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HEALTH SECTOR REFORMS AND SUSTAINABLE DEVELOPMENT IN NIGERIA: A HISTORICAL PERSPECTIVE

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ABSTRACT

The need to reform the health sector in Nigeria has been a major preoccupation of both colonial and post-colonial governments – a task undertaken to improve the health and wellbeing of its populations and ensure sustainable development. However, the country's poor health indicators and health status over the decades indicate that the desired results have not being achieved. This study undertakes a historical analysis of health sector reforms in Nigeria from the colonial era up to 2007. It further explores the reasons why Nigeria has failed to obtain optimal benefits from the reform programmes, such as inequality in access to health care, weak health systems, corruption among others. It concludes with recommendations on how Nigeria can fully maximise the benefits of health sector reform, which is key to sustainable development.

Keywords: Health sector reform, Nigeria, Health, Modern medicine, sustainable development

INTRODUCTION

Since the 1990s, the link between health and sustainable development has elicited enormous literature. This is based on the belief that economic and social progress can neither be secured nor sustainable if sufficient investments are not made to protect health status of populations. Fogel, for instance, has argued that Britain's early industrial breakthrough was largely due to the mastery of high mortality and morbidity as a result of improvement in nutritional status and conquest of many contagious diseases from the late 18th century onwards (Fogel, 1991). Good health strengthens development because it increases productivity, fortifies peoples capabilities, increases savings and investments, and promotes positive behaviour. Conversely, economic development can also facilitate financing of environmental, health and sanitation campaigns for education, immunisation and screening (Mills & Shillcutt, 2004). Likewise, social development, especially in the field of education, has been associated with improved health status through improved nutrition and reproductive health. However, this may not occur in all situations as macroeconomic changes may not filter down to benefit the whole population. Scholars have shown that many sound policies in economic terms, notably structural adjustment policies have had devastating health effects (Muiu, 2002). The recognition of the mutual relationship between health and sustainable development has informed the introduction of several reforms by the Nigerian government aimed at improving health care delivery in the country since the colonial era. Yet, many Nigerians lack access to formal health care services. Of greater concern is the fact that health indicators have worsened over the years. The World Health Report ranked Nigeria 187 out of 191 countries for health service performance (WHO, 2000), a situation that has not changed much since 2000. Infant mortality rates have been deteriorating from 85 per 1000 live births in 1982, 87 in 1990, 93 in 1991 to 100 in 2003 (NPC, 2003). In 2007, the Federal Ministry of Health reported 110 deaths per 1000 live births. Maternal mortality ratios are estimated at 1100 per 100,000 live births (WHO, 2008). Life expectancy at birth was 49 years as at 2007.

Nigeria still suffers from low level of health development and fall far below the standard of health when compared with countries at a similar level of development. In Nigeria, for example, under-five mortality and infant mortality are 189 and 97 per 1000 live births respectively, figures which are higher than the figures for Egypt and Malaysia (WHO, 2008). The life expectancy for Nigeria in 2007 was 49, which is lower than 68 and 72 years for Egypt and Malaysia respectively (WHO, 2008). The health sector is plagued by lack of effective leadership by government, fragmented health service delivery, inadequate and insufficient financing and weak health infrastructure, maldistribution of workforce and poor coordination of key players. These challenges have assume a worrisome situation compelling a study of health sector reforms in Nigeria from 1946 to 2007, with a view to ascertaining why it has not yielded the desired results.

EVOLUTION OF MODERN MEDICINE IN NIGERIA: AN OVERVIEW

Prior to the introduction of modern medicine, indigenous medicine was the dominant medical system available to Nigerians (Anaemene & Aworawo, 2014). However, the establishment of colonial rule was a turning point in the history of this age long tradition and culture. In the pre-colonial era, most communities had some form of organised social structure, an important component of which was the health care system. Attention for the provision of personal health usually centred on individuals with expertise in preventive, curative and rehabilitative medicine. Some of these traditional medicine practitioners specialised in midwifery (traditional birth attendants); treatment of psychiatric disorders, orthopaedics among others. Others were generalists to whom clients turn for a variety of ailments ranging from infertility and impotence to persistent fever, loss of weight and chronic ulcers. The indigenous healers have adopted two major approaches to healing namely, the pragmatic and the symbolic aspects (Barnett, 2000). The pragmatic aspect involves examination of patients in order to diagnose, treat and prevent disease using their

clinical judgement. On the other hand, the symbolic aspect is used when the healers attribute illness to societal imbalances rather than to biological cause.

Although, these precolonial communities were not conversant with modern germ theory of disease causation or the fundamental scientific basis of such complex issues like genetics and immunology, they established and were governed by set of rules and regulations (Health Reform Foundation of Nigeria, 2006). Unfortunately and inevitably, some of the socio-cultural practices and taboos were injurious to personal health – such as the practice of female circumcision and the use of non-sterile instruments. Uninformed post-natal care contributed to high maternal mortality while high infant mortality rates induced families to have more children to make up for the attendant wastages.

It is difficult to define a clear transition from traditional to modern medicine. Records, however, indicate that western medical care was first introduced in the Nigerian territory in the second half of the sixteenth century through the activities of the missionaries. As Ralph Schram aptly noted, 'the missionaries were to a greater extent than any that have yet been mentioned the men and women who brought modern medical care to Nigeria' (Schram, 1971: 59). Prior to the establishment of colonialism, a Roman Catholic Mission had already opened a hospital at St Thomas Island off the Bight of Benin. However, modern medicine as we know it today did not exist until the nineteenth century. This suggests that the staff of St. Thomas Hospital were not medically qualified. The first physician that visited Nigeria was Dr. E. C. Van Cooten of the Church Missionary Society in 1850. The return of two ex-slaves, Africans Horton and William Boughton Davies, from England in 1859 after qualifying as a physician gave further impetus to the evolution of modern medicine in Nigeria (Schram, 1971). Their contribution took the form of publication of books on medicine. For instance, Dr Horton wrote several medical texts*: The Medical Topography of the West Coast of Africa; A Treatise on the Guinea Worm*; and *Physical and Medical Climate Meteorology*. Dr William was also credited with carrying out in mid-19th century, several vaccination sessions and dressing of ulcers on indigenous African populations along the west coast of Africa, including the Niger Delta and Lokoja (Schram, 1971).

It has been argued that imperialism is the midwife of modern medicine in Nigeria (Ityavya, 1987). It delivered modern medicine via three main factors. Foremost is the role of Christian missionaries from Europe and North America, who took the gospel to Africa along with modern medicine. The missionaries used medical care both as reward for acceptance of the new faith and as an incentive for the doubtful (Mburu, 1981). Second, the colonisation of Nigeria by Britain was an important factor in the emergence of and development of modern medicine in Nigeria. Third, the nationalist movement that emerged after the First World War exerted pressure on the colonial administration to provide more social and economic services for Nigeria. By and large, the emergence and development of modern medicine in Nigeria by the missions and the government involved the provision and delivery of health care through the establishment of health care facilities and the supply of health manpower through the recruitment and training of human resources for health. One curious observation about the nature of modern medicine in Nigeria established by the missions and government is that from the outset cure was the goal and not prevention.

THE COLONIAL ATTEMPT

In the aftermath of the Second World War, the colonial state began to respond to the political and economic contradictions engendered by the growth of colonial capitalism and nationalism. One of such response was the decision to extend modern health and educational services to all Nigerians. Thus, the first attempt at health sector reform was the Walter-Harkness Ten-Year Plan

of 1946 – 1955 launched by the British colonial administration. The Plan completely revolutionised the history of health services in Nigeria. The health programmes proposed in the plan were progressive building of environmental hygiene; provision of adequate portable water for all; expansion of hospitals, maternity, child welfare and dispensary services and an intense campaign of preventive medicine at the grassroots level (Government of Nigeria, 1946).

One landmark feature of which was the establishment of a Ministry of Health whose primary function was to coordinate health services throughout the country. It was during the Plan period that the University College Ibadan was founded with a Faculty of Medicine and Teaching Hospital – the University College Hospital (UCH). UCH was the first quality tertiary and higher health care manpower training institution in the country. The Plan was criticised for paying little attention to preventive and primary care. It accorded more importance to curative medicine. This was not surprising as preventive medicine then was opposed to the ideology of Western modern medicine that emphasised cure - in which the planning of health services was seen to be synonymous with building of hospitals, dispensaries or medical schools. The neglect of preventive medicine in the Plan was evident as nothing was specifically budgeted for immunisation, sanitation, health education among others. While the Plan was not completely oblivious of preventive and primary care, there was incongruence between what it said of preventive services and its budget estimates. As Onoge rightly observed,

> The colonial state at that time had launched a veritable crusade that was strategically located around the slogan of preventive medicine. The slogan operated only at the realm of rhetorics and hardly was money voted for preventive health services (Onoge, 1975:220)

The 1946 health reform reveals even more limitations. It disregarded the politics of revenue allocation and was completely insensitive to the distinct regional and ethnic groups of Nigeria. The result was devastating with a preponderance of health services and health services, hospitals and rural clinics in southern Nigeria. Hospitals and dispensaries were planned only in urban and semi urban centres, such as Lagos, Enugu, Kano, Kaduna, Jos and towns, such as Makurdi and Sokoto. It was only after the 1950s that some rural areas began to have dispensaries within a radius of 100 miles. It has been argued that what may be perceived as gaps and shortcomings of the Plan may have been designed the colonial state to serve political and class interest (Ityavya, 1987).

Politically, capital health expenditure would satisfy the vocal nationalists most of whom were in cities and, as such, were direct beneficiaries of the 1946 health care reform. The new hospitals, clinics and dispensaries would serve the needs of European traders and European bureaucrats as well as the nationalists. The labour force in cities, especially those employed in mines and those in governmental offices would benefit from it, thus ensuring a healthy labour force. Nevertheless, it is apposite to assert that the 1946 health reform remains one of the most significant developments in the history of Nigerian health services. It was the first time health services became coordinated. Health services provided by missionaries, companies and government were all articulated under a health care system – a coordinated and an organised chain of health services, planning and delivery.

The full implementation of this plan was aborted by the introduction of regional governments, an outcome of Macpherson Constitution of 1951. The regional governments launched their different health plans to cover their respective areas of jurisdiction. In addition, the federal system of government was adopted in Nigeria in October 1954 before the end of Ten-year Plan period. This brought the Plan to a premature end and each of the regional governments as well as the federal government, in 1955, launched new Plans. The 1955 – 1960 Plan was revised in 1958 and extended to 1962. The health programme in the 1955 – 1962 Plan lay great emphasis on training at all levels from specialists to laboratory assistants. This resulted in the establishment of new

training institutions, which produced trained staff for the hospitals, dispensaries and rural health services (Federation of Nigeria, 1962).

POST-COLONIAL EXPERIENCE

During the post-colonial era, precisely from 1960, health sector reforms were enunciated either in the context of national development plans or as government decision on specific health issues. The first National Development Plan, 1962 – 1968 contained the groundwork for the promotion of industrial development, building of hospitals in major cities, dispensaries and maternity homes in few rural towns and villages (Federal Government of Nigeria, 1970). The health component of the Second National Development Plan, 1970 – 1974 focused in part at correcting some of the deficiencies of the health delivery services carried over from the first plan. The national objectives formulated for the 1970 – 1974 development plan was the establishment of:

1. a free and democratic society;
2. a just and egalitarian society;
3. a united strong and self-reliant nation;
4. a great and dynamic economy;
5. a land of bright and full opportunities (Federal Government of Nigeria, 1970)

In the context of the above five national objectives, the health sector was expected to pursue a mission of promoting, protecting, restoring and improving the health of all the people of the country within the recognised rights of every citizen to better health. There was a deliberate attempt to draw up a comprehensive national health policy dealing with such issues as health manpower development, provision of comprehensive health care based on basic health service scheme, disease control, efficient utilisation of health resources, medical research and health planning and management.

The health sector performed fairly well during this Plan period in terms of expansion of facilities. For instance, at the federal level, substantial funds were made available to the University Teaching Hospitals at Ibadan, Lagos and Enugu and to the specialist Hospitals in Benin, Enugu and Ilorin for expansion works. In addition, the University College Teaching Hospital Ibadan increased its bed capacity to 520. The Lagos University Teaching Hospital expanded its dentistry and other areas of medical specialisation and put into use the catering and dinning, radiotherapy and mortuary blocks, which were built during the Plan period. The OPD Ward Theatre, the Radio diagnosis and physical medicine units as well as the mobile theatre were also completed. At the state level, significant progress was also made in the rehabilitation of medical facilities in the three Eastern States. Moreover, substantial bed facilities were created in the Mid-West and Kwara states. For the States as a whole, over 300 health and maternity centres as well as dispensary units were established during the period. However, the impact of this achievement has been limited to some extent by shortages of medical and para-medical manpower. In addition, the Plan did not articulate a system with clear levels, or the assignment of responsibilities to the three levels of government.

The Third National Development Plan, 1975 – 1980 had the Basic Health Service Scheme as its focus. The Scheme was aimed at increasing the proportion of the population accessing health services from 25% to 60%. The Basic Health Scheme Service, which was incorporated into the Development plan, had the following objectives:

1. to initiate the provision of adequate and effective health facilities and care for the entire population;

2. to correct the imbalances in the distribution of health infrastructure for all preventive and curative care;

3. to provide the infrastructure for all preventive health services, such as control of communicable diseases, family health, environmental health, nutrition among others;

4. to establish a health care system best adapted to the local conditions and to the level of health technology (Federal Government of Nigeria, 1975).

The Third National Development Plan was elaborate in its health reform attempt. The Plan allocated the sum of N20 million for the National Malaria Programme. In addition, intensive vaccination campaigns on smallpox were organised in collaboration with local and international voluntary organisations. The period also witnessed the rapid expansion of the number of federally managed teaching hospitals for the training of various categories of health workers, particularly doctors, nurses, midwives, and technicians. Schools of health technology were also established for the training of intermediate level manpower for community health. The Plan, however, failed to share responsibilities between the three levels of government for resource generation, manpower for the services to be delivered, and especially on the health professional manpower for the services. All these happened in the absence of a clear policy framework.

The Fourth Development Plan, 1981 – 1985 also emphasised the Basic Health Service Scheme (Federal Government of Nigeria, 1981). The problem with BHSS was its total neglect by the Federal Government. The Federal Government paid more attention on the establishment of teaching and specialist hospitals. This was reflected in the budgetary allocations for health capital projects and programmes as they were contained in the Fourth development Plan. Specifically a total of N862.40 million was allocated to the teaching and specialist hospitals while only N101.00 million was allocated to Basic Health Services Scheme and other health related health programmes. The Fifth National Development Plan, 1987 – 1991 coincided with the period of the adoption of the primary health care strategy and the formulation of a National Health Policy in 1988.

However, it is significant to note that all health sector reforms in Nigeria before the Alma Ata Declaration (1978) and the subsequent formulation of the National Health Policy in 1988, happened in the absence of a clear policy framework (Asuzu, 2004).[27] Some of the major benchmarks since the Alma Ata Declaration include introduction of primary health care programmes in place of the existing basic health services scheme (1986), launching of the National Health Policy and Strategy to Achieve Health for all Nigerians 1988 and full devolution of the responsibility for the management and provision of PHC for four years. In 1986, the concept of a three-year National Rolling Plan was introduced. The health sector in tandem with other sectors adopted this strategy for national development. During the second half of the 1980s, considerable success was recorded with respect to the state of health systems and the health status of Nigerians. Unfortunately, this success was not sustained. From the late 1980s to early 1990s, the country began to experience a downward trend in health development. This trend is attributable to the introduction of Structural Adjustment Programme in Nigeria.

STRUCTURAL ADJUSTMENT PROGRAMME AND HEALTH SECTOR REFORM

There is no doubt that the economic crisis of 1980s negatively affected the country. It was, therefore, in the bid to contain the crisis in the economy that the Nigerian government began to obtain loans from the international capital market. As the crisis deepened and the external debts began to mount, the government had no choice but to approach the World Bank and the

International Monetary Fund for support. The administration of Shehu Shagari, 1979 – 1983, after some foot-dragging and negotiations applied for loans from the two institutions. This started the process of the involvement of the two bodies in the Nigerian economy.

However, it was not until 1986 during the General Ibrahim Babangida regime that the IMF was brought fully into the Nigerian economic crisis. A glaring manifestation was the introduction of the Structural Adjustment Programme. The implementation of SAP with its harsh conditionality negatively affected the health sector and the health status of Nigerians (Popoola, 1993). Subsequently, Nigeria began to depend on loans for funding many projects and programmes, including the ones in the health sector. Like other states that received loans from the World Bank, Nigeria had to adhere to a common agenda for initiating reforms. These included a shift from direct provisioning by government, which essentially entails greater reliance on private and voluntary services, instituting a number of financial measures like introduction of user fees and contracting out to the private sector as a way of improving efficiency and patient satisfaction. These basic set of assumptions informed the health sector reform initiatives in Nigeria during the period.

Consequent upon the introduction of SAP, health spending as a proportion of federal government expenditure shrank from an average of 3.5% in the early 1970s to less than 2% in the 1980s and 90s.[1] Such shifts in resource allocation have had major implications for public hospitals, which are almost financed entirely financed from government subventions. The result was the near collapse of acute hospital services, characterised by frequent drug shortages, run-down physical structures and the efflux of highly skilled but demotivated medical specialists. There was also a gradual abolition of free medical services via the introduction of cost recovery mechanisms and at all levels of health care delivery. There was also a drop in quality of care in public health institutions. The period also witnessed a rapid growth in market for private health care in the country (Ogunbekun, Ogunbekun, & Orobatan, 1999).

In the final analysis, the introduction of SAP and the pressure to reduce government expenditure on health and to reorganise the health sector to bring in private provisions and payments for services was seen as a major threat to equity. For instance, the development of private medical practice created a two-tier system. Patients, who could pay more, could see private practitioners, get better services and attend special clinics and hospitals. In the upper tier of this system, income determined access to services. On the other hand, in the lower tier patients were dependent on national health services, where charges put the service out of their reach. Private practice also affected the nation's health status because practitioners did not undertake the preventive and community health measures needed.

In view of the deteriorating health situation, a National Health Summit was convened in 1995 to examine critically the factors that had militated against the improvement in national health status, with a view to charting a new course for future action. The summit recommended a review of the national health policy with a view to effecting those changes that would accelerate health development in Nigeria. In response to this, the federal ministry of health organised a review of the national health policy in 1996. However, the revised national health policy was not endorsed as at that time.

DEMOCRATIC GOVERNANCE AND COMPREHENSIVE HEALTH SECTOR REFORM, 1999 – 2007

On 29 May 1999, the military handed over power to a democratically elected government. Since then, successive civilian administrations have embarked on health sector reform programmes in line with the aspirations of the Nigerian people. In 2003, the government of Chief Olusegun Obasanjo launched a comprehensive health sector reform with the implementation of its first

phase covering 2004 – 2007 (FMOH, 2004). The major objective of the reform was to improve the health status of Nigerians and reverse the vicious cycle of poverty, ill health and underdevelopment. The health sector reform was located within the country's overall macroeconomic framework called National Economic and Empowerment Development Strategy (NEEDS). Thus, the period 2004 – 2007, saw a reform agenda articulated for the health sector, which aimed at:

1. improving the stewardship role of government;
2. strengthening the national health system and its management;
3. reducing the burden of disease;
4. improving health resources and their management;
5. improving access to quality health services;
6. improving consumer awareness and community involvement, and
7. promoting effective partnership collaboration and coordination (FMOH, 2004).

One of the major issues in health sector reform is governance. The main criticism against health system governance in Nigeria has been the lack of coordinated response to critical health sector needs. A number of constraints and challenges have created serious obstacles to the role of government and these include the poor definition of roles and responsibilities of key actors. The constitution did not specify the roles the local government, state and federal government must play in the national health care delivery system (FMOH, 2004). For the health sector, this was a serious omission since Nigeria's health system is built on a three-tier system with the local government being the main implementing agents of primary health care. In addition, there was also the absence of the definite roles and responsibilities of the private sector. This state of affairs resulted in the duplication of efforts, redundancy and waste of resources that could have yielded greater dividend had they been employed elsewhere. As a response to the criticism, the Federal Government developed a system to guide and coordinate investments and actions by the three tiers of government, the private sector, donors and other stakeholders.

The most striking reform in the Nigeria health sectors was in the area of securing sustainable financing for health care. Health sector financing in Nigeria is based on a mixture of government budget, health insurance (social and private), external funding and private out-of-pocket spending to finance health care. Despite the variety of financing sources, the level of health spending was relatively low in the 1990s. Although the federal government recurrent health budget showed an upward trend from 1996 to 1998 and 1999 to 2000, available evidence indicates that the bulk of this expenditure went to personnel (WHO, 2002). Recurrent health expenditure, as a percentage of total federal recurrent expenditure, was 2.55% in 1996, 2.96% in 1997, 2.99% in 1998, 1.95% in 1999 and 2.5% in 2000 (CBN, 2000). According to UNDP, government expenditure on health, as a percentage of GDP, was 1.3% in 2003 (UNDP, 2006), a decline from 2.2% in 2000 (WHO, 2003).

In per capita terms, the government expenditure as a percentage of total expenditure on health, the Nigeria government share declined from 29.1% in 1999 to 25.5% in 2003 lagging behind many other African countries even those similarly classified by the World Bank as low income economies (WHO, 2006). In per capita terms, public spending on health stood at less than $5 and, in some parts of the country, it was as low as $2 far short of $34 recommended by WHO for low income countries (WHO, 2002). Private Health expenditure was 3.7% (UNDP, 2006). Household out-of-pocket expenditure averaged 64.5% between 1998 – 2002 (WHO, 2008). This is an indication that the burden of health expenditure on household was very high. On average, about 4% of households were estimated to have spent more than half of their total household expenditure on health care and 12% of them are estimated to spend more than a quarter (WHO, 2008).

In an effort of mitigate low per capita funding to health, the government embarked on a series of initiative. Following its commitment to improve the health system, the federal government substantially increased its allocations to health care since 2003. Some state governments also increased their resource allocation to the sector. In addition, at the federal level, there were efforts to increase the resource allocation of primary health care. For instance, the National Health Bill made provision for a primary health care development fund that would increase earmarked funds to PHC (WHO, 2008).

As part of government effort to address the problems of health financing, the National Health Insurance Scheme (NHIS) was established. NHIS was conceptualized in Nigeria in 1960, but was stalled by legislation and political instability until 1984, when the National Council on Health (NCH) set up a committee to advice the federal government on the need for its implementation. A positive response by this committee led to the setting up of National Health Insurance Review Committee in 1985 (FMOH, 2001). NHIS collected premium and purchased health services for formal sector employees. This represented less than 40% of the population leaving out over 60% employed in the informal sector, especially over 52% in the rural areas. In effect, despite the introduction of the NHIS over 90% of health services in Nigeria remained paid for through direct user fee.

The problem of the exclusion of the informal sector led to the emergence of some Community Based Health Financing Schemes CBHFs (Omoruan, Bamidele, & Philips, 2009). Some CBHF targeted members of local trade associations, such as taxi drivers association, market association like Lawanson Health Plan (LHP) in Lagos and Ariaria Trader's Health Scheme of Aba. Others focussed on members of a particular community like the Country Women Association of Nigeria (COWAN), and Ndo Nwanne Health Scheme of Enugu. At the 42nd meeting of NCH in 1997, approval was given for the repackaging of the NHIS to ensure full private sector participation by providing reinsurance coverage to the CBHF and Health Maintenance Organisations (HMOs) to form Social Health Insurance (SHI). SHI was launched in October 1997 while the enabling law establishing the scheme Decree 35 of 1999 was signed in May 1999. The implementation was delayed until 6 June 2005.

While universal coverage was intended by NHIS, beneficiaries have been limited to employees of the formal sector. Given this limitation, most people continued to pay for health care directly out-of-pocket and this has had significant access implications. As a result, there was the concern that continued growth in the number of people without coverage would further add to the downward spiral of key health indicators and, in addition to the scourge of HIV/AIDS, contribute to exacerbating an already appalling life expectancy rate. However, the launching of the $131 million Insurance Health Fund (IHF) by the Dutch Ministry of Foreign Affairs would expand coverage to a significant portion of the population (Irin, 2008). The appeal of the fund lies on its impact on the major factor militating against utilisation of health insurance cost. The scheme would subsidise the cost of premium by as much as 95% in some cases (Irin, 2008), thereby making it possible for more people to purchase coverage. Nevertheless, health insurance schemes hold the promise of ensuring guaranteed funds for health, improving the efficiency of management of health resources and protecting people against the catastrophic expenditure for health.

Donor assistance to the health sector also experienced a decline during the 1990s. A major reason for the drop in health financing in Nigeria was the decline in international contributions to the development of the health sector, which began in mid-1980s and continued until the 1990s. Following the refusal of the military government to acquiesce to demands for restoration of democracy, and its subsequent ostracisation by the international community, most donor countries, especially the United States and the United Kingdom and international agencies ceased funding projects in Nigeria including those that were health related. However, with the re-establishment of democracy in 1999, the situation improved with many of the foreign partners resuming cooperation with the government and significantly contributing to addressing priority areas of concern. The percentage of total foreign aid to the

health sector, which was 3.0% in 1998, increased to 19.8% in 1999 the year civilian regained control of government (WHO, 2002).

Another issue is that of provision of health services. The organisation of health services in Nigeria is pluralistic and complex. It includes several providers in both public and private sectors, private for-profit providers, non-governmental organisations, community based organisations, religious and traditional care providers. The overall availability, accessibility, quality and utilisation of health services decreased significantly in the 1990s. Available data from the Federal Ministry of Health indicate that in 1999, there were 18,258 registered PHC facilities, 3275 secondary facilities, and 29 tertiary across the country (WHO, 2002). The public sector accounted for 67% of PHC facilities, 25% secondary facilities and all but one of the tertiary facilities (UNICEF, 2001).

The major weakness of health services was inadequate decentralisation of services. PHC facilities offered a limited package of services. Most health services could only be accessed at secondary and the tertiary levels that are concentrated in the urban areas, limiting access by increased service delivering cost to the rural based beneficiary. The proportion of households residing within 10 kilometres of a health centre, clinic or hospital was 88% in the South West, 87% in the South East, 82% in the North Central, 73% in the North East and 67% in the North West regions (WHO, 2002). However, the fact that health facilities physically existed in these areas does not mean that they were functional. Most of them were poorly equipped and lacked essential supplies and qualified staff. In particular, the coverage of PHC interventions, such as immunisation and access to safe water and sanitation declined. In addition, marked inequalities existed between the regions, the rich and the poor, and rural and urban areas.

Furthermore, the existing health care delivery system was characterised by weak referral linkages between the different levels of health care limiting the provision of health services across a continuum of care. There was also the absence of health services, particularly in the private sectors. However, in an attempt to redress the situation, the National Health Bill legislates that "all Nigerians shall be entitled to a guaranteed minimum package of services." In 2007, the Ward Minimum Health Care Package (WMHCP) 2007 – 2012 was ratified and adopted by the Nigerian National Council on Health as a minimum standard for the delivery of primary health care services in Nigeria (WHO, 2008).

In the area of infectious disease control, the new civilian administrations made significant progress. In 1999, the government of President Olusegun Obasanjo set up a National Action Committee on AIDS charged with the responsibility of coordinating various activities related to the prevention and control of HIV/AIDS in the country. The Committee was later transformed through a legislative act into a statutory agency. In 2005, the Nigerian government committed to universal provision of antiretroviral therapy, the implementation of which has been largely funded by the Global Fund and United States Presidential Emergency Plan for AIDS Relief (PEPFAR) and the World Bank. The prevalence rate based on sentinel surveys rose from 1.8 percent in 1991 to 5.8% in 2001 but in 2006, it was estimated at 3.9 percent. Before 1999, there was no broad technical agency with the capacity for the surveillance and response to infectious diseases. However, a move was initiated to create a National Disease and Control Prevention Centre out of the existing Central Public Health Laboratory in Lagos. Routine immunization campaigns against polio and other preventable diseases have also reinvigorated.

CHALLENGES OF HEALTH SECTOR REFORM IN NIGERIA

The above examination of health sector reform in Nigeria illustrates that significant strides have been made since 1946. However, they could be considered limited when compared with the expected outcome of every health sector reform, which are, primarily,

health improvement and health gain through improved equity in health and health care services; increased and better management of health resources; improved performance of health systems and quality care; greater satisfaction of consumers and providers of health care. Experience with health sector reform in Nigeria is bedevilled by various challenges.

One major problem is the weak health care systems in the country. It takes states health care systems and at least passable local infrastructure to improve public health. However, decades of neglect have rendered local hospitals, clinics, laboratories, medical schools and health talent dangerously deficient. What this means is that despite all the public health sector reform, the health sector could not produce the desired result.

The effectiveness of health sector reform is also limited by the lack of access to health facilities. The national accessibility to health facilities in Nigeria is about 54.1 percent while the percentage of those who attended public health institutions in Nigeria was 59 percent as at 2007 (Alabi, 2007). The 54.1 percent accessibility to health facilities in Nigeria is below the 65 percent accessibility to health services estimated by UNICEF for African countries (UNICEF, 2000).

Worse still, the health facilities in Nigeria have been concentrated in the urban areas. Thus, where the urban access to health facilities was 69.7 percent, the rural areas had a rate of 46.8 percent. The urban bias in health resources and facilities distribution in Nigeria has been noted by WHO (WHO, 2003). These inequalities in the distribution of health care resources may affect the pattern of its demand. Although, there was a marked improvement in health infrastructure since 1999, whenever medical facilities exist in the rural or urban areas, such facilities usually were short staffed, poorly maintained and inadequately supplied with drugs, especially those located in the rural areas. The equity implications of user fees have not been adequately addressed. A large share, particularly the poor do not use essential health services because of price barrier. There is also the lack of complementary infrastructures to health services delivery, such as access roads, constant electricity supply etc.

Table 1: Federal Health Expenditure, 1961 – 2007

Year	Recurrent Expenditure	Capital Expenditure	Total Health Expenditure	Total Federal Exp	as% of Federal Exp
1961	1.80	11.40	13.20	163.86	8.06%
1962	2.30	10.00	12.30	167.41	7.35%
1963	2.32	8.20	10.52	183.54	5.73%
1964	3.60	9.90	13.50	220.37	6.13%
1965	1.88	9.40	11.28	236.44	4.77%
1966	0.55	9.80	10.35	255.17	4.06%
1967	0.72	4.20	4.92	258.03	1.91%
1968	4.20	0.10	4.30	349.85	1.23%
1969	3.60	1.00	4.60	556.22	0.83%
1970	6.00	-	-	903.90	-
1971	10.70	2.60	13.30	997.20	1.33%
1972	15.00	2.40	17.40	1,463.60	1.19%
1973	16.30	14.60	30.90	1,529.20	2.02%
1974	29.10	14.20	43.30	2,740.60	1.58%
1975	62.40	20.40	82.80	5,942.60	1.39%
1976	83.50	56.80	140.30	7,856.70	1.79%
1977	85.10	38.70	123.80	8,823.00	1.40%
1978	72.90	49.60	122.50	8,000.00	1.53%
1979	87.50	96.20	183.70	7,406.70	2.48%
1980	116.50	110.40	226.90	14,968.60	1.52%
1981	119.80	128.40	248.20	11,413.70	2.17%
1982	155.80	130.20	286.00	11,923.20	2.40%
1983	254.50	136.00	390.50	9,636.50	4.05%
1984	131.20	51.10	182.30	9,927.60	1.84%
1985	199.40	56.20	255.60	13,041.10	1.96%
1986	244.00	65.50	309.50	16,223.70	1.91%
1987	65.00	59.20	124.20	22,018.20	0.56%
1988	422.80	155.40	578.20	27,749.50	2.08%
1989	575.30	221.50	796.80	41,028.30	1.94%
1990	500.70	322.50	823.20	60,268.20	1.37%
1991	618.20	153.10	771.30	126,852.60	0.61%
1992	996.40	384.10	1,380.50	92,797.40	1.49%
1993	2,331.60	1,563.00	3,894.60	132,560.70	2.94%
1994	2,066.80	2,405.70	4,472.50	160,893.20	2.78%
1995	3,335.50	3,307.40	6,642.90	248,768.10	2.67%
1996	3,175.50	1,659.60	4,835.10	337,417.60	1.43%

1997	4,702.30	2,623.80	7,326.10	428,215.20	1.71%
1998	5,333.60	8,307.20	13,640.80	487,113.40	2.80%
1999	8,793.20	7,386.80	16,180.00	947,689.40	1.71%
2000	11,579.60	8,805.60	20,385.20	701,050.90	2.91%
2001	24,523.50	20,128.00	44,651.50	1,017,996.50	4.39%
2002	50,563.20	12,608.00	63,171.20	1,018,178.10	6.20%
2003	33,254.50	6,431.00	39,685.50	1,225,988.30	3.24%
2004	34,198.50	18,207.60	52,406.10	1,384,000.00	3.79%
2005	55,000.70	21,000.80	76,001.50	1,743,200.00	4.36%
2006	62,000.30	32,000.20	94,000.50	1,842,587.70	5.10%
2007	81,000.90	96,000.90	177,001.80	2,348,593.00	7.54%

Source: Central Bank of Nigeria Annual Report and Statement of Account 1968 – 2007

As can be seen from table 7, recurrent expenditure had repeatedly taken well over half of the funds spent in the public health sector. Unfortunately, up to 90 percent of the recurrent expenditure had often gone into personnel cost, such as payment of staff emoluments thereby leaving very little for the operation of services and maintenance of equipment. Thus, while available data have shown dramatic increases in absolute volume of naira budgeted for and expended on health, the impact of the expenditure had been limited. This can be traced to several factors. First, is the regular and unrestricted devaluation of Naira. It should be noted that several projects under capital expenditure required a lot of foreign material input. Thus, the constant devaluation of naira meant that there were actual decreases in the expenditures when considered in the dollar equivalent. Second, a significant proportion of the recurrent expenditure as we mentioned earlier was used to service personnel costs thereby leaving little for drugs supplies and system performance. The little left for drugs and consumables suffered additional reduction in purchasing capability because of indiscriminate devaluation of naira, as a large bulk of pharmaceutics used in the country or their raw materials are imported and paid for in hard currency. Another factor that reduced the impact of allocated resources was poor management practices that resulted in wastage of resources. Lastly, is the non-involvement of beneficiary communities in decision making on programmes and services. Poor leadership and political instability have also been the basis for unsuccessful health sector reform.

Health sector reform is constrained by corruption. Corruption is the misuse of entrusted power for private gain (Transparency International, 2011). It occurs when public officials, who have been given the authority to carry out goals, which further the public good, instead use their position and power to benefit themselves and those close to them. Corruption is a pervasive problem affecting the Nigerian health sector. Evidence abounds on the negative impact of corruption on health and welfare of Nigerians. The 1996 study of corruption by Transparency International and Goetingen University ranked Nigeria as the most corrupt nation among 54 nations listed in the study (Moore, 1997). In the 1998 Transparency International Corruption Perception Index (CPI) of 85 countries, Nigeria was 81 out of the 85 countries pooled (Lipset & Lenz, 2000).

Similarly, in the 2001 Corruption Perception Index, Nigeria was ranked 90 out of 91 countries pooled (Transparency International, 2001). Nigeria was ranked 147 out of 179 countries pooled in 2007 (Transparency International, 2007). There is no doubt that corruption remains an enormous drain on resources needed for developmental programmes including health. The Nigerian health sector is, particularly, vulnerable due to several factors. These include the uncertainty surrounding the demand for services; many dispersed actors including regulators, payers, providers, suppliers interacting in complex ways and asymmetric

information among the different actors making it difficult to identify and control for diverging interest. In addition, expensive hospital construction, high tech equipment and the increasing arsenal of drugs needed for treatment, combined with a powerful vendors and pharmaceutical companies present risks of bribery and conflict of interest in the health sector. Government officials use discretion to license and accredit health facilities, providers, services and products, thereby opening the risk of abuse of power and use of resources. The resulting corruption problems include among others, inappropriate ordering of tests and procedures to increase financial gain, absenteeism and use of government resources for private practice.

The implication of corruption problems is that not all the money appropriated for health programmes in the country end up being spent effectively. About half of the funds and materials provided for health efforts in the country never reached the lowest levels where they are needed most. For instance, the mosquito treated nets, which are meant to be given out free, are sold to the patients in some health institutions in the country. This has brought to the fore the issue of accountability and transparency. There is no doubt that lack of accountability and transparency creates opportunity for corruption. There are three components of accountability namely, a measurement of goals and results, the justification or explanation of those results to internal or external monitors and punishment or sanctions for non-performance or corrupt behaviour (Vian, 2008). Unfortunately, these components are either lacking or are not strictly adhered to in Nigeria's health sector. This can be attributed to the fact that each component of the three tier governance Federal, State and Local governments is involved in the provision of health care, which results in chaotic coordination, communication and poor accountability.

The net result of all these challenges was the inability of Nigeria to sustain the laudable health sector reform programmes initiated by government as manifested in its unsatisfactory performance in essential health indicators. In the final analysis, these factors have combined to foreclose the attainment of optimal benefits from the various health sector reforms instituted by government.

CONCLUSION

So far, we have demonstrated that Nigerian has persistently instituted health sector reforms aimed at improving the parlous health care delivery system in the country. Yet the health sector could not produce the desired results. This was due largely to inequality in access to health care, weak health systems, corruption among others. As a corollary, Nigeria has not maximised fully the opportunities provided by these reforms. However, we submit that the attainment of the desired results is essentially dependent on health sector reforms being explicit about reducing inequality in access to health services and ensuring that public health systems mitigate the impact of economic and social inequalities. This implies that equity must be built into the system from the outset to ensure that people living in poverty benefit as much as those who are better off. Experience has shown that prioritizing for-profit private healthcare delivery is extremely unlikely to deliver better health outcomes for poor people. While we are not averse to private sector participation in health sector, leaving the provision of health care to the market will only thrive in countries with strong institutions with capacity to monitor and regulate provisions as well as address the dangers of an often predatory corporate health sector. The truth is that this cannot be achieved in most African countries largely due to their weak institutional capacities.

Notwithstanding their numerous challenges, the publicly financed and delivered health care services offer higher performing, more equitable health systems.. For instance, a research conducted in Asia found that no low or middle-income country in the region has achieved universal or near universal access to health care without relying predominantly on tax funded public sector delivery. A case in point is Nepal where significant improvements in access to health care were achieved after user fees were removed for primary health care services in public services in 2008 (Witter, 2011). There is no doubt that the public services are

critical in the fight against inequality. They mitigate the impact of skewed income distribution and redistributive wealth by putting virtual income into the pockets of the poor.

Thus, in the face of the growing inequality in Nigeria, urgent and dedicated action is needed to strengthen public health systems. The government should institute reforms to address endemic corruption in the Nigeria's health sector. This is important in order to ensure transparency and accountability in the disbursement of funds meant for the health sector in the country. Efforts should also be made to implement the budget allocation to the health sector effectively. There should be efforts to establish complementary infrastructure to health services delivery, such as access roads, electricity, among others. This is vital, as available health centres are too far away from vulnerable people and those who actually need medicare. The above stated actions are imperative to enable Nigeria maximise the benefits of health sector reforms, which is key to sustainable development.

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