

HEALTH POLICY BRIEF FOR THE 2010 NIGERIAN ELECTIONS

INTRODUCTION

50 years after independence, Nigeria's health status indicators have remained poor despite the country's wealth in natural and human resources and notable achievements by Nigerians in every walk of life (including the health sector) inside and outside the country. The National Strategic Health Development Plan 2009 to 2013 (NSHDP) rehashes that *"the health status indicators for Nigeria are among the worst in the world and that on the average, health status of the population has declined, compared with the indicators of a decade earlier.* Life expectancy at birth has continued to drop and was reported to be 47 years by the 2008 Nigerian Demographic Health Survey (NDHS) report, 6 years lower than the 53 years average for the least developed countries (LDC) while maternal mortality ratio was estimated at 545 per 100,000 live births, one of the highest rates in the world. This translates to 4 maternal deaths per hour, 90 per day, and 2,800 per month totaling about 34,000 deaths annually. The NSHDP further highlights that one out of every 7 to 8 children dies before her/his first birthday and one out of 6 before her/his 5th birthday. The prevalence of communicable diseases remains unacceptably high with attendant high mortality while non-communicable diseases (hypertension, diabetes, kidney failure, arthritis etc) are on the increase especially among urban and well to do populations. The 2008 sero-prevalence survey reported an adult HIV/AIDS prevalence of 4.6%, so *Nigeria has about 3.5 million people living with HIV, one of the highest numbers of infected people in the world.* Nigeria has the fourth highest TB burden in the world.

Besides general poor health status, Nigeria also has huge disparities in health status between geopolitical regions and income groups. Infants and children under 5 years are more likely to die in the northern region of the country than in the southern region and under-5 mortality rate is 87 per 1,000 among the wealthiest population and 219 per 1,000 amongst the poorest (DHS 2008).

The persistent poor health indices have raised concerns about Nigeria's ability to achieve the millennium development goals (MDGs) by 2015. They also have serious consequences for the economy, as a healthy workforce is needed to have a vibrant economy. Unhealthy individual not only do not contribute to productivity but also cannot take care of himself and his dependants; and he may eventually become an economic and security burden to the society. These and other social welfare challenges have contributed to Nigeria's poor human development index ranking of 158 out of 182 countries in 2009 (UNDP HDR 2009).

KEY ISSUES NEEDING URGENT ATTENTION

There are numerous factors responsible for the poor health indices, but we will only highlight those that require the most urgent attention, to reverse the current trend and get back on track towards achieving the MDGs

Weak primary health care system

The 2005 mapping of health facilities by the federal ministry of health (FMOH) estimated that 85.5% of all health facilities in Nigeria are primary health facilities. These are the facilities that are closest to the people and by policy, should be able to provide the minimum ward package which include the cost

effective interventions for improving maternal and child health (immunization, treatment of diarrhoea diseases, antenatal care, deliveries, management of malaria, TB and HIV/AIDS prevention and basic care etc). Unfortunately the PHC system has been largely abandoned and is not able to provide quality primary health care. Financing of the health sector is skewed in favour of the tertiary sector with the primary care level grossly underfunded and poorly managed leading to decay of infrastructure, lack of necessary health commodities and the right quantity and mix of staff. The problem is compounded by the fact that the LGA which is the least funded tier of government with the weakest management capacity and governance structures is saddled the responsibility of funding and managing primary health care. All these have resulted in lack of access to basic packages for a significant proportion of the population especially the poor and rural dwellers.

Human resource (HR) for health challenges

Nigeria produces a huge number of health care workers every year, but despite this production, most facilities especially the primary health care facilities have huge inadequate number and mix of health care workers. Data from the HRH strategic plan 2008 shows that 88% of the 26,361 doctors practicing in the country work in hospitals, most of them (74%) in private hospitals, with only about 12% in private or public sector PHC facilities. Migration outside and within the country (health care workers are migrating outside the health sector), poor motivation and differentials conditions of service contribute to the shortages. Mal-distribution, poor skill mix and lack of performance management lead to inefficiency in the use of existing staff.

HR needs are not matched with training plans leading to inadequacies in some staff cadres and excess in some and eventual sub-optimal mixes.

Financing health care

The goal of a health financing system is to provide all people with access to needed health services of sufficient quality and ensure that the use of these services does not expose the user to financial hardship (universal coverage). Out of pocket health expenditure (OOP) has been recognized to create access barriers especially for the poor and has the potential of pushing households into poverty or further into poverty and it is recommended that all countries move away from OOP to be able to make progress towards universal coverage. WHO reports that globally, 150 million individuals experience catastrophic expenditure on health¹ and 100million are pushed into poverty every year (WHR 2010). The WHO further posits that it is only when OOP falls to 15-20% of total health expenditure that incidence of catastrophic health expenditure and improvement falls to negligible proportions. *OOP currently constitutes about 69% of total health expenditure in Nigeria (NHA 2003-2005)!*

As at 2010, Nigeria was not one of the 6 countries that had achieved the *Abuja* declaration of 2001 by African heads of states to allocate at least 15% of the total budget to health, despite being the host of the declaration! It is noteworthy that countries that have achieved this are smaller and poorer countries namely Liberia, Malawi and Burkina Faso, Djibouti, Botswana and Rwanda!

Besides government and donors, non-traditional additional resource mobilization means such as dedicated taxation for health and special funds have not been fully explored and developed.

¹ Expenditure on health more than 40% of income after deducting food expenses

Weak and unclear governance structures

There are obvious weaknesses in the stewardship and governance of the sector as demonstrated by the poor coordination of vertical health projects (by programmes and donors), numerous and sometimes conflicting policies from different programmes/departments/agencies, lack of clarity of roles and responsibilities amongst key players and poor regulation of public and private health services provision. Weak planning, budgeting, information management, HR management and logistics capacity is evident at all the levels especially the LGA level which is expected to manage primary health care. Lack of proper planning and adequate coordination of key players leads to wastes of resources through duplication of efforts or application of resources towards non-priority issues.

Poor regulation of the private and inadequate private sector involvement in the national health plan creates huge missed opportunities for tapping the enormous resources within that sector to increase access. The Ghana health service, partners not-for-profit health facilities in rural areas to increase access to Ghanaians, by deploying trained staff to these facilities. There is also a huge but unregulated traditional medicine sector.

Provider focused rather than client focused health system

The Nigerian health system is more provider focused than client focused. The discussion is always about the availability of health facilities, equipment, drugs and health care workers, with little attention to responsiveness of the system to the needs and/or expectations of the consumers. There are no systematic processes for assessing client needs and satisfaction with services, ensuring patient's rights and responsibilities and addressing complaints. Quality is mostly viewed from what is available in the health facility without recourse to the clients who the health system should be centered on.

The emphasis on the supply side also reflects on the inadequate attention to family and population focused interventions such as community based care, health awareness creation and other health promotion and prevention activities that could have reduced the need for some of the expensive hospital based care.

Poor drug and medical commodities management

Procurement supply chain management of drugs and medical commodities has improved in recent times, but a lot still needs to be done. Poor forecasting skills in the public sector leads to either expiries or stock outs. Recent assessments of the central medical store in Oshodi showed that most of the stores are in a pathetic situation, some are not adequately cooled and drugs are often poorly packed raising concerns about the integrity of these drugs by the time they leave the store. Most of the state stores are worse off and a lot of LGAs don't have functional medical stores. Vertical distribution leads to unnecessary duplication and waste of resources. An example is HIV/AIDS, tuberculosis (TB) and family planning commodities leaving same warehouse for same facility via 3 different routes/vehicles because there is no coordinated distribution between the 3 disease programs, leading to unnecessary costs. In some cases, procured commodities never make it to the facilities because there are no plans/funding for distribution. Procurement of commodities for HIV/AIDS, TB and malaria is still hugely donor, creating worries about sustainability and commodities security moving forward.

It is important to note that most indigenous pharmaceutical companies are not WHO pre-qualified, excluding them from the donor supported multi-billion dollar HIV/AIDS, TB and malaria commodities procurement contracts that could have grown the sector, created more jobs and contributed to GDP growth.

Weak information management

The health information system in Nigeria has remained very weak such that at the LGA, state or federal level, it is difficult to find in any one place, comprehensive information on health services, utilization and outcomes. Vertical disease programmes house data specific to their programmes and data is rarely aggregated across disease programmes except during report preparation. Data transmission from facilities to the national level has mostly been driven by donor requirements rather than a local need for information. As a result, information flows upwards without people making use of it at the different levels. It is hard to get reliable information on non-donor funded programme areas.

The lack of reliable comprehensive health data makes it difficult to determine priorities, plan and show evidence of what works and outcome of huge investments in health. Data from Nigeria is occasionally missing in international reports due to either data availability or reliability.

RECOMMENDATIONS

These myriad of problems requires a well thought out comprehensive approach to reviving the health sector. The current prescriptions which look at one or two of the problems will not achieve much besides short lived reliefs. Some key ingredients of any effort to improve the sector are listed below

Service delivery

- Passage of the National Health Bill (which provides additional funding for primary health care should be given the highest priority)
- Primary Health Care should be the bedrock of Health Care delivery as the most cost-effective, acceptable and affordable healthcare service to the greatest number of Nigerians and should be taken as priority by all tiers of government
- Access to improved Maternal, Newborn and Child Health as strategy for poverty reduction and national well-being
- Minimum package for primary, secondary and tertiary facilities – minimum infrastructure, staffing, equipment and services for each level

Human resource for health

- Review and roll out the national human resource for health policy – should look at assessment of needs based on mandate, review of training needs and package, review of recruitment and retention policies
- Introduction of strict performance management - basis for salary increase and incentives, disciplinary actions etc

Health financing

- Increase government allocation and expenditure to meet at the minimum, the Abuja declaration of 15% of Annual budget

- Improve transparency and accountability in the use of resources
- Health insurance should be compulsory, with pooling of contributions across different occupational, income and social groups
- Introduce insurance schemes for the informal sector and rural dwellers and introduce safety nets for the poor (e.g. equity funds from which their insurance premium is covered)
- Target additional resources through innovative financing schemes such as dedicated tax e.g. tobacco and alcohol tax, foreign exchange or air flight tax etc
- The Legislators should ensure resources are made available for improved health system performance and life expectancy

Governance

- Capacity building for health planning, policy development, implementation, monitoring and evaluation should be given a high priority by the political parties
- Management and leadership training for health managers
- National planning commission to use national sectoral plans as basis for negotiation with donors – donors should support national priorities and not their own priorities
- Clarify the legal frameworks for healthcare delivery, strengthen regulation and ensure protection of consumers
- Linkage with other sectors – education, women affairs, agriculture, information etc

Drugs and other commodities

- Revamp the central medical store Oshodi as an emergency action and establish regional stores
- Develop a national PSM plan that amongst other things, identifies cost effective mixes of public and private warehousing and distribution strategies
- Scale up fight against fake drugs and reporting/management of adverse drug reactions
- Support WHO certification of local firms and remove all barriers to certified local firms participating in procurement from agreement with donors e.g. don't grant waivers for importation of commodities that are locally produced

Information management

- Develop national health M&E plan with national indicators, tools and reporting platforms which all stakeholders including donors must agree to
- Biannual health reports developed from NHMIS
- Strengthen NHMIS to receive, warehouse and analyse on a routine basis, comprehensive health data from facilities and states
- Independent validation of data

Provider focused rather than client focused health system

- Enforce patients rights and responsibilities
- Routine patient, household and community surveys to get consumer perspective
- Focus on health promotion and prevention activities
- There should be sensitization and effective Health promotion

- Community mobilization, education, engagement, and ownership for health interventions should be improved.

CONCLUSION

Health is a key driver of development, economic growth and security. Political parties and their candidates have so far in their manifestoes and debates, not given health the attention it deserves. Parties and their candidates should formulate and showcase their strategies for addressing the priority health sector problems and achieving universal access to quality health services.

