Health System in Nigeria: From Underperformance to Measured Optimism

Olusoji Adeyi

The World Bank, 1818 H Street NW, Washington, DC 20433. USA

oadeyi@worldbank.org
Fifty-five years after independence, indicators of Nigeria’s health outcomes and coverage of basic health services show under-performance, both in absolute terms and relative to other countries at similar levels of economic development. Yet, while the decline in infant and child mortality could be swifter, the trend of these indicators overall is in the right direction. Furthermore, the country’s recent successes against Guinea worm disease, poliomyelitis, and Ebola Virus Disease, show areas of high performance despite systemic weaknesses. There are marked variations across geopolitical zones and states; some of these, such as indicators of maternal and child health service coverage and outcomes, correlate strongly with educational status and wealth. Significant positive associations between education and the use of maternal health services in Nigeria are well documented, and so are the historical cross-regional variations in education policies and school enrollment.

The past five decades have seen numerous health policies and development plans in Nigeria, culminating in the National Health Act of 2014. The Act provides for a range of responsibilities, instruments, and institutions, covering but not limited to: responsibility for health, eligibility for health services, and establishment of a national health system; financing; health establishments and technologies; rights and obligations of patients and healthcare personnel; national health research and information system; human resources for health; control of blood, blood products, tissue and gametes in humans; and regulations and miscellaneous provisions. It is, potentially, a very consequential Act. To understand what needs to be different for this Act to succeed where prior national policies mostly under-achieved, it is worth examining the context and some key drivers of Nigeria’s health.
Why has the system not achieved effective coverage for all Nigerians, especially the poor?

Five interlinked factors contribute to the underperformance of Nigeria’s health system.

- Firstly, there is a historical lack of a consequential and voter-sensitive compact between the government and the population. The context in which the health system exists lacks mutual accountabilities in a framework of principals, agents, and citizens, and that context does not work for the poor. This is due to reasons that include entrenched rent seeking, patronage, and corruption, which are well documented elsewhere. Weak public financial management enables mismanagement and corruption. The context also influences various social determinants of health. To the extent that good health depends on determinants outside the health sector, health outcomes in Nigeria are hampered by underperformance in education (low literacy rates), agriculture (with reference to nutrition), infrastructure (inadequate water, sanitation, and power supply for households and health care facilities), and the environment (air pollution).

- Secondly, there are unintended consequences of policy design, compounded by problems of execution. The federal system, which provides for concurrent responsibilities, for three levels of government (local, state, and federal), breeds unintended dysfunction and complexities that make it hard to achieve intended benefits. Consequently, the health system has delivered poorly on: ensuring universal coverage with primary health care and fostering accountability through proximity of the local government to the population; enabling access to cost-effective secondary-level hospital services at the state level; and stewardship, public goods, and access to tertiary care, as and where appropriate, at the federal level. A core dilemma is that local governments have the weakest public administration capacities among the three levels of government, yet they are responsible for
primary health care, which is essential for realizing the most cost-effective services in maternal and child health.

- Thirdly, there is the absence of an institutionalized function of evidence-based planning, research, and statistics to inform policies, enable rational resource allocation choices, and make explicit the performance of the health system at all levels.\textsuperscript{13,14} Given the wealth of well-trained professionals in health policy, business management, public policy, public health, and clinical sciences, this is a paradox of strong individuals and weak institutions.

- Fourthly, there are important dysfunctions in the architecture and dynamics of development assistance for health, including in Nigeria.\textsuperscript{15-17} For example, the vacuum created by the lack of a robust domestic planning function is filled partly by externally financed, off-budget projects, with self-contained and parallel infrastructures, including supply chains that are separate from those in the local economy. Although development assistance accounts for less than 5 percent of total health expenditures per year in Nigeria, and such off-budget projects may work well in the very short term, they are neither grounded in and unlikely to be sustainable through domestic policies and resources. One does not have to fully agree with Angus Deaton’s postulates about the problems with development assistance\textsuperscript{18} to wonder about the ultimate usefulness of such projects.

- Finally, Nigeria’s approach to health financing is too driven by inputs\textsuperscript{13} such as number of health centers built, number of health workers trained and deployed, and quantities of equipment purchased, with relatively little attention to outcomes, incentives, prospective evaluation, and factors that lead to major variations across and within geographic zones of the country. This occurs at all levels of public administration.
Prospects

Although the past is sobering and the present is challenging, there are grounds for measured optimism about the future of health in Nigeria. What will it take to achieve Universal Health Coverage? The National Health Act of 2014 provides a legal foundation for transforming a dysfunctional system into one that works for the population, especially the poor. Doing so will require sustained work on multiple fronts. The following is an outline of key considerations to enable that transformation from the status quo to a high-performance trajectory.

Public accountability for basic health services and public goods, with a backbone of public financial management and transparency: Nigeria’s total health expenditure per capita in 2014 was US$118, of which 72% was private out-of-pocket, and 25% general government health expenditure. For the country to get good value from this expenditure, it is important for the public to know what is expected of government and how well the system is working for them, with benchmarks and annual reports on expenditures, as well as targets, results and gaps between targets and achievements for service coverage and health outcomes, by local government and state. This applies to clinical services received by the individual, and to public goods that require multi-sectoral collaboration, such as the control of tobacco and air pollution. These reports should be widely available in the public domain, in local languages, and publicized via social media, newspapers, radio, and television. A transition to combinations of pre-paid insurance and funding from general revenues will reduce the risks of financial hardship from catastrophic out-of-pocket expenditures at the point of service delivery. By enabling accountability, these measures can address problems arising from a weak social compact, policy design and execution, and evidence-based planning. The Mozambique Public Financial Management for Results Program is an emerging example of that Nigeria could consider for local adaptation to improve the transparency and efficiency of expenditures for the storage,
distribution, and availability of medicines and supplies, and for more transparent and accountable management of health care facilities at the local government level.

A credible, professional, and effective health planning, finance and metrics function in the Federal and State Ministries of Health. The need is to go beyond individual competencies of staff to the effective performance of institutional functions, with a continuous capacity to: define evidence-based options and inform decisions about resource allocation for the highest returns on investment; set priorities amidst resource constraints; pay attention to the epidemiological transition, including changes in service delivery that are required to deal with chronic non-communicable diseases; ensure that medium-term expenditure frameworks align with public policy priorities; and better align development assistance with domestic planning and financing cycles. More immediately, this function is essential to translate from paper to reality the provisions of the National Health Act of 2014, central to which is the establishment of the Basic Health Care Provision Fund to be funded from a federal government annual grant of not less than one percent of its Consolidated Revenue Fund, grants by international donor partners, and funds from other sources. Doing so would make it possible for the country to get an overarching grip on progress towards Universal Health Coverage, with attention to sustainable financing from domestic sources, and effective support for local governments through Primary Health Care Under One Roof.

A shift to performance-based financing of essential health services. The deeply entrenched tradition of input-based financing has not served the country well. The government’s adoption of performance-based funding through the Saving One Million Lives Initiative, which is funded partly by a credit from the World Bank, is a promising development in this direction. Reaping maximum benefit from this approach will entail its use to inform the purchasing of services from the private sector by government and the National Health Insurance Scheme. Performance-
based financing would also help to address the chronic challenge of getting health service
delivery value out of money spent on federal government-owned teaching hospitals. The
purpose here is to enable a system-wide shift, at all levels of public administration, from merely
counting inputs to accountability for independently verifiable results. Instead of massive
additional expenditures on government-owned clinics and health centers, government and the
National Health Insurance Scheme should consider functioning as strategic purchasers of
services from the private sector, with better use of private sector service providers through
contracts that include service level agreements on the scope, scale, and levels of performance.
This could improve value for money realized from the National Health Act.

Better use of the private sector for supply chains and clinical service delivery. Nigerians are
familiar with choice of service providers for telecommunications services, and there is a big
difference between telecommunications service delivery by the chronically inefficient NITEL
(Nigerian Telecommunications Limited) when it was a government-owned monopoly for
telephone services, and the current array of private telephone service providers.23 Yet, in a
contrast in efficiency between the supplies chains for the telecommunications and health
sectors, there persist government-owned and government-managed medical stores and
distribution systems in Nigeria, the functions of which are not inherently governmental, and
which could be contracted to the domestic private sector. Similarly, it is hard to make a
convincing case for development assistance for health that creates or relies on supply chains
run by external contractors that substitute for, instead of using and improving, domestic private
sector supply chains. After all, those domestic supply chains get varieties of non-health
commodities to remote parts of the country.

Development of institutions to perform core public health functions. The case is strong for
carefully managed investments in the Nigeria Center for Disease Control, and for the proposed
regional ECOWAS Center for Disease Control (ECOWAS is the Economic Community of West African States). Nigeria’s relative success in curbing the spread of Ebola underscores the need to continue investing in institutions to perform the core public health functions of disease surveillance across the human and animal health sectors, detection and control of epidemics, and cross-country coordination across the Africa region. The rationale for public investments in the functions and institutions for regional disease surveillance and response systems is five-fold.24 Firstly, while there are unmet needs, individuals and the private sector lack the combination of information and incentives to develop such systems; there is a failure in the “market” for disease surveillance and response. Secondly, the benefits of effective disease surveillance and response are public goods; individuals cannot be excluded from those benefits, and their use by one person does not prevent others from benefiting. Thirdly, there is an equity dimension. In highly stressed health systems, the poorest suffer the most from the consequences of disease outbreaks. Fourthly, given the potential destabilization that could arise from massive disease outbreaks, disease surveillance and response are arguably parts of national security measures, much the same as initiatives against terrorism. They cut across multiple sectors, including but not limited to agriculture, animal health, and the environment. Finally, while a few countries may be able to build effective national detection and response capacities, they will remain vulnerable to the spread of outbreaks from elsewhere. Performing core public health functions will both require and promote the use of scientific evidence to inform public policy and program implementation.

With the multitude of partners and stakeholders with mandates and interests in this agenda, it is imperative that support to countries be effectively coordinated. A high-level mapping of stakeholders, emphasizing their relevant competencies and resources, is essential. It would enable the country and its regional partners to specify current assets, mission-critical gaps and resources required for the effective launch of the regional Center for Disease Control. Key areas
for attention include cross-sectoral cooperation (among human health, animal health and agriculture sectors), planning for financial sustainability by embedding country-level commitments into public expenditure frameworks, public financial management, and whole-of-system approaches to monitoring and evaluation.

**Channeling civil society activism and the emerging accountability paradigm.** There is a commendable history of critiques of tolerance or indifference to corruption, poor services, and weak infrastructure in Nigeria. It has been described as “Shuffering and Shmiling” amidst plenty, a syndrome that consists of hardships due to poor governance and harsh living conditions, rationalization of those hardships based on faith in religious pathways to luxury in heaven, and ironic blindness to the fact that the leaders of religions live in comfort here on earth instead of deferring it to heaven. Apathy amidst entrenched corruption has also been decried as being “shocked to the state of unshockability.” Yet, there is plenty of hope. The growing quest for accountability, civil society engagement, the artful deployment of social media, such as through the Nigeria Health Watch, and the push for transparency in budgets, give cause for optimism that, this time, it could be positively different. The health sector would benefit from embracing demand for accountability as an opportunity to put the system to work for better performance.

The Nigerian health system has a track record of underperformance. With sustained attention to informed policies, institutions, and accountability for results, there are grounds for measured optimism about its future.
Acknowledgments and disclaimer: The author thanks Oluwole Odutolu, Kelechi Ohiri, and Michael R. Reich for helpful critiques and comments on a draft of the paper. The themes, views and conclusions in this paper are the author’s alone, and should not be attributed to the World Bank or any other institution with which he is associated.
REFERENCES


