basis essential and specialized drugs and other health supplies as a result of dependence on imported drugs are common. In addition to this, the drug distribution system is chaotic because of adherence to pharmaceutical regulations that need to be updated. Although very vital to provision of quality service, provision of drugs and vaccines alone cannot build systems nor ensure quality of care, but without the appropriate facilities and materials to do their job, health workers cannot function. Therefore, whenever health systems cannot deliver, people turn elsewhere. This has contributed greatly to poor client satisfaction, which makes clients to turn to private sector and unqualified health workers. This poor drug supply system has also led to drug resistance, the resistance to anti-malaria drugs by the disease pathogens is clear example, (HERFON, 2006, FMoH, 2004, Travis et al, 2004).

- (iv) Poor human resources and management: Although human resources are no panacea for the poor health situation in any country, no health intervention can be successful without an effective workforce. Every country should, therefore, have a national workforce plan to build sustainable health systems to address national health needs. These plans should aim to provide access to every family to a motivated, skilled, and supported health worker. To optimize health system performance, workers should be recruited from, accountable to, and supported for work in their community where feasible. The 2003 and 2004 World Health Reports proposed improving rewards to health workers to improve productivity, along with deploying community health workers and engaging community in their health care. The 2004 report advocated using such approaches as contracting local government financing, empowering community, using vouchers, etc., to subsidize key health services for the poor.

There is currently inadequate and inequitable distribution of health personnel at various levels in Nigeria, especially in the rural and hard-to-reach areas. The provider-client relationship is also poor, while poor

incentives and compensation for health workers and structures are already worsening the brain drain syndrome and refusal of health workers to accept posting to rural areas.

- (v) Poor remuneration and motivation: Over the years, poor remuneration of health workers have had an adverse effect on their morale such that over 21,000 Nigerian doctors are practicing abroad, while there is an acute shortage of physicians in Nigeria. Health workers are paid meager salaries (about 75% lower than that of a doctor even in Eastern Europe) and they work in insecure areas and have heavy workloads, but lack the most basic resources, and have little chance of career advancement. Doctors complain of 'brain waste' and seek better opportunities for professional development in countries with better medical infrastructure. Nigeria is one of the several major health-staff-exporting countries in Africa. For example, 432 nurses legally migrated to work in Britain between April 2001 and March 2002, out of a total of about 2000 legally emigrating African nurses, a trend perceived by Nigeria's government as a threat to sustainable health care delivery (Lambo, 2006).
- (vi) Lack of fair and sustainable health care financing: Beyond the level of spending, the key questions concern how the health system is financed and what proportion of contributions comes from users themselves, either through out-of-pocket expenditure or through insurance payments. The WHO is promoting the principle that whatever system of financing a country adopts should not deter people from seeking and using services. In most cases, this will mean that payment at the point of service will need to be eliminated, or at least be related to ability to pay. The financing system should also, as a minimum, protect people from catastrophic expenditure when they become ill, promote treatment according to need, and encourage providers to offer an effective mix of curative and preventive services.
- (vii) Pervasive Corruption: Corruption has often manifested in Nigeria's health sector through the supply of fake drugs, substandard equipments, willful misdiagnosis of diseases, sharing of unallocated budget funds, inflation of contracts, diversion of drugs, favoritism in treatment and appointments based on political patronage. Some examples abound: a consignment of vitamin A supplement by the Canadian government through its bilateral assistance to Nigeria was diverted in 2008 and it is now found in most itinerant chemist shops across the country (UNICEF, 2007). A former minister of health, Adenike Grange was sacked in 2008 for her complacency in the sharing of N300 million unallocated health sector fund. Corruption deprives the economy in general and the health sector in particular of vitally needed funds (Thisday, 2008). It has been estimated that Nigeria lost £225 billion to corruption over the period. Nigeria's Debt Management Office (DMO) has also indicated that the country wasted US\$300 billion during the period (World Bank, 2006, DMO, 2006).
Given the pervasiveness of corruption in Nigeria's national life and its acknowledged consequences for development and good governance, the consequences of corruption for public and private health is a matter of major interest to health professionals and social scientists. Some observers of the pervasiveness of corruption in African countries have suggested that it should be treated as a disease that afflicts the African condition. While this has been rightly criticized for its racist undertones of the observation, there is, no doubt, that corruption is symptomatic of the level of anomie that characterizes a society which can be treated as a major problem of health sector growth and development.
- (viii) Very low governments spending on health: According to Central Bank of Nigeria reports, federal government health spending increased from the equivalent of US\$141 million in 1998 to the equivalent of US\$228 million in 2003. Health spending as a proportion of total federal spending decline between 1998 and 2000, but increased in subsequent years, reaching 3.2% in 2003. Most federal health spending goes to teaching and specialized hospitals and federal medical centres. State spending on health is currently around 6.3% of total spending, estimated for 2003 at about US\$420 million or US\$3.50 per capita. Like federal spending, state health spending is concentrated on the main area of state responsibility, secondary hospitals, and is also most likely on personnel. For 2003, the data available showed that spending on health was equivalent to US\$300 million or US\$2.45 per capita. Like other levels of government, most health spending by local governments is on personnel (World Bank CRS, Nigeria, 2005).
- (ix) High out-of-pocket expenditure on health: This has further exacerbated the pauperization of the adverse economic condition of the poor. The 2004 Nigeria Living Standard Survey (NLSS) collected data on household health expenditures from a representative sample of 19,159 households. The estimate from these data of average annual per capita out-of-pocket spending on health is Naira 2,999, equivalent to around US\$22.50. The survey data indicate that this out-of-pocket spending on health services accounts for 8.7% of total household expenditures. This health spending includes expenditure on outpatient care, transportation to health care facilities and medication. This is one of the largest share of health expenditure out of total household expenditure in developing countries.

Over the years, government resources dedicated to health are extremely low in Nigeria. According to World Health Organization (WHO; 2004), private health spending represents the largest proportion of total health expenditures in Nigeria. In 2004, private out-of-pocket health expenditure was equal to nearly 70% of total health expenditure in Nigeria. Prepaid plan represent around 5% of total health spending. Government health expenditures represent 30.4% of total health expenditure for the period.

- (x) Absence of integrated system for disease prevention, surveillance and treatment: This has manifested in the lack of targeted efforts at outreach, health promotion and disease prevention activities designed to reach the people where they are. This has resulted in low immunization coverage, pre-natal care and screening. Public health, where it exists, is in a passive mode, with little activity designed to motivate people to change their behavior or to adopt attitudes and practices that reduce their risk to disease. The result is that many children are still not immunized, pregnant mothers do not receive the pre-natal care they need, older men and women do not have the regular screening they need for blood sugar and cholesterol, for breast and cervical cancer. When health professionals refer to low incidence rate for cancer in Africa, they forget that what is not screened for is not reported. Given the extremely low screening rates for cancer, diabetes, hypertension and other chronic and communicable diseases, no wonder the reported incidence and prevalence rate are low too!

3. Health Sector Reforms in Nigeria

Health sector reform is defined as the fundamental change in policy, regulation, financing, provision of health services, re-organization, management and institutional arrangements, which is led by government and designed to improve the performance of the health system to attain a better health status for the population. (Regional Committee, WHO African Region, 1999).

According to World Health Organization, (1995), health sector reform is defined as a sustained process of fundamental change in policies and institutional arrangements, guided by government, designed to improve the functioning and performance of the health sector and ultimately the health status of the population.

The goals of reform are to make health care accessible and, therefore, equitable, affordable, cost-effective, and cost-efficient. It also includes the reduction of the disease burden, particularly due to the malaria scourge and the HIV/AIDS epidemic and various other communicable and chronic diseases in general (FMoH, 2004; FRN, 2004; NACA, 2002). It is the duty of the government to provide the citizenry with accessible, affordable, qualitative, efficient and effective healthcare system. Against this background, the Nigerian government has adopted various national health policies and reforms. Health policy reforms are specifically designed to facilitate the achievement of stated health programme goals and objectives. They are meant to help in strengthening the elements of the enabling environment for better health so as to make the implementation of health programmes achieve their objectives in terms of coverage, equity, efficiency and effectiveness. These include: safe water and sanitation, food security and nutrition, health care, especially primary health care, education especially that of women, purchasing power; decent housing, family planning, cultural consideration (World Bank, 1994).

There are different strategies for reform, and these include decentralization and centralization, substitution policies, redefinition of functions of hospitals and primary care centres, creation of new roles for professionals, improved management, cost-containment, and orientation. No matter the strategy adopted, the aim of a reform is to provide health care that is oriented towards outcomes, based on evidence, and focused on effectiveness and efficiency. It is to increase availability and accessibility of services, client/patient satisfaction, and quality of care.

The health sector in Nigeria has witnessed several policy and institutional reforms, particularly since the enunciation of the National Health Policy (NHP), a strategy to achieve health for all Nigerians in 1988. This development has, in essence, been a vindication of government's readiness to demonstrate its real commitment to the attainment of the desired goal of a level of health that would enable all Nigerians to achieve socially and economically productive lives (Aregbeyen, 2001, Olaniyan, 1995)).

The response of FMoH to the unacceptable health conditions in Nigeria through increased commitment and willingness was undertaken to achieve a comprehensive health sector reform. A new reform commenced in 2003 within the context of the National Economic Empowerment and Development Strategy (NEEDS), MDGs and NEPAD. The National Health Policy which was revised in 2004 created the reform environment whilst the health sector reform programme 2004 established the framework including goals, target and priorities that should guide the action and work of the FMoH and, to some extent, those of State Ministry of Health (SMoH) and health development partners over a four-year period (2004-2007). The document describes the direction for strategic reforms and investment in key areas of the national health system (FMoH, 2004).

In 2004, the Federal Government launched the National Economic Empowerment and Development Strategy (NEEDS), in it the government promised to “improve the health status of Nigerians as a significant co-factor in the country’s health sector reform aimed at strengthening the national health system and enhancing the delivery of effective, efficient, quality and affordable health services to Nigerians”. The federal government explained that the reform was aimed at raising life expectancy in Nigeria to 65 years and reducing infant mortality to 50 per 1,000 births.

The policy thrust includes:

- a) To improve Government performance of its stewardship role of policy formulation, health legislation, regulation, resource mobilization, coordination, monitoring and evaluation. The WHO defines stewardship as the oversight role of the state in shaping, regulating and managing health systems. Government is expected to provide public and private health system actors with an overall policy direction, to create conditions that allow them to do their jobs and ensure oversight across the whole system with particular attention to equity concerns. Stewardship is also often used to describe the more political function of the State in relation to health systems.
- b) To strengthen the National Health System and improve its management.
- c) To improve the availability and management of health resources (financial, human, infrastructure, etc).
- d) To reduce the disease burden attributable to poverty, diseases, and health problems including, malaria, tuberculosis, HIV/AIDS and reproductive ill health.
- e) To improve the populations’ physical and financial access to quality health services through the:
 - i) Establishment and institutionalization of a system for quality assurance;
 - ii) Registration and regulation of traditional and alternative health care providers;
 - iii) Establishment of a reliable system for the procurement, distribution, and management of drugs and medical supplies;
 - iv) Establishment of a system that will regulate the location, practice and quality of human and material resources in both public and private health facilities, and to strengthen regulatory mechanisms, including professional codes of conduct.
- f) To increase consumer’s awareness of their health rights and obligations, and
- g) To foster effective collaboration and partnership with all health actors

The expected results from these policy thrust was equally outlined with plans of action. There have been some achievements but other challenges still remain. Improving access to health care services and infrastructure, especially for the poor is feasible if the new health sector reform programme is pursued vigorously with focus and sincere commitment from the presidency and the implementers. The key challenges are the effective revitalization of PHC and getting the health bill, which defines the role of the different levels of government passed by the relevant bodies into law.

The current Federal government plans to tackle the disturbing health scenarios through the adoption of several health policy options aimed at the transformation of the health system. These measures are encapsulated in the human capital development (health and education) policy plan of action of its 7-point agenda.

In its health policy reform implementation plan of action towards the realization of human capital development, it notes that: “The provision of health, education and functional social safety nets are absolutely essential to achieving desirable human capital outcomes. Human Capital outcomes in Nigeria lag behind other countries at similar stages of development. The country’s dismal health system is ranked 191 out of 201 in the comity of nations, according to the World Health Organization. ...Infant mortality rate is 260 deaths/1000 live births in the North Western and North Eastern parts of Nigeria. This is one of the highest anywhere in the world. About 2.6 million or 4.4% of 15-49year olds are living with HIV/AIDs (FGN, 2007).

One of the several health policy options to be adopted would be to domesticate the sectoral transformation in order to model globally acceptable health transformation around our unique national culture and institutions. Structural transformation will emphasize on strengthening the management capacity of the National Primary Health Care Development Agency (NPHDA) to co-ordinate Primary Health Care (PHC) Policy, re-establishment or enthronement of the health referral system within 24 months in every state. It will also require improving human resources for tackling maternal and child mortality, and mobilizing additional resources to address funding gaps for health sector programmes. In addition, all public funded health agencies should align their expenditure with key priorities that address basic health services, with effective pro-poor services at secondary and tertiary levels.

Despite the health sector policy reform in Nigeria, institutional reforms were also prominent;

Institutional reforms in the health sector are needed to strengthen the sector’s institutional capacities and management practices of federal, state and local government levels in order to enhance efficiency, effectiveness, transparency and equity in the provision of health care services. Moreover, health sector reforms cannot be very effective

without the required institutional arrangements that are conducive to the attainment of stated health programme goals and objectives. Such arrangement would for example enhance inter-agency approach to the promotion, delivery and management of health care services. An effective institutional reform must address the three (3) critical areas below:

- a) Organizational change –effective organization
- b) Financing change –financial sustainability
- c) Service delivery change –service delivery function.

a) Organizational change:

This entails a process of ensuring a more purposeful, result oriented, cost effective and sustainable health care delivery system that can be achieved if changes are made to respond to prevailing health issues. Some changes have been made in the health sector in response to the many intractable health issues in the country. They include professionalization of the health ministries, decentralization and institutional pluralism and intersectoral cooperation.

Professionalization of the health ministry's have revealed through experience that health system cannot be run efficiently without skilled managers required for planning, programming and budgeting. Such skills are required to translate policies into implementable projects and programmes and also to ensure the availability of human and material resources. Since managers with such skills are often lacking in most ministries, the federal government in response to this need, professionalized all ministries both at the federal and state levels following the 1998 civil service reform in the country. Consequently, eight and five departments were established in each ministry at the federal and state levels respectively. The federal level department, which is Federal Ministry of Health (FMoH) is as follows:

- i) department of primary health care
- ii) department of population activities
- iii) department of disease control and international health
- iv) department of hospital services and training
- v) department of drug and food administration and control
- vi) department of finance and supplies
- vii) department of health management
- viii) department of planning, research and statistics

The National Health policy (NHP) provides for the appointment of Local Government Health Committees (LGHCs) in each LGA for the purpose of facilitating the delivery of health services to the communities and to enhance community participation. The establishment of the State Hospital Management Board (SHMB) was informed by the need to promote efficiency, effectiveness and transparency in the management of state-owned hospital. The SHMB function under the general supervision of and the policies established by the State Ministry of Health (SMoH), and is responsible for management of hospitals which comes under the jurisdiction of the SMoH.

Decentralization is meant for the devolution of decision making responsibilities to the point of service delivery so as to afford an effective implementation of health programmes. This has become important because local government authorities (LGA's), Non-Governmental Organizations (NGOs) and communities are becoming increasingly involved in priority-setting and decision making. Decentralization brings decision-making nearer to the grassroots and gives opportunity to those who understand the problems of the local communities to be directly involved in the planning and execution of programmes meant to benefit such communities. Furthermore, it enhances community participation which gives room for the adaptation of health programmes to local cultures and traditions in contrast to the hitherto top-down programme that sought to change behavior, thereby disregarding the socio-cultural concerns of the communities. This has informed the thinking that prompted the Federal Government to make PHC delivery services the primary responsibility of the local government areas in Nigeria.

Institutional pluralism and inter-sectoral cooperation is vital because improving health services management as well as institutional reforms in the health sector alone cannot bring about better health, rather, other social and economic sectors concerned with state and community development and whose activities directly and indirectly impact on health should be encouraged. Hence, the national health care system in Nigeria emphasizes a coordinated health care system which encourages; the federal, state and local governments to coordinate their efforts in order to provide the citizens with effective health services at all levels; cooperate with private voluntary and non-governmental organizations which provide health care to ensure that the services provided by these other agencies are properly coordinated with those of governments and are in line with the overall national health policy; the involvement and coordination of the activities of all sectors related to health and all aspects of national and community development in particular agriculture, animal

husbandry, rural development, food industry, social development, housing, water supply, sanitation and communications (FMoH, 1988).

b) Financing Change:

This involves the various reforms through which the government seeks to make health care system affordable, accessible and financially sustainable to the people. That the poor in Nigeria lack easy access to basic health care services and receive low quality medical care due to their inability to pay for quality medical care is a truism that should not be overlooked (Aregbeyen, 1992). This is why it is stipulated in the Nigerian National Health Policy that "government of the federation shall explore avenues for financing the health care system" (FMoH, 1988). Previous reforms in health care financing in Nigeria includes -reallocation of public expenditure in line with identified priorities, appropriate pricing policy and NHIS and community financing.

Reallocation of public expenditure in line with identified priorities is concerned with the fact that the common causes of morbidity in Nigeria are still preventable infectious and avoidable disease; government is encouraging the shift of investment to preventive services from the hitherto high investment on curative services which had often been to the detriment of preventive services.

Appropriate pricing policies arises from the experience of the down-turn of the Nigerian economy during the last two decades resulted in a decline in the funding of many vital sectors of the economy including health. Since government can no longer bear the burden of providing certain health care services alone as a result of financial constraints, and to ensure an uninterrupted provision of adequate, regular and high quality services, minimal fees which are in fact less than the cost of providing such services are charged. Such services includes laboratory and ancillary services, surgical operation fees, private/special admission facilities, private ambulance use, mortuary services, hospital bed and feeding services, specific ante-natal care and so on (Aregbeyen, 2001).

c) Service Delivery Change:

Service delivery change reform in the health system is aimed at improving the quality of care and consumer satisfaction, ensure efficiency in the use of resources as well as enhance clinical effectiveness and to ensure equity and access to health care and thus promote social well-being. Some of the important health care services delivery reforms in operations in the country are -priority setting and essential health service packages

Priority setting involves various actions directed towards those in vulnerable groups who may be marginalized if they are left to the competitive market. Hence, commitments to the provision of such services are in accord with the goal of health equity which closely correlates with efficiency consideration. An example of priority setting/targeting is the national programme on immunization against the major infectious diseases which is specially directed towards the eradication of the six childhood killer diseases (diphtheria, pertussis –whooping cough, polio myelitis, measles, tetanus and tuberculosis). So also is family planning which is directed towards the reproductive group.

Essential health services packages reform was adopted in pursuit of the goal of health for all Nigerians and certain health care services delivery reforms were enunciated. These include:

- i) The Primary Health Care (PHC) Scheme -the adoption of the PHC system was a major development in health policy reform in the country. Consequently, the national health system has since been based on primary health care. The concept of PHC clearly articulates the need for multisectoral linkages and community participation, not only to bring about individual health care but more importantly, to cater for the health of communities on an area-wide basis.
- ii) The revolving fund scheme -the drug revolving fund scheme was introduced following government's adoption of the Bamako Initiative in March, 1990 in order to alleviate the problem of persistent shortage of drugs in public health care facilities. The principle objective of this reform is to ensure a self-sustaining supply of drugs and to provide continuity in funding the purchases, utilization and evaluation of essential drugs (Aregbeyen, 2001, Berman, 1995).

4. Some Major Achievements of the Reform

Government has made some key achievements in the implementation of the health sector reform programme towards the attainment of the health MDGs. These achievements are summarized as follows.

1. To provide a favourable environment for the establishment and implementation of the Health Sector Reform Program (HSRP), the National Health Policy was revised in 2004 and approved by the Federal Government

and National Council on Health (NCH), providing favourable platform for addressing most of the issues already highlighted. The stewardship role of the FMOH has been defined in the national policy to consist of three basic tasks:

- a. Setting an explicit health policy framework
 - b. Exerting influence and ensuring compliance through regulation, and
 - c. Generating a reliable information base system for informed decision-making and performance assessment
2. A National Health Sector Reform Program has been formulated approved by the Federal Government and signed into law and is currently being implemented.
 3. A number of new national policies have also been developed in many areas; health promotion, public-private partnership in health, traditional medicine practice, national health equipment, national health management information system, national drug policy, national food and nutrition policy, integrated disease surveillance and response, child health, blood transfusion service policy, among others.
 4. In addition to these, FMOH has developed a national health care finance policy and a national human resource policy to guide health care financing and human resource planning and management for the country.
 5. Development of cost medium-term strategic plans for routine immunization, VVF control, health sector response to HIV/AIDS, TB control, malaria control, and adolescent health and development are in progress.
 6. Launching and implementation of National Health Insurance Scheme, (NHIS), aimed at improving access of the people to quality health care at the three levels of care.
 7. An increasingly effective NAFDAC is reducing the menace of adulterated and sub-standard drugs and foods, resulting in greater availability of quality drugs and establishment of pharmacovigilance.
 8. Blood supply and screening is largely ad hoc, but a number of centralized transfusion centres are being established. The government is making efforts to address the blood supply situation in order to reduce the risks of transmitting infectious diseases, particularly HIV, through transfusion. Government also has opened some of the planned seven centralized transfusion centres where screening will be routine and standardized.
 9. A National Health Bill was presented by the Federal government to the National Assembly in 2004, this bill codifies the structures of the 1988 Health Policy, answers some of the implementation questions raised by the NEEDS, and the MDG program, particularly the division of responsibility between the federal, state and local governments, with a significant role in primary health care for the federal government.
 10. There is a steady increase in numbers of health professionals produced in Nigeria and serving Nigeria's healthcare needs. There were reported 31,000 physicians in 2001, produced from the 15 medical schools in the country. The number of newly trained nurses and midwives was reported to be about 95,000 nurses and 70,000 registered midwives.

4. 1 Gap in Reform and Outcome

1. Developing and ensuring the availability of nationally acceptable integrated data management tools. The HSRP document of the current administration makes the following observations in relation to health information: "...the FMOH is accountable for the health of the nation, it is imperative that it sets goals for the entire nation and monitors progress. This is not yet happening ...There is an ineffective and fragmented information system in place ..." The health management information system is weak and has not been able to provide adequate data and evidence for policy/programme development and implementation.
2. Putting in place clearly defined mechanisms for intra and inter-sectoral relationships for better coordination, collaboration, and partnership. The coordination committee, made up of key stakeholders set up to monitor progress of the reform process, is currently not functioning.
3. Marketing and giving adequate technical support to states, the private sector and other stakeholders to adapt and utilize the tools already developed at the federal level to create appropriate institutions, and to drive and speak the same language of reform at all levels.
4. In spite of the apparently more visible attention to Primary Health Care (PHC), Nigeria's MCH health status indicators have not been particularly encouraging over the years. Studies suggest that inconsistent policies, implementation of uncoordinated and highly fragmented vertical programmes, which have high short-term impact but largely unsustainable, as well as poor funding and lack of political will by governments at all levels, are some of the causes of these problems.
5. There are defective basic infrastructure and lack of logistics support in most public health care facilities: This situation is attributed in part to inadequate maintenance of buildings, equipment, vehicles and infrastructure

thereby aggravating the problems of unreliable supply of water, electricity, medical supplies and drugs which is a manifestation of poor funding.

6. Inefficiency and waste in the management of health care services as well as inadequate basic health statistics. While the lack of reliable statistics poses a major handicap at all stages of planning, monitoring and evaluation of health services, inadequate capacity development and resource constraints often result in the failure to achieve results and inability to meet set targets.

5. Health Care Financing in Nigeria

Health financing refers to the collection of funds from various sources (e.g; government, households, businesses, and donors) pooling them to share financial risk across larger population groups and using them to pay for services from public and private health care providers. The objectives of health financing are to make funding available, ensure appropriate choice and purchase of cost-effective interventions, give appropriate financial incentives to providers and ensure that all individuals have access to effective health services.

The level of government expenditures in the Nigeria health sector over the years tells a story of neglect. Before the civilian government came into power in 1999, the annual government expenditures on health was \$533.6 million in 1980 after which it nose-dived, reaching a trough of \$58.8 million in 1987. By 1999, significant increases in health expenditure were noticed, reaching a peak in 2002 at \$524.4 million (HERFON, 2006, CBN, 2006)

The major sources of finance for the health sector in Nigeria are the three tiers of government (Federal State and Local Government), public general revenue accumulated through various forms of taxation, the health insurance institutions (private and public), the private sector (firm and households), donors and mutual health organizations. Table 2.3.3 shows that private and household expenditure on health between 1998-2002 was the highest with an average of 69.1% and 64.3%, while government expenditure in the same period was a paltry 20.6%. Donor's average expenditure in the period was 10.3%, while firms input were 4.9% respectively (Soyibo et al, 2005).

Table 1: *Distribution of Nigeria's Total Health Expenditures and by Source (%)*

Source	1998	1999	2000	2001	2002	5-year average
General govt health exp	15.0	16.6	18.8	27.2	21.6	20.6
Federal	9.7	9.4	10.6	17.6	12.4	12.4
State	3.9	3.6	6.3	8.0	7.4	6.2
Local	1.4	3.6	1.9	1.7	1.8	2.0
Private expenditure	72.0	69.5	65.0	67.2	72.3	69.1
Firms	2.7	3.5	4.7	5.7	6.4	4.9
Household	69.2	66.0	60.3	61.5	65.9	64.3
Donors	13.1	13.8	16.2	5.6	6.1	10.3

Source: *Computed from Soyibo et al (2005)*

Public health facilities in Nigeria are financed primarily by the public through tax revenue. The federally collected revenue consist of crude oil and gas export proceeds, petroleum profit tax, royalties and the related proceeds of domestic crude oil sales/other oil revenues, companies' income tax, customs and exercise duties, value-added tax (VAT), tax on petroleum products, education tax, and other items of independent revenues to the federal government. On the other hand, as part of the internally generated revenues, states have rights to capital gain tax, personal income tax excluding those on armed forces, (external affairs officers, residents of Federal Capital Territory and Nigerian police), stamp duties, capital transfer tax, pools betting and betting taxes, motor vehicle and driver licenses. Similarly, sources of internal revenue for Local Government Areas are license fee on television set and wireless radio and market and trading fees/licenses.

The share of the Federal Government from the federation account has created a lopsided budgeting allocation amongst three tiers of government and this has equally affected the allocation from lower tiers of government to the health sector. There has been a call for fiscal federalism; a situation that is believed will improve the situation.

5.1 Health insurance/resource pooling.

Resources pooling mechanism or pooling of resources refers to "the accumulation of health assets on behalf of a

population". By pooling of resources, the financial and health risks are spread and transferred among the population. By pooling, the financial resources are no longer tied to particular contributor. The essence of "health insurance" is the pooling of funds and spreading the risk for illness and financing.

The various types of resources pooling mechanism are social insurance (such as the National Health Insurance Scheme (NHIS), Private insurance and community based insurance scheme.

- a) National Health Insurance Scheme. The National health insurance scheme (NHIS) is a corporate body established under act 35 of 1999 by the federal government of Nigeria to improve the health of all Nigerian at an affordable cost. At present, the programme covers only federal government employee. Contributions are earnings related and currently represent 15% basic salary. The employer is to pay 10% while the employee will only contribute 5% of basic salary to enjoy the benefit package. The contributions made by/for an insured person entitled him or herself, a spouse and four children under the age of 18 years to full health benefit. There are health maintenance organizations that ensure that the affiliated providers provide health care services to the contributor who registers with their organizations through their employer or directly as the case may be. Health care providers under this programme are either paid by capitation or fee-for-services.
- b) Community health insurance. Community based health financing or community financing for health is referred to as a mechanism whereby households in a community (the population in a village, district or other geographical area, or a social-economic or ethnic population group) finance or co-finance the current and/or capital costs associated with a given set of health services, thereby also having some involvement in the management of the community financing scheme and organization of health services.

There may also be various forms of community financing; a scheme can involve the direct payment of health services or health services inputs such as drugs, the payment of user fees for services organized via the scheme, or community based health insurance. Community health insurance is common denominator for voluntary health insurance schemes that are labeled alternatively as mutual health insurance schemes (mutual health organization, HMO) and medical aid societies or medical aid schemes. The common characteristics however are that they are run on a non-profit basis and they apply the basic principle of social health insurance.

- c) Private health insurance. Private health insurance (PHI) is funded through direct and voluntary pre-payments by insured members. Benefit packages depend on insured people's contributions. In Nigeria, approximately one million individuals hold private insurance, that is, around 0.8% of the population. However, the private health sector is expanding across the country.

Private health insurance in one way might reduce the out-of-pocket (OOP) expenditure and evolve in the long run towards a broader social health insurance system. Unless majority of the people is covered by the social health insurance or tax based financial health systems, there is a need to have appropriate regulation of private health insurance schemes to ensure the basic principles of solidarity, solvency requirements, cross-subsidization and control of exclusion (Ogunbekun et al, 1999).

Private health insurance financing may also be in the form of servicing of medical retainer-ship. This is an arrangement under which workers and specified dependants obtain medical treatment in designated hospitals at the expense of their employers.

5.2 Out-of-pocket health financing.

Out-of-pocket health expenditure is another form of private health financing. Out-of-pocket health expenditures are payments for health services at the time of illness (that is, out-of-pocket expenditures), often levied on essential interventions. Experience has taught repeatedly that user fee end up excluding the poor from essential health services, while at the same time recovering only a tiny fraction of cost. Out-of-pocket health expenditures can represent a large and sometimes catastrophic burden on a household. An overall trend on OOPs is that consultations and medications are the most costly to individuals relative to other health related expenses. However for the non-poor, hospitalization is on average more costly than medications (Ogunbekun et al, 1999).

5.3 Strategic purchasing.

Strategic purchasing requires that the insurance agency or agency managing insurance fund must make various arrangements for purchasing services from health care providers on behalf of insured consumers. Health care providers from national public or private health care systems should ensure that the health care packages which they provide have to be responsive and financially fair. This can be achieved through strategic purchasing.

The successes in strategic purchasing depend not only on what types or mixes of health care interventions to buy, but also from whom to buy and how to buy them. Good purchasing contributes to achieving health sector policy goals by ensuring that funds are allocated and used effectively. Strategic purchasing of an appropriate set of interventions requires a continuous search for the best interventions to purchase, the best providers to purchase from and also the establishment of the best payment mechanisms and contracting arrangements. The provision of competition, either between providers or, more rarely, between financiers of health care, is already being used as a strategy to finance health reform programmes in Nigeria. There are evidences across the country of the effective implementation of public-private-partnership in financing and provision of health services.

5.4 Donor/foreign aid health financing.

Donor health funding is a form of health financing which is required to fill the domestic health sector savings-investment gap. Even if poor countries allocate more domestic resources to health, this would still not resolve the basic problem, because poor countries lack the needed financial resources to meet the most basic health needs of their populations. At \$30 to \$40 per capita for essential interventions, basic health costs would represent more than 10% of GNP of the least developed countries, far above what can be mobilized out of domestic resources.

With the return of the country to democratic governance in 1999, and subsequent lifting of economic sanctions, donor interest in Nigeria has been increasing. This is likely to reverse the declining trend in external assistance and hence lead to increased funding to the Nigerian economy. In particular, total external assistance, which was estimated at \$375.1 million in 1994, declined to \$83.4 million in 1998 and rose by 87% (to \$156.0 million) in 1999 and \$185.9 million in 2000.

Aids assistance to Nigeria has been through investment projects with technical cooperation component, free standing technical cooperation (FTC), and concessional loans and grants. Investment project assistance remains the major source of external assistance to Nigeria, with its share at 52.4% in 1997, increasing to 56.5% in 1998 and 58.2% in 1999. Government macroeconomic reforms attracted some support under programme budget assistance; which amounted to 1.4% external assistance in 1998 (HERFON, 2006).

5.5 Debt relief health financing.

Debt relief is another method of health financing in low-income countries through deeper debt relief with the savings allocated to the health sector. The heavily indebted poor countries (HIPC) initiative will reduce debt servicing by around 2% of GNP for some 30 heavily indebted poor countries, and perhaps around one-fourth of that will be allocated directly to the health sector. Given the outstanding results of the first phase, in terms of channeling debt savings into social expenditure, there seem to be additional initiatives worth taking, although it would entail further bilateral financial support for strengthening the HIPC initiative.

Nigeria was able to negotiate her exit from the burden of debt overhang of her various creditor institutions, which created about \$18 billion in savings from debt servicing. Government has committed itself to spending such savings on social and economic development such as health, education, agriculture, and infrastructure (HERFON, 2006).

6. Comparism of Health Sector with other Sectors

Federal government capital expenditure on health has not been significant over the years. In the Abuja Declaration which Nigeria and other 43 other African countries signed, in 2001, they committed themselves to spending 15% of their annual budgets on public health, but this has not been achieved over the years as the Nigerian government continues to pay lip service to the funding of the nation's health services system.

Table 6.1.1 and 6.1.2 below shows Federal Government capital and recurrent expenditures to the health sector between 2003 and 2007. The federal government capital expenditure on health were N6.4 billion (2.6%) in 2003, N18.2 billion (5.2%) in 2004, N21.8 billion (4.2%) in 2005, N32.2 billion (5.8%) in 2006 and N41.8 billion (5.5%) in 2007, a clear downward trend. The health sector total capital expenditure in the period 2003-2007 was 5.0% compared with allocation to agriculture, (13.7%), education (6.5%), administration, (33.1%), economic services, (47.9%). Funding to the health sector got to its peak in 2006 after which it started to decline in subsequent years.

The WHO's Commission on Macroeconomic and Health has estimated that most developing nations need to spend \$30 to \$40 per person a year to reach the United Nations' Millenium Development Goal, Nigeria's annual per capital spending is only about \$20. This is far less than the minimum of \$34 per capital to deliver essential services package as recommended by the commission on macroeconomics and health.

Table 2: Federal Government capital expenditure, 2003 – 2007 (=N= Billion)

Units/Year	2003	2004	2005	2006	2007	Total	% Total
Administrative	88.0	137.8	171.5	185.2	220.9	803.4	33.1
General administration	66.7	109.0	132.6	152.8	181.1	642.2	26.5
Defence	10.7	8.7	16.8	15.7	22.5	74.4	3.1
Internal security	-	18.2	17.8	12.6	10.6	59.2	2.4
National Assembly	2.0	1.9	4.3	4.1	6.7	19.0	0.8
Economic Services	98.1	167.8	265.0	262.2	367.9	1,161.0	47.9
Agriculture and Natural Resources	8.5	38.7	60.3	89.5	136.3	333.3	13.7
Transportation and Communication	6.6	7.0	15.6	8.2	11.3	48.7	2.0
Others	45.9	60.1	84.8	81.8	97.2	369.8	15.3
Social and Community Services	55.7	30.0	71.3	78.7	131.1	366.8	15.1
Education	14.7	9.1	31.9	32.7	68.3	156.7	6.5
Health	6.4	18.2	21.8	32.2	41.8	120.4	5.0
Others	34.6	2.8	17.6	13.8	21.0	89.8	3.7
Transfers	-	15.7	11.5	26.3	39.4	92.9	3.8
Capital Supplementations	-	15.7	11.5	26.3	39.4	92.9	3.8
Add(i) External Loans/drawdown	11.3	-	-	-	-	11.3	0.5
Total	241.8	351.3	519.4	552.4	759.3	2,424.2	100.0

Sources: NBS, CBN (Statistical Bulletin) and Federal Ministry of Finance, 2008

Table 6 3: Recurrent expenditure of the Federal Government, 2003 – 2007 (=N= Billion)

Units/Year	2003	2004	2005	2006	2007	Total	% Total
Administrative	307.9	306.8	434.7	522.3	699.5	2,271.2	35.5
General administration	166.1	101.3	248.7	284.6	395.6	1,196.3	18.7
Defence	51.0	76.3	71.7	84.2	99.7	382.9	6.0
Internal security	68.4	97.8	82.0	118.0	153.3	519.5	8.1
National Assembly	22.4	31.4	32.3	35.5	50.9	172.5	2.7
Economic Services	96.0	58.9	64.2	79.7	115.2	414.0	6.5
Agriculture	7.5	11.3	16.3	17.9	28.0	81.0	1.3
Construction	16.9	14.9	17.9	20.1	25.8	95.6	1.5
Transportation and Communication	22.7	8.1	8.0	9.8	17.8	66.4	1.0
Other Economic Activities	48.9	24.6	22.0	31.9	43.6	171.0	2.7
Social and Community Services	102.7	134.4	151.7	194.2	247.4	830.4	13.0
Education	64.8	76.5	82.8	119.0	136.9	480.0	7.5
Health	33.3	34.2	55.7	62.3	89.6	275.1	4.3
Others	4.6	23.7	13.2	12.9	20.9	75.3	1.2
Transfers	477.7	610.6	670.7	594.0	527.2	2,880.2	45.0
Public Debt Charges	363.3	382.5	394.0	249.3	213.7	1,602.8	25.1
Domestic	169.7	188.8	200.3	130.9	110.5	800.2	12.5
Foreign	193.6	193.7	193.7	118.4	103.2	802.6	12.5
Pension and Gratuities	34.1	72.2	84.1	101.2	106.2	397.8	6.2
Other/Other CFR Charges	79.9	78.0	97.5	99.9	29.3	384.6	6.0
Total	984.3	1,110.7	1,321.3	1,390.2	1,589.3	6,395.8	100.0

Sources: NBS, CBN (Statistical Bulletin) and Federal Ministry of Finance, 2008

Furthermore, Government recurrent expenditures are a subject of worry. Between 2003 and 2007, recurrent expenditures constitute an average of 4.3 % of total government expenditures on health. During 2003 – 2007 an annual average of 35.5% total government expenditures on health went to recurrent items (table B). These were mainly for personnel costs, with little left for tools and materials. The Federal Government annual recurrent expenditure on health were N33.3 billion (3.4%) in 2003, N34.2 billion (3.0%) in 2004, N55.7 billion (4.2%) in 2005, N62.3 billion (4.5%) in 2006 and N89.6 billion (5.6%) in 2007 respectively. The average percentage of recurrent expenditure in the period 2003-2007 stood at 4.3% compared with education, (7.5%).

7. The Way Forward

The Federal Government should explore ways towards improving access to primary health care. Extending the reach of primary health care and improving its performance requires action on several fronts' simultaneously-including new delivery models to increase access, a greater role for nonprofit and private organizations in service delivery, and the introduction of performance incentives to improve it.

There should be a ban on the financing of government officials going overseas for medical treatment. It is very wrong. Taking cue from the practice in Saudi Arabia, which I think could be very helpful in this country, is that no matter the kind of illness anybody, even the king of Saudi Arabia has, nobody sends him overseas for treatment. What they do is to import any machine required. If they don't have the manpower that can handle it, they would import the manpower as well so that when that VIP recovers, other people can use the same machine. But here, one person runs abroad, spend the whole money that can build a hospital just on one person and at the end of the day, nothing comes to the people.

Better mind-sets and behaviour. Pay-for- performance bonuses and other incentive programs would motivate health workers to provide high-quality care efficiently. Improved delivery of supplies would reduce frustration. Better management capabilities would help ensure that workers were paid on time. To further improve the attitudes of health workers, the system should give them management training and other skill-development opportunities and a more supportive working environment. A mind-set shift among patients is needed as well so that they seek needed treatments more promptly. The presence of community health workers in each village may help change the mind-sets by making patients see that the health system is addressing their immediate needs. Experience in other sub-Saharan countries suggest that many of them face similar problems.

The systems delivering health to Nigerian people need a radical reform, with clear explicit goals against which progress can be measured not just by bureaucrats but also by the common people. Examples of such targets could be a 20% reduction in maternal mortality over the next 5 years or putting 100,000 people living with HIV/AIDS on treatment in the next 3 years. The health of the Nigerian people should no longer be measured in terms of how many health centres are built or how many teaching hospitals are refurbished or indeed how many tones of fake drugs are burnt, but in terms of real quantifiable change in disease burdens and mortality. Can we reduce the number of children who dies from vaccine preventable diseases such as measles and polio? Can we eradicate guinea worm? Reform in health sector, should not be vague rhetorical term that means nothing to the average Nigerian but a collection of measurable policies and strategies with well defined, measurable outcomes.

Strategic and progressive leadership in health delivery service. At a time when much is being made of foreign reserves that are being built up and the general improvement in Nigerian economic indices, it is perhaps time to re-examine the systems that will be needed to deliver results to the Nigerian people from the funds that have been stock piled through prudent economic management. We owe a duty to the people of Nigeria to utilize the windfalls from the increases in oil prices to effect changes in their lives. One way we can do this is through ensuring that these funds are used to eradicate preventable diseases and despair.

To achieve this, the Federal Ministry of Health will need to provide strategic, progressive leadership. A leadership that is willing to discard failed and tired structures, systems and indeed individuals. A leadership that is willing and able to maximize and harness all resources that come the country's way through this ministry; one that can manage and direct these in a planned and structured way with the best interest of all Nigerians as its ultimate goal. A leadership that is willing to set targets for itself, is ready to communicate these targets to the general public and willing to be held to account in the way that, for instance, the Ministry of Finance has taken the lead in publishing its accounts and disbursements. The Nigerian public and the media will then be in a better position to judge when real progress is being made in improving the health of the nation.

Effective monitoring and evaluation (M&E) of performance and tracking the use of resources, health policies and reforms. The Government should appoint a committee or set up an agency in the monitoring and evaluation (M&E) of performance and tracking the use of resources, health policies and reforms continuously to enable technical efficiency in the delivery of their services. Implementation of health financing policies and actions need to be monitored and evaluated at regular intervals. Monitoring and evaluation exercise is needed for building evidence for future policies and for the assessment of whether the policy objectives have achieved the expected results. Monitoring and evaluation strategies contribute to the assessment of MDG, child and maternal health and other national and international development goals. The evidence will be useful for better targeting of donor action on MDG. The amount of investments in health is expected to increase with the provision of evidence to justify the magnitude of investment. It is also necessary to ensure the effectiveness of public health expenditure through the institutionalization of performance based budgeting and other mechanisms for preventing fraud.

Building a fairer economic relation with the world. There should be concerted effort to “build a fairer world” that limits the health damaging consequences of the unjust economic and political relation between the developed and the developing countries, to which Nigeria belong. In this regard, the power of the World Bank, the IMF and WTO in forcing programmes on the poor countries that exacerbate poverty and endanger the health of the population must be addressed. The current WTO agreements on intellectual property rights, which effectively limit the access of the poor countries to essential medicines and cheap drugs, must also be opposed by the governments and peoples of the poor countries. The framework of unequal economic and political relations between Nigeria and the advanced capitalist countries -unequal trade, the ecological debt, the external debt, has to be addressed. Specifically, the neo-liberal economic policies of the Nigerian State privatization, deregulation, massive retrenchment of employees in the public sector, which are dictated by the global unequal framework, must be rejected in favour of policies that advance the true interest of Nigeria, including its health interest. The NEEDS and the 7-point agenda framework, which is a product of the neo-liberal ideology, cannot therefore provide the answer to the critical challenges that the health sector and the health needs of the Nigerian people pose in current period.

Increased funding to the health sector. Government should massively increase investment and public spending on health. The health system currently rely on mixture of government budget, health insurance, external funding and private sources including non-governmental arrangements and out of pocket payments. Despite the variety of financing sources, the level of health spending is relatively low. Nigeria spends less than 5% of her gross domestic product (GDP) on health and per capita health spending is slightly lower than US\$35 per person per year. The ridiculously low per capita health spending in Nigeria indicates a negligent lack of commitment by Federal, State and Local Government to health, and the leadership continues to pay lip service to healthcare services. At a minimum, per capita health spending must increase to \$60 in order to provide a minimum range of services.

Implementation of integrated model for community-based chronic and communicable disease control in health services delivery. The FMoH should promote the implementation of integrated model for community-based chronic and communicable disease control in health services delivery. Government should develop guidelines for the practice of traditional medicine and facilitate the retraining and registration of traditional medical practitioners to improve their skills and effectiveness and thus, help promote their integration with the primary health care system. Also, government should strive to promote the development of industries and relevant manpower to enhance local capabilities in the production of drugs, including ARV and laboratory reagents, medical equipment and spare parts to improve supplies and maintenance capabilities so as to reduce cost and improve efficiency.

Reform in itself is not an event, but a description of a process that should lead to an improvement in the way a service is delivered. True reform takes time, but even in the realm of public health, where indices takes time to change, seven years is long enough time for measurable change to have occurred. If over a period of seven years, these improvements are still difficult to quantify, or cannot be described, then there is no justification for the use of the term “reform” (Chike et al, 2006).

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