### HEALTH POLICY AND SYSTEMS RESEARCH PROJECT
EBONYI STATE UNIVERSITY/WORLD HEALTH ORGANIZATION

**POLICY BRIEFS ON HEALTH SYSTEMS BUILDING BLOCKS**

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HEALTH POLICY AND SYSTEMS RESEARCH PROJECT
EBONYI STATE UNIVERSITY/WORLD HEALTH ORGANIZATION

Policy Brief  No.1

STRENGTHENING THE GENERATION/STRATEGIC USE OF HEALTH INFORMATION AND EVIDENCE FOR HEALTH SYSTEMS OPERATIONS AND POLICYMAKING IN NIGERIA

KEY MESSAGES:

The Policy Issue: The availability of accurate, timely, reliable and relevant health information is the most fundamental step toward informed public health action. Therefore, for effective management of health and health resources, governments at all levels in Nigeria have overriding interest in supporting and ensuring the availability of health data and information as a public good for public, private and NGOs’ utilization.

Magnitude of the Problem: The major constraints in the generation/strategic use of health information and evidence for health systems operations and policymaking in Nigeria include: Nigeria health information system characterized by suboptimal data collection and analysis system; inadequate quality control measures; inadequate and ineffective staff training in data analysis, interpretation and use at all levels; misreporting of conditions, poor understanding, low confidence and acceptability; weak monitoring, evaluation and managerial capacity at the periphery and; inadequate IT facility and technology; lack of skills and incentives to access information.

Policy Options:

(1). Role of government: The role of government must extend to ensuring standardization and financing of health data infrastructure, especially with respect to establishing and strengthening relevant organizational structures for Health Management Information System (HMIS) activities.

(2). Special initiative on health information: There should be the launching of a special initiative to improve access to health information in Nigeria.

(3). Research information and learning needs and barriers to use of information: Support systematic reviews and new research into information needs, barriers to access, and barriers to use of information among healthcare providers in Nigeria.

(4). Access to existing materials for healthcare providers in developing countries: Libraries and resource centres should provide cost-effective access to computers, the internet, and printed materials for healthcare providers.

(5). Internet and e-mail connectivity: Support the provision of e mail and internet connectivity worldwide, giving priority to individuals and groups where access will have most impact at the point of greatest need.

(6). Skills development and training: Investigate the training and learning needs for each group within the knowledge cycle at different levels of healthcare; identify and support effective training programmes.
COMPLETE REPORT

Introduction

The availability of accurate, timely, reliable and relevant health information is the most fundamental step toward informed public health action. Therefore, for effective management of health and health resources, governments at all levels in Nigeria have overriding interest in supporting and ensuring the availability of health data and information as a public good for public, private and NGOs’ utilization (FMHN, 2007). This has necessitated the establishment of effective National Health Management Information System (NHMIS) by the governments at all levels in Nigeria to be used as a management tool for informed decision-making at various levels. Health information and evidence have been identified as major components of the ‘building blocks’ of health systems in the World Health Organization’s Framework for Action on health systems (WHO 2007). This is because better health systems can be developed when timely and reliable information and evidence are used for decision- and policy-making.

The use of health information has been promoted as having tremendous promise in improving the efficiency, cost-effectiveness, quality, and safety of medical care delivery in our nation’s healthcare system (SCEPC, 2006). According to WHO, a well functioning health information system is one that ensures the production, analysis, dissemination and use of reliable and timely health information by decision-makers at different levels of the health system, both on a regular basis and in emergencies. It involves three domains of health information as follows: health determinants; health systems performance; and health status (WHO 2007).

To achieve this, the World Health Organization’s Framework for Action on health systems (WHO 2007), recommends that a health information system must:

1. Generate population and facility based data: from censuses, household surveys, civil registration data, public health surveillance, medical records, data on health services and health system resources (e.g. human resources, health infrastructure and financing);
2. Have the capacity to detect, investigate, communicate and contain events that threaten public health security at the place they occur, and as soon as they occur;
3. Have the capacity to synthesize information and promote the availability and application of this knowledge.

The advent and global spread of the internet has brought with it the potential to achieve universal access to healthcare information. This means ready access to relevant, reliable, and up to date information for all those who want it. Healthcare providers are an extremely diverse group with widely varying social, educational, cultural, economic, and behavioural attributes. While many at all levels in health care will actively seek information and the skills to interpret it, many will not or will be frustrated in the attempt.

Most healthcare providers in Nigeria continue to lack access to the information they need to deliver the best possible healthcare with available resources. There is little evidence that the majority are better served than they were 10 years ago, particularly at primary care level. However, important progress has been made in many areas:

(i). increasing availability of information and communication technologies;
(ii). increasing number and range of health information support programmes;
(iii). increased availability of free resources on the internet;
(iv). evolution of a loose international community committed to improving health information access; and
(v). increasing political interest in access to healthcare information as a key development issue.
Information is vastly more usable if it is in electronic form. Electronic information can be viewed as the raw material, which can then be made available to end users via a range of methods and platforms, including paper and digital radio. It is particularly important that producers of healthcare materials and other health information professionals have adequate internet connectivity. The availability of information online has driven improvements in connectivity. But even with full political commitment and substantial funding, universal Internet and e-mail connectivity is an enormous challenge.

Therefore in Nigeria there is a dire need to strengthen the health information system through the provision of appropriate infrastructure, and the establishment of mechanisms/procedures for collecting and analyzing health data to provide needed information:

(a) To assess the state of the health of the population;
(b) To identify major health problems;
(c) To set priorities at the local, state and national levels;
(d) To monitor the progress towards stated goals and targets of the health services;
(e) To provide indicators for evaluating the performance of the health services and their impacts on the health status of the population;
(f) To provide information to those who need to take action, those who supplied the data and the general public.

**Definition and magnitude of the problem**

In recent years, WHO has placed more emphasis on evidence-based decision-making. Most developing countries including Nigeria are attempting to enhance their national health information systems, often with the support of partner agencies. However, overall progress has been slow. The National Health Management Information System (NHMIS) became operational in Nigeria in 1995 as a management tool for informed decision making at all levels. However, data returns have been untimely and of poor quality, and utilization is low with little reporting and feedback. Although priorities have been identified for health research and operational guidelines for health research (ethical, institutional, social and legal) existence, there is yet to be a framework for the coordination of health research in Nigeria. Planning, monitoring and evaluation of health services are hampered by the dearth of reliable data. The basic demographic data about the size, structure and distribution of the population are unreliable on a national scale. The system for the registration of births and deaths nationally is defective and hence it is not possible to calculate the simplest indicators like the crude birth rate, crude death rate and infant mortality rate. The state of health of the population is assessed on the basis of scanty information, which has been collected in a few limited surveys and research studies. The health services at the national, state and local government levels cannot be managed efficiently on the basis of the available data.

The World Health Organization has reported that several countries including Nigeria are making better use of information technology in recent times, leading to improvements in the disease surveillance systems. Nevertheless, most of these countries still use a wide range of data collection and analysis tools, some of which collect the same data. An increasing volume of data is available, but coverage and quality are variable, thus linking information to policy-making at the national level remains critical, but elusive, goal. If the quality of health information is highly variable, it is unlikely to be widely used as is observed in Nigeria. Problems faced by developing countries according to WHO include the following:

(a) weak organizational support for data collection systems;
(b) lack of standardization and coherence in attempts to improve health information systems;
(c) untimely collection of data;
(d) inadequate use of information and evidence for decision-making;
(e) inadequate data analysis and communication skills; and
(f) overambitious computerization of health information systems that countries are unable to maintain.

The Federal Ministry of Health Nigeria (FMHN, 2007), have identified the major constraints in the generation/strategic use of health information and evidence for health systems operations and policymaking in Nigeria as follows:
1. The existing health information system in Nigeria is characterized by extensive duplication of data collection, entry and analysis (no fewer than 50 data forms are in use at the federal level alone); multiple data pathways;
2. Lack of standard case definitions;
3. Lack of clarity with regards to data submission and responsibilities;
4. Inadequate quality control measures;
5. Inadequate and ineffective staff training in data analysis, interpretation and use at all levels;
6. Misreporting of conditions, poor understanding, low confidence and acceptability;
7. Weak monitoring, evaluation and managerial capacity at the periphery and;
8. The absence of a strong central coordinating institutional framework.

Barriers to accessing information and using it are still poorly understood, especially among healthcare providers and patients in the developing world. These barriers need more research. Known and assumed barriers include:
(i). Lack of physical access (slow or unreliable internet connectivity, high cost of paper, high subscription cost to products);
(ii). Lack of awareness of what is available;
(iii). Lack of relevance of available information (not meeting needs in terms of scope, style, language, format);
(iv). Lack of time and incentives to access information; and
(v). Lack of skills to interpret it.

**Policy options and implementation strategies for addressing the problem**

1. **Role of government**
   The role of government must extend to ensuring standardization and financing of health data infrastructure, especially with respect to establishing and strengthening relevant organizational structures for Health Management Information System (HMIS) activities. It should also extend to procurement and installation of appropriate information technology, staff training and collection, storage, analysis, dissemination and use of health information, as well as in financing essential systems and biological research.
   The government should institute mechanisms that would ensure the following:
   (a). Establishment, development and strengthening of HMIS units appropriate to each level of service delivery and decision making;
   (b). Provision of information, to manage the health care system;
   (c). Provision of information for assessing the state of health of the population;
   (d). Provision of information to identify major health problems and to set priorities at the local, state and national levels;
   (e). Provision of information to monitor the progress towards stated goals and targets of the health services;
(f). Provision of indicators for evaluating the performance of health services and their impact on the health status of the population;
(e). Provision and validation of standardized data collection forms, technical support and review of data validation and quality assurance processes;
(f). Preparation and dissemination of protocols for collecting comparable data on national health objectives and indicators, and appropriate HMIS manuals for the operation of the system;

2. Special initiative on health information
There should be the launching of a special initiative to improve access to health information in Nigeria. The initiative should include the establishment of working groups to draft strategy, objectives, and programmes of work in the following seven key areas:
(a). Researching information needs and barriers to use of information.
(b). Providing access to existing materials for healthcare providers in Nigeria;
(c). Providing access to the results of research;
(d). Improving relevance and usability of materials for healthcare providers in Nigeria;
(e). Improving reliability and currency of materials for healthcare providers in Nigeria;
(f). Improving internet and e-mail connectivity;
(g). Skills development and training.

3. Research information and learning needs and barriers to use of information.
(a). Support systematic reviews and new research into information needs, barriers to access, and barriers to use of information among healthcare providers in Nigeria.
(b). Support initiatives that strengthen local information cycles, through face to face meetings or e mail list serves; both within sectors (eg. healthcare providers) and across sectors (involving healthcare providers, producers of knowledge materials, systematic reviewers, researchers, editors, and indexers). Such cycles or groups could be used to identify information needs, barriers to access, barriers to use of information, influential initiatives, and suggestions for future activity.

4. Access to existing materials for healthcare providers in Nigeria
(a). Explore ways for libraries and resource centres to obtain a comprehensive overview of publications available for different types of end user.
(b). Consider creating a global online library for health that could pull together, organise, catalogue, and annotate existing electronic knowledge resources (drug formularies, guidelines, handbooks), making it easy for libraries and end users to find information relevant to their needs.
(c). Consider specific support for national reference centres that would provide full access to each country's formal publications (electronic and print).
(d). Support access to 'essential' products in local languages: for example, core learning materials (eg textbooks, manuals) and reference materials (eg drug formularies).
(e). Explore the potential of radio and television for local exchange of healthcare information and distance learning.

5. Internet and e-mail connectivity
(a). Support the provision of e mail and internet connectivity worldwide, giving priority to individuals and groups where access will have most impact at the point of greatest need. In our view, these priority groups are libraries, local resource centres, and local producers of materials for healthcare providers.
(b). Explore potential for involving the private section through subsidies from internet providers and satellite services.
(c). Investigate the potential of leap frog technologies
(d). Explore ways to increase provision of computers and other hardware, and to increase the availability of IT support.

6. Skills development and training
(a). Investigate the training and learning needs for each group within the knowledge cycle at different levels of healthcare (primary/secondary/tertiary) and in different countries and settings. In each case, identify and support effective training programmes, and evaluate them to ensure value for money.
(b). Support the rationalisation of existing training initiatives within regions and sectors.
(c). Support experimentation with active adult learning techniques, including learning needs assessment, interactive learning, reflection and response, and personal development plans.
(d). Establish meaningful incentives to encourage uptake of training, such as CME points and re-accreditation.
(e). Support schemes that encourage sustainable mentoring and peer support at local, regional, and international level.

References & Further Reading


KEY MESSAGES

The Policy Issue: A well-functioning health system ensures equitable access to essential medical products, vaccines and technologies of assured quality, safety, efficacy and cost-effectiveness, and their scientifically sound and cost-effective use. In many developing countries including Nigeria, there is currently increasing awareness of the importance of essential medical products and technologies. Initiatives and strategies for improving availability and use of essential medical products and technologies are being instituted in many parts of the developing world and these include: rational selection, rational use, affordability, sustainable financing, reliable supply, quality and combating counterfeits, monitoring, and the effects of globalization.

Magnitude of the Problem:
The major issues associated with medical products, equipments and technologies in Nigeria bother on standards and quality in pharmaceuticals, equipment and health technology. These issues include: counterfeits, over-prescribing, and unsatisfactory purchasing and pricing arrangements for pharmaceuticals, equipment and technology.

Policy Options:
1. Establishment of a national drug policy as a common framework to solve problems in pharmaceuticals

Experience in many countries has shown that the complicated and interdependent problems associated with quality and use of essential drugs can best be addressed within a common framework, as piecemeal approaches can leave important problems unsolved and often fail. WHO recommends that all countries formulate and implement a comprehensive national drug policy (NDP) (WHO, 2008b). A national drug policy is a commitment to a goal and a guide for action. It expresses and prioritizes the medium- to long-term goals set by the government for the pharmaceutical sector, and identifies the main strategies for attaining them. It provides a framework within which the activities of the pharmaceutical sector can be coordinated.

2. Health technology assessment

Health technology assessment (HTA) has increasingly emerged as a tool for informing more effective regulation of the utilization and diffusion of health technologies. HTA thus seeks to consider the broader impacts of health technologies and to evaluate their benefits and costs in both medical and economic terms. It helps to identify a particular intervention’s optimal utilization, its appropriate placement in the spectrum of care, and the patients who will benefit.

3. Establishment and Implementation of the National Health Equipment Policy for Nigeria

The implementation of the National Health Equipment Policy for Nigeria shall be by legislation, which will include the establishment of a regulatory body. To ensure success, the strategies shall take into account, expressed fears and needs of all interest groups. This shall be followed by the drawing up of regulations for carrying out the provisions of the law.
COMPLETE REPORT

1.0 Introduction

A well-functioning health system ensures equitable access to essential medical products, vaccines and technologies of assured quality, safety, efficacy and cost-effectiveness, and their scientifically sound and cost-effective use (WHO 2007). In many developing countries including Nigeria, there is currently increasing awareness of the importance of essential medical products and technologies. Initiatives and strategies for improving availability and use of essential medical products and technologies are being instituted in many parts of the developing world and these include: rational selection, rational use, affordability, sustainable financing, reliable supply, quality and combating counterfeits, monitoring, and the effects of globalization (WHO 2008a).

To ensure equitable access to essential medical products, vaccines and technologies of assured quality, safety, efficacy and cost-effectiveness, the World Health Organization (WHO, 2007) noted that the following are needed:

(i). National policies, standards, guidelines and regulations that support policy;
(ii). Information on prices, international trade agreements and capacity to set and negotiate prices;
(iii). Reliable manufacturing practices and quality assessment of priority products;
(iv). Procurement, supply, storage and distribution systems that minimize leakage and other waste;
(v). Support for rational use of essential medicines, commodities and equipment, through guidelines, strategies to assure adherence, reduce resistance, maximize patient safety and training.

The World Health Organization has a strong track record in helping countries frame national policies. It promotes evidence-based selection of medicines, vaccines and technologies by developing international standards, norms and guidelines through WHO’s Expert Committees and consultation processes. It promotes equitable access and rational use, for example, through essential medicines lists, clinical guidelines, strategies to assure adherence and safety, training and working with consumer organizations. It also supports technology assessments and policy development (WHO, 2007).

1.1 Essential Drugs

Essential drugs play a crucial role in many aspects of health care. If available, affordable, of good quality and properly used, drugs can offer a simple, cost-effective answer to many health problems (WHO 2008b).

The work of WHO in essential drugs contributes to WHO’s four strategic directions:

Strategic direction 1: reducing the burden of excess mortality and disability by increasing access to essential drugs;

Strategic direction 2: reducing risk factors for human health by monitoring the emergence of anti-infective drug resistance, and creating safer environments for drug prescription, distribution, and consumption.

Strategic direction 3: Assisting with the development of health systems by building sustainable management capacity in pharmaceuticals as a fundamental component of functional and reliable health systems.

Strategic direction 4: Developing an enabling policy and institutional environment in the health sector by supporting countries in the development of national drug policies within the framework of national health policies and involving all partners in the pharmaceutical sector.

In view of the centrality of efficacious drugs to the success of the health care system, the Nigeria National Health Policy noted that there should be consistent implementation of the National Drug Policy at all levels of health care delivery with necessary steps taken to:-

1. Draw up a list of essential drugs and vaccines and set up mechanisms to ensure that the drugs are available and are rationally used at all levels of the health care system;

2. Develop local capability to produce essential drugs, vaccines and dressings and to reduce dependence on imports by offering suitable incentives to firms which are engaged in the local manufacture, research and development of drugs;
3. Keep surveillance on the quality of food, drugs, cosmetics and other regulated products, through effective monitoring of importation and distribution channels and enforcement of relevant regulations; develop a system of monitoring the adverse effects of drugs;
4. Establish efficient systems for the procurement, storage and distribution of drugs and vaccines, including a reliable "cold chain" for the latter;
5. Allocate resources for relevant drug research, including traditional remedies;
6. Control the advertisement of drugs and other health-related regulated products;
7. Establish Drug Information Centres at all levels;
8. Establish guidelines for the clinical trials of new drugs and for drug donations;
9. Allocate a specific percentage of the total health budget to drugs.

1.2 Medical Equipment

Medical equipment are devices used in different aspects of health care delivery and designed to aid in the prevention, diagnosis, treatment, rehabilitation etc. of medical problems. It is usually designed with rigorous safety standards. There are several basic types of medical equipment such as:
(a). Diagnostic equipment: which include medical imaging machines used to aid diagnosis e.g. ultrasound, MRI, CT-scans, PET, and x-ray machines.
(b). Therapeutic equipment: infusion pumps, medical lasers, surgical machines etc.
(c). Life support equipment: is used to maintain a patient's bodily function such as medical ventilators, heart-lung machines, ECHO, and dialysis machines.
(d). Medical monitors: allow medical staff to measure a patient's medical state. Medical laboratory equipment automate or help analyse of blood, urine and genes.

Concerning medical equipment, the Nigeria National Health Policy noted that there should be:
1. The selection, ordering and maintenance of equipment and devices (e.g., x-ray machines, anaesthetic equipment, refrigerators) shall be rationalized so as to obtain savings in their cost of purchase and maintenance as well as ensuring their reliable service.
2. Existing maintenance units in tertiary and secondary health facilities shall be strengthened to be more effective and efficient to facilitate an enduring maintenance culture.
3. Ministries of Health shall co-operate by exchanging information, standardization of specifications and the sharing of facilities for the maintenance of equipment.
4. Technological transfer and training shall be part of contracting conditions for the purchase of complex and sophisticated medical equipment.

1.3 Health Technologies

Health technologies are developed to solve a health problem and improve quality of lives. They form an indispensable component of the services health systems can offer in the prevention, diagnosis and treatment of disease and in alleviating disability and functional deficiency. Access, including in primary health care, to safe and effective health technologies relies on policies for selection and management based on scientific evidence and best practice for organization of their management and use.

The Nigeria National Health Policy identifies National Health Technology as an important element of the health care delivery system as follows:
1. The most appropriate health technologies shall be selected for use at all levels of the health care system. Particular care shall be taken to identify the most cost-effective technologies and to maintain them at the highest level of efficiency. In order to reduce importation of supplies, indigenous manufacturing capabilities shall be fostered in the spirit of self-reliance.
2. The policy on national health technologies shall be directed at ensuring the selection, development and application of appropriate technologies at each level of health care. Appropriateness shall be
judged on the basis of effectiveness, safety, the ability of the community to pay for it, and the availability of expertise to utilize and maintain the technologies.

3. A systematic assessment shall be made of the health technologies being considered for use in each priority programme. This shall include measures for health promotion, disease prevention, diagnosis, therapy and rehabilitation.

4. The process of determining health technologies shall also entail specifying for each programme what measures shall be taken by individuals and families in their homes and by communities; whether by individual or community behaviour or by specific technical measures. Measures to be taken by the health services at the primary, secondary and tertiary levels, as well as those to be taken by sectors, shall be specified.

5. To arrive at appropriate technologies, mechanisms for effective consultations with other relevant government departments, institutions as well as communities shall be established.

2.0 Definition and magnitude of the problem
Decentralization of both pharmaceuticals and technology has presented a challenge to the implementation of policy in many aspects in Nigeria. Two very important questions that are very crucial to availability and equitable access to essential medical products, equipment and technologies in Nigeria are as follows:
(1) What are innovative methods for selecting, financing, maintaining, monitoring, promoting access and encouraging the rational use of medical products, equipment and technology?
(2) What needs to be done in countries with regard to medical products, equipments and technologies to promote quality and universal access for all?

The major issues associated with medical products, equipments and technologies in Nigeria bother on standards and quality in pharmaceuticals, equipment and health technology. These issues include: counterfeits, over-prescribing, and unsatisfactory purchasing and pricing arrangements for pharmaceuticals, equipment and technology.

2.1 Problems with essential Drugs
Despite the obvious medical and economic importance of drugs there are still widespread problems with lack of access, poor quality, irrational use and waste. In many settings essential drugs are not used to their full potential.

Poor quality: In Nigeria drug quality assurance systems are not optimal because they lack all the necessary functional components. Although there exist the National Agency for Drugs & Food Control & Administration (NAFDAC), the agency lacks adequate resources and infrastructure to enforce the drug legislation and regulations. Thus, substandard and counterfeit products still circulate freely. In addition, inappropriate handling, storage and distribution also alter the quality of drugs. All these factors may have serious health consequences and lead to a waste of resources. Counterfeit medicines are found everywhere in Nigeria. They range from random mixtures of harmful toxic substances to inactive, ineffective preparations. Some contain a declared, active ingredient and look so similar to the genuine product that they deceive health professionals as well as patients. But in every case, the source of a counterfeit medicine is usually unknown and its content unreliable. Counterfeit medicines are always illegal. They can result in treatment failure or even death. Eliminating them is a considerable public health challenge.

Irrational use of drugs: Even people who have access to drugs may not receive the right medicine in the right dosage when they need it. Many people buy, or are prescribed and dispensed, drugs that are not appropriate for their needs. Some use several drugs when one would do. Others use drugs that carry
unnecessary risks. The irrational use of drugs may unnecessarily prolong or even cause ill-health and suffering, and results in a waste of limited resources.

Persistent problems and new challenges: These problems have persisted despite all the work done to improve access to essential drugs, to ensure drug quality and to promote rational drug use. The reasons are complex and go beyond simple financial constraints. To understand them it is necessary to look at the characteristics of the drug market, and to study the attitudes and behaviour of governments, prescribers, dispensers, consumers and the drug industry. Health sector development, economic reform, structural adjustment policies, trends towards liberalization, and new global trade agreements all have a potential impact on the pharmaceutical situation in many countries. They may also affect the ultimate goal of achieving equity in health.

2.2 Medical Equipment

The State of Medical Devices Situation in Nigeria: According to FMHN (2005), in reviewing the state of medical devices in Nigeria, a Ministerial Committee visited some hospitals and other health care institutions in the country and found as follows:

(i). All Teaching/Specialist Hospitals had similar problems ranging from lack of competent maintenance/teaching personnel, to various obsolete and broken down equipment.

(ii). The Committee was unable to determine the date of manufacture and/or year of purchase of certain equipment, due to non-availability of reliable inventory and inadequate records in others.

(iii). The non-availability of spare parts and limited technical capability rendered a great number of multi-million naira equipment useless and inoperable.

(iv). The methods adopted for the maintenance and repairs of equipment in most were based on trial and error, which rendered a lot of the equipment useless.

(v). The difficulties in maintenance and repairs stem from lack of standardization of equipment

(vi). End users are not adequately trained.

(vii). Non-involvement of end users at the planning stage of procurement.

(viii). Most of the suppliers of Medical devices have no after-sales service.

(ix). Health Professionals and other categories of staff involved in the use and maintenance of health equipment often resort to improvisations, which may have affected the accuracy and reliability of their efforts.

(x). In most of the Teaching/Specialist Hospitals and other health-care institutions the concept of commercialization of technical services in terms of repair and maintenance of health equipment has not been in practice. Hence, their revenue generation capabilities have not been tapped.

(xi) Poor storage conditions in some hospitals may have contributed to the breakdown of equipment after commissioning.

(xii). Planned Preventive Maintenance Service (PPMS) not in practice in the Health Institutions and Hospitals.

(xiii). Inadequate financial allocation specifically “ring fenced” for health equipment maintenance and replacement of spare parts.

Implications and consequences of the state of Medical Devices in Nigeria: The lack of a Health Equipment Policy in the country has resulted in a situation characterized by the following:

a. Inappropriate selection and uncoordinated acquisition of medical devices;

b. Unserviceable, obsolete and poorly maintained medical devices;

c. Inability to achieve set health objectives;

d. Purchase of equipment without consultation with the end-users or any technical advisory body;

e. Acceptance of equipment from donors without scrutiny and regard to standards;

f. Over dependence on imported medical devices;

g. Lack of job satisfaction, low morale and decreased productivity;
h. Loss of scarce resources in the importation of inappropriate medical devices;

i. Lack of human resource development and training;

j. Inadequate technical information support to the health sector; and

k. Lack of adequate budgetary provision for medical equipment maintenance, repair and replacement of obsolete equipment.

3.0 Policy options and implementation strategies for addressing the problem

3.1 Establishment of a national drug policy as a common framework to solve problems in pharmaceuticals

Experience in many countries has shown that the complicated and interdependent problems associated with quality and use of essential drugs can best be addressed within a common framework, as piecemeal approaches can leave important problems unsolved and often fail. In addition, the different policy objectives are sometimes contradictory, and so are the interests of some of the stakeholders. On the basis of this experience, WHO recommends that all countries formulate and implement a comprehensive national drug policy (NDP) (WHO, 2008b). A national drug policy is a commitment to a goal and a guide for action. It expresses and prioritizes the medium- to long-term goals set by the government for the pharmaceutical sector, and identifies the main strategies for attaining them. It provides a framework within which the activities of the pharmaceutical sector can be coordinated.

A functional national drug policy is needed in Nigeria for the following reasons:

(i). to present a formal record of values, aspirations, aims, decisions and medium- to long-term government commitments;

(ii). to define the national goals and objectives for the pharmaceutical sector, and set priorities;

(iii). to identify the strategies needed to meet those objectives, and identify the various actors responsible for implementing the main components of the policy;

(iv). to create a forum for national discussions on these issues.

The drug policy should be able to accomplish the following:

(a). *Establish norms and standards:* Set, validate, monitor, promote and support implementation of international norms and standards to promote the quality of medical products, and ethical, evidence-based policy options and advocacy.

(b). *Procurement:* Encourage reliable procurement to combat counterfeit and substandard medical products, and to promote good governance and transparency in procurement and medicine pricing.

(b). *Access and use:* Promote equitable access, rational use of and adherence to quality products, through providing technical and policy support to health authorities, professional networks, consumer organizations and other stakeholders.

(c). *Quality and safety:* Monitor the quality and safety of medical products, by generating, analysing and disseminating signals on access, quality, effectiveness, safety and use.

(d). *New products:* Stimulate development, testing and use of new products, standards and policy guidelines, emphasizing a public health approach to innovation, and on adapting successful interventions, with a focus on essential medicines that are missing for children and for neglected diseases.

3.2 Health technology assessment (HTA)

Health technology assessment (HTA) has increasingly emerged as a tool for informing more effective regulation of the utilization and diffusion of health technologies. While there are various definitions, often relating to evidence-based medicine and comparative effectiveness research, HTA can be seen as
“a multidisciplinary process of policy analysis that examines the medical, economic, social, and ethical implications of the incremental value, diffusion, and use of a medical technology in health care” (Sorenson et al., 2008). HTA thus seeks to consider the broader impacts of health technologies and to evaluate their benefits and costs in both medical and economic terms. It helps to identify a particular intervention’s optimal utilization, its appropriate placement in the spectrum of care, and the patients who will benefit. The impact of HTA can be enhanced if: key stakeholders (e.g. patients, providers and industry) are adequately involved; decision-makers give a prior commitment to use assessment reports (and assessments meet their needs); the necessary resources are available for implementing decisions; there is transparency in the assessment and decision-making processes; and collaboration, knowledge and skills are transferred across jurisdictions.

3.3 Establishment and Implementation of the National Health Equipment Policy for Nigeria

The implementation of the National Health Equipment Policy for Nigeria shall be by legislation, which will include the establishment of a regulatory body. To ensure success, the strategies shall take into account, expressed fears and needs of all interest groups. This shall be followed by the drawing up of regulations for carrying out the provisions of the law. The strategies are considered under the following:

a. Inventory of Medical Equipment: Although a large proportion of medical devices are not functioning in most health care setting in Nigeria, the exact number, brand and location are not known. Therefore the first step is to take inventory of all the medical equipment in a given health care facility.

b. Standardization of Medical Devices: This strategy is expected to solve the existing problem of a wide variety of equipment models imported from a number of countries, which made maintenance difficult. Foreign manufacturers-suppliers with representatives in Nigeria shall be preferred.

c. Selection of Medical Devices (Technical Specification): Selection of medical devices shall be based on the disease pattern in the country, their suitability for tropical environments and the staff available to operate them.

d. Procurement System: The procurement process shall be properly planned and managed. This is because equipment supply has to be coordinated with the construction of a new facility or the modification of an existing one for proper installation.

e. Regulatory System and Registration of Medical Devices: The Body shall regulate medical devices either by direct government involvement, third party certification or a combination of both methods.

f. Human Resource Development (Training & Re-training): The Body would be responsible for funding the Training Centres, development of the curricula in conjunction with Federal Ministry of Education. The Training Centres would serve a dual purpose that is teaching and conducting repairs of medical devices.

g. Indigenous manufacturing and servicing of Medical Devices: The way out of our present over-dependence on foreign technology is to develop local capability for equipment production. Manufacturing of certain categories of medical devices locally within stipulated standards should be promoted and encouraged.

h. Maintenance of Medical Devices: The regulatory body shall promote and encourage a maintenance culture. Health Care Institutions only pay attention to maintenance when there is a major equipment breakdown.

i. Monitoring and Evaluation: The Agency shall conduct monitoring and evaluation activities periodically to ensure that the set objectives are achieved.
References & Further Reading


KEY MESSAGES

The Policy Issue:
Health system financing is described as a broad area and covers: inputs such as health expenditure, revenue collection, fund pooling and purchasing, and the measurement of key health system outcomes such as catastrophic health expenditures and impoverishment. A good health financing system raises adequate funds for health, in ways that ensure people can use needed services, and are protected from financial catastrophe or impoverishment associated with having to pay for them.

Magnitude of the Problem:
In Nigeria, health financing seems to be a much more complex issue. According to the country’s National Health Policy (2004), the country relies on disaggregated mixture of health financing — including government budget, health insurance (social and private), external funding and private out-of-pocket spending to finance health care. Nigeria’s public expenditure on health is less than $8 per capita, compared to the $34 recommended internationally; and private expenditures are estimated to be over 70% of total health expenditure with most of it coming from out-of-pocket expenses in spite of the endemic nature of poverty. Furthermore, a broad-based health financing strategy is essentially lacking.

Policy Options:
1. Development of Health financing strategies through information and research
   Assess and disseminate information about what works and what does not work in health financing strategies; facilitating the sharing of country experience in various types of health financing reforms; and the development of tools, norms and standards including those required to assist the generation and use information.

2. Improvement or development of pre-payment and risk pooling mechanisms
   Ensuring that health-financing systems include mechanisms for pre-payment of financial contributions for health care, with a view to sharing risk among the population, and avoiding catastrophic health-care expenditure and impoverishment of individuals.

3. Evolving strategies for increasing and sustaining health financial resources
   Development of the potential to attract a higher share of government’s funding; and also from private and external sources.

4. Improving efficiency in health financial management
   Focusing on improving individual and institutional capacities in the area of budgeting, accounting, auditing, and reporting of health financial access and transactions.

5. Formulating models, guidelines and proposal on improving health financing
   A model design of what works and what does not work, in terms of access and availability of adequate health financing should form major area of government’s health policy considerations.
**COMPLETE REPORT**

**1.0 Introduction**

Health system financing is described as a broad area and covers: inputs such as health expenditure, revenue collection, fund pooling and purchasing, and the measurement of key health system outcomes such as catastrophic health expenditures and impoverishment (WHO, 2004). Within the financing function, there are important unanswered research questions relating to the three sub-functions: revenue collection, pooling and purchasing, as well as to the interactions between them. A good health financing system raises adequate funds for health, in ways that ensure people can use needed services, and are protected from financial catastrophe or impoverishment associated with having to pay for them (WHO, 2007). Health financing systems that achieve universal coverage in this way also encourage the provision and use of an effective and efficient mix of personal and non-personal services. The World Health Organization noted that three interrelated functions are involved in order to achieve this:

(i). The collection of revenues – from households, companies or external agencies;
(ii). The pooling of pre-paid revenues in ways that allow risks to be shared – including decisions on benefit coverage and entitlement; and
(iii). Purchasing, or the process by which interventions are selected and services are paid for or providers are paid.

The interaction between all three functions determines the effectiveness, efficiency and equity of health financing systems.

Managing health institutions and programmes for effective health services delivery in resource poor nations including Nigeria have come under serious threats. The sources of these threats seem to have generated two major issues of concern. Whereas some have argued that one of the major problems stems from insufficient funding of the health system, others are of the view that the problem is more on the inability of health system managers to make optimum use of available funds (USAID, 2008). Those who hold the latter view maintain that health financing decisions in most developing countries are characterised by issues relating to corruptions, inefficiency/wastages, misappropriation of resources, poor governance structures, among others. Buttressing the impact of poor governance structure on the utilisation of funding, for instance, USAID (2008) argued that as global programmes inject huge amounts of funding targeting specific diseases, weaknesses in health system governance threaten to undermine the effective utilization of funds. This implies that financing concerns in the health sector in developing areas are not just about availability, but are also on the capacity to make efficient use of available funds.

According to World Health Organization (WHO 2007), changes in health financing aimed at strengthening the health systems must be tailored to the history, institutions and traditions of each country and important principles to guide any country’s approach to financing should include:
(a). Raising additional funds where health needs are high, revenues insufficient, and where accountability mechanisms can ensure transparent and effective use of resources;
(b). Reducing reliance on out-of-pocket payments where they are high, by moving towards prepayment systems involving pooling of financial risks across population groups (taxation and the various forms of health insurance are all forms of pre-payment);
(c). Taking additional steps, where needed, to improve social protection by ensuring the poor and other vulnerable groups have access to needed services, and that paying for care does not result in financial catastrophe;
(d). Improving efficiency of resource use by focusing on the appropriate mix of activities and interventions to fund and inputs to purchase, aligning provider payment methods with organizational arrangements for service providers and other incentives for efficient service provision and use including
contracting, strengthening financial and other relationships with the private sector and addressing fragmentation of financing arrangements for different types of services;

(e). Promoting transparency and accountability in health financing systems;

(f). Improving generation of information on the health financing system and its policy use.

Health care financing in Nigeria as in other developing countries is typified by a dependence on out-of-pocket expenditure, which contributes to problems with access, equity, quality, catastrophic health expenditure and exclusion of vulnerable groups. There is therefore need for an increase in public resources for health and increased pre-payment and risk-pooling. The following according to WHO (2008) are important questions that must be addressed in this kind of situation:

(1). What practical steps can be taken to move from out-of-pocket to prepaid and risk-pooled health care financing systems?

(2). What is pro-poor, pro-equity health financing?

(3). What needs to be done in health care financing to promote universal access for all?

2.0 Definition and magnitude of the problem

In Nigeria, health financing seems to be a much more complex issue. According to the country’s National Health Policy (2004), the country relies on disaggregated mixture of health financing - including government budget, health insurance (social and private), external funding and private out-of-pocket spending to finance health care. This is a uniform pattern even across the three tiers of government in the country. The implication therefore is that less than 5% of the country’s gross domestic product (GDP) is annual spent on health, as against the MDG’s benchmark of xx percent. Financing problem, at state level, is heightened by the fact that the 36 States and 774 LGA's are responsible for all financial aspects of Secondary Health Care (SHC) and Primary Health Care (PHC) departments, including personnel costs, consumables, running costs and capital investment. According to the Federal Ministry of Health, Nigeria’s public expenditure on health is less than $8 per capita, compared to the $34 recommended internationally; and private expenditures are estimated to be over 70% of total health expenditure with most of it coming from out-of-pocket expenses in spite of the endemic nature of poverty (FMHN, 2004). Furthermore, there is no broad-based health financing strategy.

In the bid to solve the national health challenges generally, the country has had to come up with a national health financing policy (NHFP), whose main goals are to address the background issues in health financing in the country, with its objectives being to: establish mechanisms for continuous availability of adequate funds for the provision of cost-effective health services; ensure that all citizens have timely access to quality health services as needed and for better health outcomes without financial barriers; ensure the efficient use of financial resources for health; and to put in place adequate regulatory frameworks for health financing (NHFP, 2006). The existence of a comprehensive health financing policy in the country has not contributed significantly towards resolving the controversies of availability, accessibility and judicious utilization of health finance. By implication, the major issues highlighted in the above national health financing goals include:

(i). continuous availability of adequate health financing;

(ii). removing financing barriers to equitable delivery of health services;

(iii). efficiency in the use of health financial resources, and;

(iv). need to regulate health financing – in terms of sources and allocation.

At the centre of these issues is no doubt how to ensure efficiency in the financing process. Ironically, health ministry and health agencies continue to live under the illusionary view that the problem of health services delivery has more to do with availability of funds. Little attention has been paid on either improving funding efficiency or creating platforms for increased access to funding. While answers on how to make health funding an efficient process in developing areas have not in any way
been scarce, the problems lie mostly on the tenability and environmental consistency of such answers. As argued by Gottret and Schieber (2006), countries operate within highly different economic, cultural, demographic and epidemiological contexts, and the development of their health provision and financing systems—and the optimal solutions to the challenges they face—will continue to be heavily influenced by these and other historical factors as well as political economy considerations. They argue that even so, countries can learn from both the successes and the failures of each other’s health financing efforts.

Suggestions focusing just on more funding tend to assume away realities such as misuse, corruption and manpower capacity. This is the case in Nigeria, where the political structures are so much in a disconnect.

To assist in resolving the pending controversies on the financing challenges facing the health system, therefore, this brief focuses on the following goals:

- Education on the dominant health financing challenges in developing areas;
- Identification of available strategies for increased access to health financial sources;
- Review of the available health financing models in use at the state government level in Nigeria;
- Develop optimal model for increased access to and efficiency of health financing at the state government level; and
- Propose policy options to address health financing issues and challenges at the state government level.

3.0 Policy options and implementation strategies for addressing the problem

Five Policy options are here recommended as to how to ensure continuity in the flow of health finance and efficient utilization of available funds.

3.1 Development of Health financing strategies through information and research

Assess and disseminate information about what works and what does not work in health financing strategies; facilitating the sharing of country experience in various types of health financing reforms; sharing of key information required by country policy makers; and the development of tools, norms and standards including those required to assist the generation and use information. Policy-makers need to be understood what health financing challenges are. Identification of impeding challenges must have to be evidence-based. Over generalisation must also have to be carefully made. States should first understand its environmental health peculiarities, and in so doing find out which financial problems are more eminent in their respective states.

3.2 Improvement or development of pre-payment and risk pooling mechanisms

It is important to ensure that health-financing systems include mechanisms for prepayment of financial contributions for health care, with a view to sharing risk among the population and avoiding catastrophic health-care expenditure and impoverishment of individuals as a result of seeking care. These mechanisms have the potential of reducing the extent of financial catastrophe and impoverishment due to out-of-pocket payments, and to extend financial and social protection. Social Health Insurance (SHI) is a form of compulsory insurance that aims to provide universal coverage. The compulsory nature of such schemes should reduce adverse selection and enable extensive redistributive mechanisms between healthy and sick people, as well as between poor and better off groups.

3.3 Evolving strategies for increasing and sustaining health financial resources

The ministry of health should develop the potential to attract a higher share of government
funding. The health sector can become engaged in debates about fiscal policies that directly affect health (e.g. taxes on products that are harmful to health), as well as by ensuring that health activities are included in poverty reduction strategy papers and medium-term expenditure frameworks. Funding might also be increased through financial arrangements between the government and non-government sectors. Various mixes of tax funding with social, community and private health insurance, provide the alternative institutional frameworks for such arrangements. Private sector participation in human resources for health development should be encouraged through foundations, philanthropies, and endowments.

Over reliance on budgeting provisions as a major source of health finances has prove very inadequate. Efforts need to be made to identify other ways/strategies for increasing health funding, without undermining the issue equity in health services delivery.

3.4 Improving efficiency in health financial management

Achieving efficiency should focus on improving individual and institutional capacities in the area of budgeting, accounting, auditing, and reporting of health financial access and transactions. This also has to do with improving economic efficiency of revenue-raising, in not creating distortions or economic losses in the economy. Ensure available funds are used equitably and efficiently, by appropriate provider payment mechanisms, aligning financing and service delivery incentives; addressing fragmented financing systems; appropriate use of tools, such as contracting, to achieve appropriate balance between activities, programmes, inputs, capital versus recurrent expenditures, and ensuring protection of vulnerable population groups.

3.5 Formulating models, guidelines and proposal on improving health financing

A model design of what works and what does not work, in terms of access and availability of adequate health financing should form major area of government’s health policy considerations. Areas of policy proposal should focus on Access and Efficiency in health financial resources; improving financial reporting systems in the health sector; balancing arguments on risk pooling and affordability of health services.

References & Further Reading

Bennett, S. and Gilson, L. (2001), Health Financing, Designing and Implementing Pro-Poor Policies, DFID Health Systems Resources Centre, Working Paper


KEY MESSAGES

The Policy Issue:
Health services are the most visible part of any health system, both to users and the general public. Health services, be they promotion, prevention, treatment or rehabilitation, may be delivered in the home, the community, the workplace, or in health facilities. Effective health service delivery depends on having some key resources: motivated staff, equipment, information and finance, and adequate drugs. Improving access, coverage and quality of health services also depends on the ways services are organized and managed, and on the incentives influencing providers and users.

Magnitude of the Problem:
In Nigeria, there are numerous barriers and challenges to improving health service delivery. At the community and household levels, factors such as socioeconomic, gender effects on behaviour, access, use of care and absence of social pressures to improve access, are all determinants of the availability and quality of health service delivery. Lack of 'managerial capacity' at all levels of the health system is increasingly cited as a 'binding constraint' to scaling up health service delivery. Other constraints to improving health service delivery include: shortages of skilled health; lack of funds; shortages of medicines; inability to generate and use information, and inadequate public health information systems. Another major problem with service delivery in Nigeria is that many of the programmes adopt the vertical approach rather than the integrated one.

Policy Options:
1. Improving and strengthening health service delivery through adoption and implementation of innovative strategies
There is need to adopt and implement innovative strategies that have the potential to strengthen health service delivery such as: contracting with NGOs; delegation of authority for setting priorities; user fees exemptions; subsidies for the poor; performance-related pay and incentives; and social marketing.
2. Integrated service delivery
Integrated service delivery has been described as the organization and management of health services so that people get the care they need, when they need it, in ways that are user-friendly, achieve the desired results and provide value for money.
3. Improving management capacity for service delivery
There is need to improve knowledge base of health service managers on effective approaches to building management capacity.
4. Effective engagement of non-state sectors in health service delivery
According to WHO (2005b), the non-state sector plays a very significant role in the delivery of health services, and the provision of health and health related commodities in developing countries including Nigeria.
5. Establishment of service delivery monitoring mechanism
There is need to establish mechanisms for the monitoring of service delivery, notably physical access to services. Such data derived from such process need to be complemented by other dimensions of access and technical quality (safety, efficiency, and effectiveness of selected interventions).
1.0 Introduction

Health services are the most visible part of any health system, both to users and the general public. Health services, be they promotion, prevention, treatment or rehabilitation, may be delivered in the home, the community, the workplace, or in health facilities. Effective health service delivery depends on having some key resources: motivated staff, equipment, information and finance, and adequate drugs. Improving access, coverage and quality of health services also depends on the ways services are organized and managed, and on the incentives influencing providers and users. In any health system, good health services are those which deliver effective, safe, good quality, personal and non-personal care to those that need it, when needed, and with minimal waste (WHO 2007). While many questions remain about how to improve the organization and management of health service delivery so as to achieve better and more equitable coverage and quality, it is important to draw on experiences from elsewhere when considering strengthening health service delivery.

Strengthening service delivery is a key strategy to achieve the Millennium Development Goals. This includes the delivery of interventions to reduce child mortality, maternal mortality, and the burden to HIV/AIDS, tuberculosis and malaria. Service provision or delivery is an immediate output of the inputs into the health system, such as health workforce, procurement and supplies and finances (WHO 2008a). Increased inputs should lead to improved service delivery and enhanced access to services. Ensuring availability and access to health services is one of the main functions of a health system. Such services should meet a minimum quality standard. Different terms such as access, utilization, availability and coverage are often used interchangeably to reflect on whether people are receiving the services they need (Shenghelia et al., 2003). Access is a broad term with different dimensions. Comprehensive measurement of access requires a systematic assessment of physical, financial and socio-psychological access to services.

The World Health Organization (WHO 2007) noted that there are no universal models for good service delivery, but observed that there are some well established requirements. One of such requirements for effective provision of health services is availability of trained staff working with the right medicines and equipment, and with adequate financing. Success also requires an organizational environment that provides the right incentives to providers and users. WHO (2007) also noted that the service delivery building block is concerned with how inputs and services are organized and managed, to ensure access, quality, safety and continuity of care across health conditions, across different locations and over time. According to WHO, attention is needed on the following:

(i). Demand for services. Raising demand, appropriately, requires understanding the user’s perspective, raising public knowledge and reducing barriers to care – cultural, social, financial or gender barriers. Doing this successfully requires different forms of social engagement in planning and in overseeing service performance.
(ii). Package of integrated services. This should be based on a picture of population health needs; of barriers to the equitable expansion of access to services, and available resources such as money, staff, medicines and supplies.
(iii). Organization of the provider network. The purpose of an organized provider network is to ensure close-to-client care as far as possible, contingent on the need for economies of scale; to promote individual continuity of care where needed, over time and between facilities; and to avoid unnecessary duplication and fragmentation of services. This means considering the whole network of providers, private as well as public; the package of services (personal, non-personal); whether there is over – or under – supply; functioning referral systems; the responsibilities of and linkages between different levels and types of provider including hospitals; the suitability of different delivery models for a
specific setting; and the repercussions of changes in one group of providers on other groups and functions (e.g. on staff supervision or information flows).

(iv). Management. The aim is to maximize service coverage, quality and safety, and minimize waste. Whatever the unit of management (programme, facility, district, etc.) any autonomy, which can encourage innovation, must be balanced by policy and programme consistency and accountability. Supervision and other performance incentives are also key.

(v). Infrastructure and logistics. This includes buildings, their plant and equipment; utilities such as power and water supply; waste management; and transport and communication. It also involves investment decisions, with issues of specification, price and procurement and considering the implications of investment in facilities, transport or technologies for recurrent costs, staffing levels, skill needs and maintenance systems.

Improving service delivery to the poor in a developing country as Nigeria therefore involves all the major stakeholders in the health system - the policymakers in ministries of health, finance, and public administration, health service managers and workers, public and private providers and clients and communities themselves. Better access depends on a wide range of factors - on health policies, strategy and plans that prioritise health needs and set out revenue sources and resource requirements (including mechanisms to address inequalities), on motivated and properly trained and remunerated health workers, on infrastructure, drugs and equipment, on good referral links and communication, and – last but not least - on well-informed clients and their representative bodies.

2.0 Definition and magnitude of the problem

In Nigeria, there are numerous barriers and challenges to improving health service delivery. At the community and household levels, factors such as socioeconomic, gender effects on behaviour, access, use of care and absence of social pressures to improve access, are all determinants of the availability and quality of health service delivery. The nature of health services, health sector policy and management strategies contribute to the challenges with delivery of health services in Nigeria. According to Travis et al. (2004) and WHO (2004), these challenges are associated with the following:

(a). Inequitable availability of services;
(b). Multiple providers, public and private;
(c). Provider behaviour to clients;
(d). Case management: poor adherence, increasing drug resistance, adverse events;
(d). Physical infrastructure, equipment;
(e). Human resources availability and management, including payment mechanisms, quality of care, supervision;
(f). Drug supplies, supply systems;
(g). Service management capacity;
(h). Referral and other communication failures
   (i). High level political interference to the specific problem or programme;
(j). Financial constraints, resource allocation;
(k). Insufficient coordination between donors, nongovernmental organisations, government bodies;
(l). Lack of effective regulation or legislation to affect both public and private actors;
(m). Weak links between programmes leading to inefficiencies and competition for limited resources;

Currently, a great deal of attention is being placed on scaling up service delivery to achieve the Millennium Development Goals (MDGs) in most developing countries including Nigeria. However, scaling up depends on having some key resources but it also depends to a large degree on how those resources are managed. Lack of 'managerial capacity' at all levels of the health system is increasingly cited as a 'binding constraint' to scaling up services and achieving the MDGs (WHO 2005a) and this
rather non-specific diagnosis is being coupled with exhortations that 'something must be done' about management. Apart from the lack of managerial capacity in most settings in Nigeria, other constraints to improving health service delivery include:

(i). Shortages of skilled health;
(ii). Lack of funds;
(iii). Shortages of medicines;
(iv). Inability to generate and use information, and inadequate public health information systems.

A major problem associated with the type of health services in many parts of Nigeria is that many of these programmes adopt the vertical approach rather than the integrated approach. Vertical programmes (also known as stand-alone, categorical or free-standing programmes or the vertical approach) refer to instances where “the solution of a given health problem [is addressed] through the application of specific measures through single-purpose machinery” (Msuya, 2005). In contrast, integrated programmes (also known as horizontal programmes, integrated health services or horizontal approaches) seek to “tackle the overall health problems on a wide front and on a long-term basis through the creation of a system of permanent institutions commonly known as ‘general health services’” (Msuya, 2005) and include “a variety of managerial or operational changes to health systems to bring together inputs, delivery, management and organization of particular service functions” (Briggs and Garner, 2006). Little is known about how to scale up health services rapidly in the face of urgent public-health problems and to integrate “vertical”, single-disease programmes into the broader health system. There is a dearth of research evidence on organization and delivery of health services in Nigeria (WHO, 2004).

One priority area relates to developing effective and efficient approaches to dealing with populations that have special needs, such as dispersed rural populations and populations living in urban slums, particularly in order to improve their access to effective services. More research needs to be done to find ways of helping health workers make sure patients are taking medicines. There is a need for more research on approaches to improving drug supplies, including cost-recovery schemes and interventions to improve prescribing and dispensing. These interventions should not be restricted to the formal health sector but also include drug retailers who are important providers of health-related products in many countries. Another challenging area is evaluating the development and implementation of strategies to ensure quality in the health system setting.

3.0 Policy options and implementation strategies for addressing the problem

3.1 Improving and strengthening health service delivery through adoption and implementation of innovative strategies

There is need to adopt and implement innovative strategies that have the potential to strengthen health service delivery. Some of the innovative strategies outlined by WHO (2006) that can address the challenges of service delivery include:

(a). Contracting with NGOs, with other private sector provider organizations, and organizations within the government, with a focus on health service delivery.
(b). Delegation of authority for setting priorities, allocation and managing financial and human resources, and taking other key decisions to State and local government level health authorities.
(c). User fees exemptions, specifically whether the poor were given an exemption from user fees, or other scheme in differential pricing designed to benefit the poor.
(d). Subsidies for the poor, whether some form of cash transfer, vouchers, or financial risk sharing either disbursed directly to beneficiaries or communities, or through providers.
(e). Performance-related pay and incentives, considering new approaches to improve workforce performance, using benchmarks to determine the level of pay and incentives to be provided.

(f). Reorganizing outreach workers, including changing the use of home-based and health post workers, and changing their professional requirements or volunteer status.

(g). Social marketing, to influence the health behaviour of clients and use of health products such as bednets, condoms, essential drugs, and oral rehydration therapy.

(h). Community engagement, including new ways to involve communities in the oversight, planning or operations of health services, approaches to give voice to community concerns, and public disclosure of information to improve transparency and accountability.

3.2 Integrated service delivery
Integrated service delivery has been described as the organization and management of health services so that people get the care they need, when they need it, in ways that are user-friendly, achieve the desired results and provide value for money (WHO 2008c). There are increasing concerns that a singular emphasis on “vertical”, that is single-disease or single intervention, programmes may no longer be adequate to deal with the entire spectrum of today’s global health challenges particularly in a developing economy like Nigeria. Many benefits are claimed for integrated health services as follows:

(i). It involves discussions about the organization of various tasks which need to be performed in order to provide a population with good quality health services.

(ii). Supporting integrated services does not mean that everything has to be integrated into one package. The aim is to provide services which are not disjointed for the user and which the user can easily navigate.

(iii). Managing change in the way services are delivered may require a mix of political, technical and administrative action. It may require action at several levels, including sustained commitment from the top. It is useful to look for good 'entry points' for enhancing integration and to consider what incentives there are for health workers and their managers to change their behaviour.

(iv). Integration is not a cure for inadequate resources. It may provide some savings, but integrating new activities into an existing system cannot be continued indefinitely without the system as a whole being better resourced.

3.3 Improving management capacity for service delivery
There is need to improve knowledge base of health service managers on effective approaches to building management capacity. This can be achieved through the following strategies:

(a). Help develop country specific management development strategies: This needs to build on any existing efforts and address practical problems. Questions to ask in the development of a strategy include: what aspect needs to be tackled most - knowledge, skills, management systems or work environment? Which managers should be the initial target? Where multiple interventions are needed, which are the most important ones to begin with? Who should be involved? What are the resource implications?

(b). Identify ways to help managers better do their job in the current circumstances: For example, by helping national authorities to: (i) Clarify responsibilities and roles at different levels of the system (ii) produce a simple handbook for managers and a managers help line to respond to queries on rules and procedures, identifying delegated functions, managing relations with new partners etc (iii) identify critical aspects of managers' knowledge and skills that need urgent attention, and the sort of training that would help.

(c). Develop more operational management support systems: These cut across all aspects of service delivery. For example: financial; personnel, drugs, equipment, vehicle maintenance systems etc.
(d). *Revise rules, regulations and incentives:* Changes to these may need to be developed as part of wider overall organizational and financing changes within the system and are likely to constitute medium to long term efforts.

(e). *Identify ways to encourage more coherent support by international agencies:* Are there some common international standards and guides that could be developed – such as generic competency frameworks, or performance standards? A resource pack could be developed of known, effective interventions, costed for different situations, to serve as a reference point when commissioning management development activities and guide curricula of training programmes.

### 3.4 Effective engagement of non-state sectors in health service delivery

According to WHO (2005b), the non-state sector plays a very significant role in the delivery of health services, and the provision of health and health related commodities in developing countries including Nigeria. In both urban and rural settings, private for-profit and non-profit health care providers and suppliers of health-related commodities serve both rich and the poor. Clients often perceive non-state sector health care providers to be more responsive to consumers’ preferences (in terms of privacy and speed of service) and they are often also more geographically accessible than the public providers.

### 3.5 Establishment of service delivery monitoring mechanism

There is need to establish mechanisms for the monitoring of service delivery, notably physical access to services. Such data derived from such process need to be complemented by other dimensions of access and technical quality (safety, efficiency, and effectiveness of selected interventions). Monitoring service delivery is not about the coverage of interventions, which is defined as the proportion of people who receive a specific intervention or service among those who need it. Coverage depends on service delivery and the utilization of the service by the target population. Monitoring service delivery has immediate relevance for the management of health services, which distinguishes this area from other health systems building blocks. Shortages of drugs, uneven distribution of health services, and poor availability of equipment or guidelines can all be addressed as part of basic service management.

### References & Further Reading


KEY MESSAGES

The Policy Issue: Human resources for health (HRH) are the cornerstone and drivers of health systems and must be adequate if the health millennium development goals are to be achieved. HRH are only effective if the system in which they function is able to do the following: (i). Educate sufficient numbers of adequately trained and appropriate health workers; (ii). Providing sufficient financing for their salaries, supplies and transportation; (iii). Effectively motivate them and manage their administrative, information, logistics and supply needs; (iv). Establish appropriate physical infrastructure and delivery models; and provide safe working conditions.

Magnitude of the Problem: Among the many challenges facing the health system in Nigeria, is acute shortage of competent health care providers. As a result of inadequate infrastructure and poor compensation packages, a sizeable number of physicians, nurses and other medical professionals are lured away to developed countries in search of fulfilling and lucrative positions. Related to brain drain is the problem of geographical distribution of health care professionals. There is a disproportionate concentration of medical professionals in urban areas. The main factors driving this problem have been identified and these include: (i). insufficiently resourced and neglected health systems; (ii). Poor human resources planning and management practices and structures; (iii). Unsatisfactory working conditions.

Policy Options:
1. Establishment of research mechanisms for provision and update of evidence on health workforce
   Quality data and accurate projection of future HRH requirements are needed to inform the health policy planning process. There is need to establish research mechanisms that will synthesize and disseminate evidence.
2. Introduction of reforms in medical training
   The following reforms can be introduced to address the scarcity of health workforce in the rural areas: Locating Health Training Institutions in rural areas; award of scholarships to students from rural areas; introduction of a compulsory rural training curriculum in all the health institutions.
3. Improving salaries and other incentives for health workers
   Available information indicates that financial incentive is an option to aid recruitment and retention in under serviced areas. Multiple incentives and motivation to make working in unattractive areas more appealing can be introduced.
4. Establishing skill-mix initiatives
   Skill-mix initiatives change roles directly through extension of roles or skills, delegation, and the introduction of a new type of worker; they change them indirectly through modifications of the interface between services – that is, where care is provided.
5. Instituting measures for the management of health workforce migration
   Three types of measures have been proposed to assist in mitigating any negative impact of migration on the supply of health workers as follows: (i). Measures to improve monitoring of health worker migration; (ii). Measures to direct migratory flows; (iii). Measures to improve human resource policy and practice.
COMPLETE REPORT

1.0 Introduction
Human resources for health are essential for health systems. They are the cornerstone and drivers of health systems and must be adequate if the health millennium development goals are to be achieved (WHO, 2000). Health workers are all people engaged in actions whose primary intent is to protect and improve health. A country’s health workforce consists broadly of health service providers and health management and support workers. This includes: private as well as public sector health workers; unpaid and paid workers; lay and professional cadres. The World Health organization (WHO 2007) noted that overall, there is a strong positive correlation between health workforce density and service coverage and health outcomes. Rowe et al. (2005), indicated that human resources for health are only effective if the system in which they function is able to do the following:
(i). Educate sufficient numbers of adequately trained and appropriate health workers;
(ii). Providing sufficient financing for their salaries, supplies and transportation;
(iii). Effectively motivate them and manage their administrative, information, logistics and supply needs;
(iv). Establish appropriate physical infrastructure and delivery models; and provide safe working conditions.
According to WHO (2007), in any country, a “well-performing” health workforce is one which is available, competent, responsive and productive. To achieve this, actions are needed to manage dynamic labour markets that address entry into and exits from the health workforce, and improve the distribution and performance of existing health workers. These actions address the following:
(a). How countries plan and, if needed, scale-up their workforce asking questions that include: What strategic information is required to monitor the availability, distribution and performance of health workers? What are the regulatory mechanisms needed to maintain quality of education/training and practice? In countries with critical shortages of health workers, how can they scale-up numbers and skills of health workers, in ways that are relatively rapid and sustainable? Which stakeholders and sectors need to be engaged (e.g. training institutions, professional groups, civil service commissions, finance ministries)?
(b). How countries design training programmes so that they facilitate integration across service delivery and disease control programmes.
(c). How countries finance scaling-up of education programmes and of numbers of health workers in a realistic and sustainable manner and in different contexts.
(d). How countries organize their health workers for effective service delivery, at different levels of the system (primary, secondary, tertiary), and monitor and improve their performance.
(e). How countries retain an effective workforce, within dynamic local and international labour markets.

Nigeria has one of the largest stocks of human resources for health in Africa comparable only to Egypt and South Africa. In 2005, there were about 39,210 doctors and 124,629 nurses registered in the country, which translates into about 39 doctors and 124 nurses per 100,000 populations as compared to the Sub-Saharan African average of 15 doctors and 72 nurses per 100,000 populations (FMHN, 2008). The health workers are poorly distributed and in favour of urban, southern, tertiary health care services delivery, and curative care. About 60% of the states in Nigeria provide rural incentives to health workers that volunteer to serve in the rural areas, while others make rural service a condition for some critical promotion. Health workers are produced in designated health training institutions. There is poor distribution of these training institutions in favour of southern parts of the country. Health workers are employed both in public and private sector (FMHN, 2008). In the private sector, though there is optimal utilization of workers, however, salaries and wages are far below those of their contemporaries.
in the public sector. Private sector workers used to earn more than public sector workers before 1990, however in the public sector, there had been regular salary increases over the years. This has resulted from negotiations prompted by health workers associations that have been influencing the salary of health workers in the public sector (FMHN, 2008). To enhance the distribution, efficiency and performance of health workforce in a developing country like Nigeria, WHO (2008) noted that the following questions must be addressed:

(1). How can countries develop and implement plans for a balanced workforce taking a primary health care approach?

(2). What is the role of multi-skilled teams and primary care providers?

(3). What needs to be done in countries with regard to the health workforce to promote universal access for all?

2.0 Definition and magnitude of the problem

Nigeria continues to export health-care professionals to the developed world. Many factors contribute to the brain drain in the 21st century. Some of these factors included the fact that the doctors are trained at a higher level than the facilities they were provided with could deal with, and that in Nigeria they typically earn about 25 per cent of what they would earn working in North America, Europe, or the Middle East (Uneke et al., 2008). Another factor is little incentive for doctors who have relocated to go back to Nigeria and work (Adesanya, 2005). In a recent paper on the brain drain in Nigeria, the World Health Organization outlined these reasons for migration and proposed some solutions, including maintaining minimum standards for local hospitals, increasing salaries, and making incentives for doctors showing willingness to work on underserved diseases (Adesanya, 2005).

Among the many challenges facing the health system in Nigeria, is acute shortage of competent health care providers. As a result of inadequate infrastructure and poor compensation packages, a sizeable number of physicians, nurses and other medical professionals are lured away to developed countries in search of fulfilling and lucrative positions (Raufu 2002; Awofeso 2008). In fact, some of these countries have established recruiting agencies and examination protocols targeting the best and brightest medical minds in Nigeria, prompting the government to require that these agencies register with the Federal Ministry of Health and operate within an established framework (Raufu 2002). Related to brain drain is the problem of geographical distribution of health care professionals. There is a disproportionate concentration of medical professionals in urban areas. While access to medical personnel is readily available in cities, rural dwellers often have to travel considerable distance in order to get treatment. Health workers in under-served areas usually have motivational problems at work which may be reflected in a variety of circumstances, but common manifestations include: (i) lack of courtesy to patients; (ii) failure to turn up at work on time and high levels of absenteeism; (iii) poor process quality such as failure to conduct proper patient examinations, and (iv) failure to treat patients in a timely manner (Hargreaves 2002; Chankova et al. 2007).

Doctors and nurses are reluctant to relocate to remote areas and forest locations that offer poor communications with the rest of the country and few amenities for health professionals and their families. Urban areas in Nigeria are more attractive to health care professionals for their comparative social, cultural and professional advantages. Large metropolitan centers in the country offer more opportunities for career and educational advancement, better employment prospects for health professionals and their family (i.e. spouse), easier access to private practice (an important factor in Nigeria because public salaries are relatively low) and lifestyle-related services and amenities, and better access to education opportunities for their children (Chankova et al. 2007). In addition, the low status often conferred to those working in rural and remote areas further contributes to health professionals' preference for settling in urban areas, where positions are perceived as more prestigious. This has significant consequences on the health of inhabitants of rural areas as unavailability of
physicians and nurses within close proximity often leads to delaying and postponing visits to health care facilities until the condition becomes unbearable (Chankova et al. 2007).

According to Adesanya (2005), Raufu (2002) and Uneke et al. (2008), the main factors driving this problem have been identified and these include:

(i). insufficiently resourced and neglected health systems;
(ii). Poor human resources planning and management practices and structures;
(iii). Unsatisfactory working conditions characterized by: heavy workloads, lack of professional autonomy, poor supervision and support, long working hours, unsafe workplaces, inadequate career structures, poor remuneration/unfair pay, poor access to needed supplies, tools and information, and limited or no access to professional development opportunities;

3.0 Policy options and implementation strategies for addressing the problem

3.1 Establishment of research mechanisms for provision and update of evidence on health workforce

Adequate human resources for health (HRH) are a key requirement for reaching health goals. Quality data and accurate projection of future HRH requirements are needed to inform the health policy planning process. In Nigeria, as in many countries in the region, scarce data on the availability, distribution, and trends in HRH has been a barrier to effective HRH planning. According to WHO (2007), there is need to establish research mechanisms that will synthesize and disseminate evidence on the following:

(i). ways to organize the health workforce for more effective service delivery and improved health worker performance;
(ii). Strategies to better retain health workers that include attention to both salaries and working conditions and differential effects on male and female staff; and
(iii). Ways to monitor health worker performance.

Furthermore a more solid knowledge and evidence base would help to inform the challenges associated with the health workforce. WHO (2004) identified seven key themes that human resources for health research should be organized around. These include: (1). Assessment, policy and planning; (2). Managing size, skill mix and organization; (3). Using incentives to improve performance; (4). Mobility/migration; (5). Educating and training; (6). Legislation and regulation; (7). Influence of political and macroeconomic contexts on the development of national HRH strategies and policies

3.2 Introduction of reforms in medical training

The following reforms can be introduced to address the scarcity of health workforce in the rural and semi-urban areas:

(i). Locating Health Training Institutions in rural and semi-urban areas.
(ii). Reforms in medical education which stipulates a special allocation of student admission quota to candidates from rural areas into Health Training Institutions.
(iii). Award of special yearly bursary allowance and scholarships to exceptional students from rural areas.
(iv). The introduction of a compulsory rural training curriculum in all the health institutions, and the State University medical college and health sciences departments. There is also the introduction of rural-oriented medical curriculum and rural practice learning experiences in the Medical college curriculum as well as residency rotations in rural areas were the best educational experiences to prepare physicians for rural practice are acquired.
(v). Implementation of special incentive/welfare package to health workers in the rural areas such as provision of housing; in-service training and career development opportunities; subsidy for school fees and transportation for in-service training and; increase in hardship pay/allowances.
3.3 Improving salaries and other incentives for health workers
Since human resources for health is influenced by incentives, it is obvious that effects of salaries and benefits aimed at one group of professionals will reverberate through the entire system. Available information indicates that financial incentive is an option to aid recruitment and retention in under serviced areas. Multiple incentives to make working in unattractive areas more appealing can be introduced and may include: (a). health insurance and vacation time; (b). Tuition reimbursement; (c). Flexible work hours; (d). Bonuses based on experience or length of commitment; (e). Study and recreation leaves; (f). Employment opportunities for doctor's spouses; (g). Better accommodation facilities and improvements in educational institutions for doctor's children; (h). Hardship pay for rural/underserved areas.

3.4 Establishing skill-mix initiatives
Skill-mix initiatives focus on changing professional roles – directly and indirectly. According to Bourgeault et al. (2008), skill-mix initiatives change roles directly through extension of roles or skills, delegation, and the introduction of a new type of worker; they change them indirectly through modifications of the interface between services – that is, where care is provided. Skill-mix initiatives may be motivated both by qualitative considerations (such as quality improvement, professional development and quality of work-life concerns) and quantitative considerations (such as shortages, mal-distribution and cost–effectiveness). Bourgeault et al. (2008), noted that policy instruments that support the effective implementation of skill-mix initiatives include:
(i). Modifying or introducing new professional roles through the development of different organizational and regulatory arrangements, including regulating professional scopes of practice and overcoming institutional barriers;
(ii). Supporting new or enhanced professional roles through collective financing and altered financial incentives; and
(iii). Ensuring the educational foundations (competence and capacity) for the new and expanded professional roles.

Skill mix strategies include but not limited to the following: (a). Utilization of unemployed and retired health workers: – expanded hiring and contracting; (b). Scaling up and adjusting skills mix of pre-service training; (c). Rural recruitment and training; (d). Use of community health workers and new cadre of health workers.

3.5 Instituting measures for the management of health workforce migration
Three types of measures have been proposed by Buchan (2008), to assist in mitigating any negative impact of migration on the supply of health workers as follows:
(i). Measures to improve monitoring of health worker migration: Policy-makers should ensure that the two main indicators required for assessing the relative importance of migration and international recruitment are available: trends in the inflow of workers into the country from other source countries (and/or outflow to other countries) and the actual number of international health workers in the country at any point in time.
(ii). Measures to direct migratory flows: Several policy interventions can be used actively to direct the inflow or outflow of international health workers, including bilateral agreements and codes of conduct, but the current absence of research and evaluation in this area is a major policy constraint. A priority for policy-makers must therefore be to contribute to improving the evidence base by sharing experiences and commissioning evaluations of their effects.
(iii). Measures to improve human resource policy and practice: The migration of health professionals does not occur in isolation from other dynamics within health care labour markets. Migration may be a symptom of deeper problems in health systems, such as the challenges of retaining health professionals
and improving workforce planning to reduce over- or undersupply. Attention must therefore be paid to more general human resource practice in health systems, and specifically to fair and equitable treatment for all health professionals (be they home-trained or international) and efficient deployment.

**References & Further Reading**


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KEY MESSAGES

The Policy Issue: Leadership and governance of health systems, also called stewardship, has been described as the most complex but critical building block of any health system. Leadership and governance are associated with the role of the government in health and its relation to other actors whose activities impact on health; and this involves overseeing and guiding the whole health system, private as well as public, in order to protect the public interest.

Magnitude of the Problem: In Nigeria, there is weak governance and limited accountability mechanisms. These have become a fertile ground for corruption, nepotism, political interference and conflicts of interest. While these are ways people use to avoid extreme poverty, they become a norm and work to the detriment of health services and patients. These further reduce people’s sense of entitlement to services and governments’ accountability as duty-bearers. Corruption is perhaps the most dramatic governance-related threat, but in addition poor accountability and transparency, weak incentives for responsiveness and performance, and limited engagement of citizens in health affairs contribute to low levels of system effectiveness as well.

Policy Options:

1. Accountability of the key actors in the health system to the beneficiaries:
   Governance rules should ensure some level of accountability, which means that there need to be formal mechanisms by which patients and the broader population can hold key actors responsible for achieving the objectives of access to quality services, satisfaction, and fair financing.

2. A policy process that enables the interplay of the key competing interest groups to influence policymaking:
   Health governance should involve a policy process that enables the interplay of the key competing interest groups to influence policymaking on a level playing field, for improving quality of services, satisfying demands of patients and the public, and equitable financing.

3.3 Sufficient capacity, power, and legitimacy to manage and regulate the policymaking process:
   Health governance requires sufficient state capacity, power, and legitimacy to manage the policymaking process effectively, to plan and design programmatic interventions, and to enforce and implement health policy decisions.

3.4 Effective engagement of non-state actors in the policy arena:
   Governance depends upon the engagement and efforts of non-state actors in the policy arena, as well as in service delivery partnerships and in oversight and accountability. Effective engagement of these actors calls for strengthening the power and capacities of societal groups.

3.5 Instituting performance measurement system:
   There is need to institute a performance measurement mechanism to ensure active stewardship through the development of a clear conceptual framework and a clear vision of the purpose of the performance measurement system.

3.6. Establishing health system research mechanism:
   This will help generate and interpret intelligence and research on policy options. It will facilitate access to knowledge on approaches to policy and systems development.
COMPLETE REPORT

1.0 Introduction

Leadership and governance of health systems, also called stewardship, has been described as the most complex but critical building block of any health system (WHO 2007). According to World Health Organization, leadership and governance are associated with the role of the government in health and its relation to other actors whose activities impact on health; and this involves overseeing and guiding the whole health system, private as well as public, in order to protect the public interest (WHO 2007). Stewardship (leadership and governance) therefore requires both political and technical action, because it involves reconciling competing demands for limited resources, in changing circumstances, for example, with rising expectations, more pluralistic societies, decentralization or a growing private sector.

Because stewardship of the health system is principally a government responsibility, to discharge it requires an inclusive, thought out policy vision which recognizes all principal players and assigns them roles and uses a realistic resource scenario and focuses on achieving system goals (WHO 2000). Stewardship also calls for the ability to identify the principal policy challenges at any time, and to assess the options for dealing with them. Influence requires regulatory and advocacy strategies consistent with health system goals, and the capacity to implement them cost-effectively.

The World Health Organization in a recent publication noted that there is no blueprint for effective health leadership and governance (WHO 2007). However, since the paramount goal of an effective leadership and governance mechanism is to enhance the performance of the health systems, experience suggests that there are some key factors that must be in place to ensure functionality of the health systems, irrespective of how these are organized. These factors of functions have been described by WHO (2007) and include the following:

(i). Policy guidance: Formulating sector strategies and also specific technical policies; defining goals, directions and spending priorities across services; identifying the roles of public, private and voluntary actors and the role of civil society.

(ii). Intelligence and oversight: Ensuring generation, analysis and use of intelligence on trends and differentials in inputs, service access, coverage, safety; on responsiveness, financial protection and health outcomes, especially for vulnerable groups; on the effects of policies and reforms; on the political environment and opportunities for action; and on policy options.

(iii). Collaboration and coalition building: Across sectors in government and with actors outside government, including civil society, to influence action on key determinants of health and access to health services; to generate support for public policies, and to keep the different parts connected - so called ‘joined up government’.

(iv). Regulation: Designing regulations and incentives and ensuring they are fairly enforced.

(v). System design: Ensuring a fit between strategy and structure and reducing duplication and fragmentation.

(vi). Accountability: Ensuring all health system actors are held publicly accountable. Transparency is required to achieve real accountability.

While ultimately it is the responsibility of government, this does not mean all these leadership and governance functions have to be carried out by central ministries of health. An increasing range of instruments and institutions exist to carry out the range of functions required for effective leadership and governance. Instruments include sector policies and medium-term expenditure frameworks; standardised benefit packages; resource allocation formulae; performance based contracts; Patient’s Charters; explicit government commitments to non-discrimination and public participation; public fee schedules. Institutions involved may include other ministries, Parliaments and their committees, other levels of government, independent statutory bodies such as professional councils, inspectorates and
audit commissions, NGO ‘watch dogs’ and a free media (WHO 2007). Health systems are therefore shaped by the choices made by political actors, policy makers and by how leaders, managers and other stakeholders in health sector exercise authority. They are a product of decisions about how resources should be raised, allocated and rationed, how public inputs are organized and listened to, and the signals sent to health workers about their roles, orientation and performance. These features of governance and accountability are recognized to be central to the performance of health systems (WHO 2000; Navarro 2001).

A general consensus exists that a good leadership and governance platform can enhance health systems performance to enable them achieve:

(i) Improvements in health status through more equitable access to quality health services and prevention

and promotion programs;

(ii). Patient and public satisfaction with the health system, and

(iii). Fair financing that protects against financial risks for those needing health care (WHO 2000).

According to Brinkerhoff and Bossert (2008), good governance in health systems is therefore about developing and putting in place effective rules in the institutional arenas (Civil society; Politics; Policy; Public administration) for policies, programs, and activities related to fulfilling public health functions so as to achieve health sector objectives. These rules determine which societal actors play which roles, with what set of responsibilities, related to reaching these objectives. Under a good health governance, roles/responsibilities and relationships are governed by: Responsiveness to public health needs and beneficiaries’/citizens’ preferences while managing divergences between them; Responsible leadership to address public health priorities; The legitimate exercise of beneficiaries’/citizens’ voice; Institutional checks and balances; Clear and enforceable accountability; Transparency in policymaking, resource allocation, and performance; Evidence-based policymaking; Efficient and effective service provision arrangements; Regulatory frameworks, and management systems.

Brinkerhoff and Bossert (2008) further noted that good health governance rationalizes the role of government: reducing its dominance and sharing roles with non-state actors; empowering citizens, civil society, and the private sector to assume new health sector roles and responsibilities; and creating synergies between government and these actors. Health ministries redefine their roles as stewards of the health system, with input from citizens, civil society, and the private sector; and establish oversight and accountability mechanisms. Policies incorporate evidence and analysis to allow assessment of progress and evaluation of effectiveness. Health insurance agencies oversee providers to ensure effective service delivery, respect for payment procedures, and absence of fraud. Procurement agencies employ transparent and fair contracting and purchasing mechanisms to ensure that resources are well spent and to reduce corrupt practices. Civil society and the media apply their skills and capacities to exercise oversight and hold policymakers and providers accountable. Health policymaking balances beneficiary participation with science-based determination of appropriate services.

2.0 Definition and magnitude of the problem

In Nigeria as in most developing countries, there is weak governance and limited accountability mechanisms. These have become a fertile ground for corruption, nepotism, political interference and conflicts of interest. While these are ways people use to avoid extreme poverty, they become a norm and work to the detriment of health services and patients. These further reduce people’s sense of entitlement to services and governments’ accountability as duty-bearers. Brinkerhoff and Bossert (2008), noted that as global programmes inject huge amounts of funding targeting specific diseases, weaknesses in health system governance threaten to undermine the effective utilization of the funds. Corruption is perhaps the most dramatic governance-related threat, but in addition poor accountability and transparency, weak incentives for responsiveness and performance, and limited engagement of citizens in health affairs contribute to low levels of system effectiveness as well.
The World Health Organization observed that Ministries of health in low and middle income countries including Nigeria have a reputation for being among the most bureaucratic and least effectively managed institutions in the public sector. They became large centralized and hierarchical public bureaucracies, with cumbersome and detailed administrative rules and a permanent staff with secure civil service protections (WHO 2000). The problems with the leadership and governance of the health systems in Nigeria particularly as they affect the health ministries are similar with those obtained in many developing countries, WHO has categorized these problems into three as follows:

(i). **Health ministries often suffer from myopia:** Because they are seriously short-sighted, ministries sometimes lose sight of their most important target: the population at large. Patients and consumers may only come into view when rising public dissatisfaction forces them to the ministry’s attention. In addition, myopic ministries recognize only the closest actors in the health field, but not necessarily the most important ones, who may be in the middle or far distance. Ministries deal extensively with a multitude of public sector individuals and organizations providing health services, many of which may be directly funded by the ministry itself. Often, this involvement means intensive professional supervision and guidance. But sometimes just beyond their field of vision lie at least two other groups with a major role to play in the health system: nongovernmental providers, and health actors in sectors other than health. In their size and potential impact on achieving health goals, these little recognized individuals and organizations may be more important than the public resources directed through the health ministry. Yet information about them may be scant, and a policy approach towards them is often lacking. In Nigeria for example, privately financed and provided medical care is three or four times as big, in expenditure terms, as spending on public services (Ogunbekun et al. 1999). But the many different types of private providers in Nigeria are barely recognized in legislation and regulation. Ministries are also myopic in the sense that their vision does not extend far enough into the future. Investment decisions – new buildings, equipment and vehicles – frequently occupy the foreground, while the severe and chronic need to improve the balance between investment and recurrent funding fades into the hazy distance.

(ii). **Tunnel vision in stewardship:** This takes the form of an exclusive focus on legislation and the issuing of regulations, decrees, and public orders as means of health policy. Explicit, written rules have an important role to play in the performance of the stewardship function. But formulating regulations is relatively easy and inexpensive. It is also often ineffective, with ministries lacking the capacity to monitor compliance: there are seldom enough public health inspectors to visit all food shops and eating places or enough occupational safety inspectors to visit all factories regularly. On the rare occasions when sanctions are invoked they are too mild to discourage illegal practices or to affect widespread disregard of regulations. Good stewardship needs the support of several strategies to influence the behaviour of the different stakeholders in the health system. Among these are a better information base, the ability to build coalitions of support from different groups, and the ability to set incentives, either directly or in organizational design. As authority becomes devolved, delegated and decentralized to a wide range of stakeholders in the health system, the repertoire of stewardship strategies needs to move away from dependence on “command and control” systems towards ensuring a cohesive framework of incentives.

(iii). **Health ministries sometimes turn a blind eye:** Blind eye is sometimes turned to the evasion of regulations which they themselves have created or are supposed to implement in the public interest. A widespread example is the condoning of illicit fee collecting by public employees, euphemistically known as “informal charging”. Though such corruption materially benefits a number of health workers, it deters poor people from using services they need, making health financing more unfair, and it distorts overall health priorities. In turning a blind eye, stewardship is subverted; trusteeship is abandoned and institutional corruption sets in. A blind eye is often turned when the public interest is threatened in other ways. Ensuring probity in decisions on capital projects and other large purchasing
decisions (equipment, pharmaceutical orders), where corruption may be particularly lucrative, is another frequent challenge to good stewardship.

3.0 Policy options and implementation strategies for addressing the problem

3.1 Accountability of the key actors in the health system to the beneficiaries
Governance rules should ensure some level of accountability of the key actors in the system to the beneficiaries and the broader public. Accountability means that there need to be formal mechanisms by which patients and the broader population can hold key actors – politicians who make general policy decisions, decision-makers in financing institutions (social insurance and private insurance), providers of curative and preventive services – responsible for achieving the objectives of access to quality services, satisfaction, and fair financing. Accountability mechanisms for holding these actors responsible include, for example, fair competitive elections, systems of judicial redress, procedures to combat corruption, transparency of information, advisory committees, community boards, and media access.

3.2 A policy process that enables the interplay of the key competing interest groups to influence policymaking
Health governance should involve a policy process that enables the interplay of the key competing interest groups to influence policymaking on a level playing field. An effective process for improving quality of services, satisfying demands of patients and the public, and equitable financing requires some level of compromise among the various interests in the system – the different providers, insurers, administrators, and the representatives of different groups of beneficiaries. An open policy-making process, accompanied by fair rules of interest group competition, is needed to ensure the level playing field and to address the governance equivalent of "market failures" – reducing unfair lobbying practices, limiting corruption, and ensuring responsiveness to underserved populations. In addition to these elements, the level playing field requires checks and balances to ensure that the rules of interest group competition are respected so that all voices can be heard and adequate representation is achieved.

3.3 Sufficient state capacity, power, and legitimacy to manage and regulate the policymaking process
Health governance requires sufficient state capacity, power, and legitimacy to manage the policymaking process effectively, to plan and design programmatic interventions, and to enforce and implement health policy decisions. Governance, whether in health or other sectors, depends upon the operational capacity of government institutions to function effectively in providing public goods and services, and in responding to citizens' needs and demands. At the most basic level, government needs the capacity to amass resources through tax collection and/or from donor agencies and to program and allocate those resources effectively. Design, implement and monitor health related laws, regulations and standards, especially in the areas of International Health Regulations; regulation of medical products, vaccines and technologies; regulation concerning occupational health and workplace safety.

3.4 Effective engagement of non-state actors in the policy arena
Governance depends upon the engagement and efforts of non-state actors in the policy arena, as well as in service delivery partnerships and in oversight and accountability. Effective engagement of these actors may call for strengthening the power and capacities of societal groups that may not necessarily have the resources and skills to participate in an open policy process, to partner with providers, or to fulfil accountability or watchdog functions. For example, community groups and local non-governmental organizations (NGOs) may be disadvantaged relative to organizations of health professionals, or nurses' and doctors' associations. Participation is an essential element of governance,
in health and beyond, and is facilitated not just by public structures and processes that support and encourage it, but also by a vibrant civil society. Measures to strengthen civil society are needed and these include: the development of social capital – trust in community members and local officials; knowledge and information sharing; and greater participation in voluntary organizations. These have been shown to contribute to improved health governance and service delivery.

**3.5 Instituting performance measurement system**

There is need to institute a performance measurement mechanism to ensure active stewardship. According to Smith et al. (2008), stewardship responsibilities associated with performance measurement can be summarized under the following headings:

1. *Development of a clear conceptual framework and a clear vision of the purpose of the performance measurement system:* alignment with accountability relationships; alignment with other health system mechanisms, such as finance, market structure and information technology.
2. *Design of data collection mechanisms:* detailed specification of individual indicators; alignment with international best practice.
3. *Information governance:* data audit and quality control; ensuring public trust in information; ensuring well-informed public debate.
4. *Development of analytical devices and capacity to help understand the data:* ensuring analysis is undertaken efficiently and effectively; ensuring local decision-makers understand the analysis; commissioning appropriate research on, for example, risk adjustment, uncertainty and data feedback mechanisms.
5. *Development of appropriate data aggregation and presentational methods:* ensuring information has appropriate effect on all parties; mandating public release of summary comparative information; ensuring comparability and consistency.
6. *Design of incentives to act on performance measures:* monitoring effect of performance information on behaviour; acting to enhance beneficial outcomes and negate any adverse consequences;
7. *Proper evaluation of performance-measurement instruments:* ensuring money is spent cost-effectively on information resources.
8. *Managing the political process:* developing and monitoring policy options; encouraging healthy political debate; ensuring that specific interest groups do not capture the performance information system.

**3.6 Establishing health system research mechanism**

This will help generate and interpret intelligence and research on policy options. It will facilitate access to knowledge on approaches to policy and systems development: by promoting a more systematic health systems research agenda; by building capacity in observatories or their equivalent; and by increasing access to and use of new knowledge management technologies. It will work to strengthen national capacity in health policy analysis and links to policy decision-making. Pang et al. (2003) proposed that stewardship within the health research system (HRS) should include four components as follows: definition and articulation of a vision for a national HRS; identification of appropriate health research priorities and coordination of adherence to them; setting and monitoring of ethical standards for health research and research partnerships; and monitoring and evaluation of the HRS itself.

**References & Further Reading**


