POLITICS AND HEALTH CARE DELIVERY IN NIGERIA

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Abstract

Power, moreover, is relative and relational, and manifests at levels ranging from policy decision-making to the local implementation of interventions. Scholars have highlighted that the exercise of power occurs not only among actors typically considered powerful on the global stage, such as international agencies whose institutional roles, resources, and alliances can shape global action on health. This study examined politics and health care delivering in Nigeria. It was concluded that a healthy nation is a wealthy nation. Good public health does not come by chance. It is often the result of well-articulated plans emanating from public institutions. This informs the effort of Government in articulating programmes to boost the health system. Such efforts are usually associated with challenges and prospects as is the case with the Nigerian healthcare system. It is heartwarming to reveal that while the challenges are obvious, there prospects are certain. Thus, shortage of medical professionals (doctors, nurses, pharmacists etc) are being addressed. However, the rate at which these challenges are being addressed is quite low and calls for more concerted efforts. It was recommended that the following measures are suggested to improve the current Healthcare delivery system in the country. A conducive working environment should be emplaced to stem the tide of emigration on the part of health professionals. Better salaries, allowances, decent accommodation, etc should be introduced to beef up the welfare package for such professionals; Efforts should also be made by government to further enhance adequate training for nurses and doctors; The National Drug law enforcement agency must learn to do more to address the issue of the use of adulterated and fake drugs; Facilities and other equipments should be provided particularly at the local government and community levels to enhance the door step delivery of health services. This will make the primary healthcare delivery services more effective; there should be a greater public enlightenment on the need to consult well trained medical practitioners rather than quacks and road side drug peddlers.

Key words; *Politics, Health, Care delivery, Nigeria.*

Introduction

Health services are provided through the various hospitals and clinics owned by federal, state, and local governments. The local government is responsible for primary healthcare,(PHC) which includes comprehensive health centers, primary healthcare centre, health clinics and health posts (Joseph, 2018). A comprehensive health centre should have

at least three doctors and offer both services and a limited number of secondary clinical services. There should be at least one comprehensive health centre per local government area. Each ward should have at least one Basic Essential Obstetric and Neonatal Care Centre (BEONC) staffed by medical officers or NYSC doctors, 2 midwives, 2 community health officers (CHOs) with nursing/midwifery background; senior and junior community health extension workers, laboratory and pharmacy technicians, offering basic preventive and curative services (Croke, 2017). All these are not been the situation on ground which indicates that there are obvious a lot challenges and prospects. Moreover there is no fact that the system has recorded some successes overtime (Brinkerhoff et al., 2018).

The national healthcare system is decentralized into a three tier structure with responsibilities of the three levels of government, all the three tiers are involved, to some extent in all the major health system functions such as stewardships, financing and service provision (World Health Organization, 2019). Specifically, the Federal Ministry of Health (FMOH) is responsible for policy and technical support to the overall health system, international relations on health matters, the national health management information system and the provision of health services through the tertiary and teaching hospitals and national laboratories. The state ministries of health (SMOH) are responsible for secondary hospitals and for the regulation and technical support for primary healthcare service. Primary healthcare is the responsibility of the local government where health services are organized through the ward (Armah-Attoh., 2016).

Nigerian politics takes place within a framework of a federal, presidential, representative democratic republic, in which executive power is exercised by the government, and the first election took place in 1951 and it was granted independence in 1960.The Federal government of Nigeria is composed of three distinct branches namely the legislative, executive, and judicial, whose powers are vested and bestowed upon them by the Constitution of the Federal Republic of Nigeria, the National Assembly, the President, and lastly the federal courts, which includes the Supreme Court which is regarded as the highest court in Nigeria respectively. One of the major functions of the constitution is that it provides for separation and balance of powers among the three branches and aims to prevent the repetition of past mistakes made by the government. Some other functions of the constitution includes that it divides power between the federal government and the states, and it also protects various individual liberties of the citizens of the nation, (Ecoomist Intelligence Unit, 2019).

Nigeria is a federal republic in the sense that there is both a national government and governments of its states and it utilizes the form of government in which the people hold power, by elect representatives to exercise and utilize that power with the executive power exercised by the president. The president is the head of state, the head of government, and also the head of a multi-party system, when Nigerian politics takes place within a framework of time.

Effects of politics on health care delivering

Power, moreover, is relative and relational, which manifests at levels ranging from policy decision-making to the local implementation of interventions. According to Factor and Kang,

(2015) have highlighted that the exercise of power occurs not only among actors typically but considered powerful on the global stage, such as international agencies whose institutional roles, resources, and alliances can shape global action on health or actors at the national level, such as political parties whose ideologies can influence the equity and universality of public policy. Mackenbach, (2014) reveal that actors across the health system who may be powerful in particular local contexts such as Administrators, bureaucratic agents, and frontline health workers may exercise power in the course of everyday health service delivery, with negative or positive consequences for the people they serve (Erasmus,et al., 2014).

The World Health Organization Commission on the Social Determinants of Health (CSDH, 2019), recognised that health inequities resulted from 'a toxic combination of poor social policies and programmes, unfair economic arrangements, and bad politics, which conceptualised and assembled evidence on a wide range of social forces and casual processes that affect health inequity. But it was less clear or analytical about political strategies, competing political priorities, contested political ideologies, and other 'battles of values and ideas' that advocates of health equity inevitably confront in moving forward policy agendas (Erasmus, et al., 2014).

CSDH (2019) report on the 2014 report of the Lancet University of Oslo Commission on Global Governance for Health further drew attention to the role of power asymmetries in shaping health inequities. The report defined the 'global political determinants of health' as the norms, policies and practices that arise from global interactions among entities (states, transnational corporations, and civil society organisations, among others) with 'different interests and degrees of power' (Ottersen et al., 2014).

Since the politics critical role in public health issues and disease prevention, the political leaders adopt incremental policy changes rather comprehensive reforms even when the health is faced with serious public health problems. The political bias and behavioral health is another problem facing health systems just like Baker-polito administration in Massachusetts who prioritized creation of behavioral health system in the state (Department of Justice, 2020).

Consequences of bad governance on health sector

The health sector is a dynamic system composed of complex interactions between patients, providers, payers, suppliers, and policy makers. It is exactly this complexity that makes it particularly vulnerable to corruption, which is defined as the "abuse of entrusted power for private gain, which is a problem within health care systems globally. However, it is important to note that "corruption" not only encompasses actions that are illegal in most countries, but also those that could reasonably considered as unethical, and when pervasive, weaken and foster distrust in the health systems (Factor & Kang, 2015).

Corruption takes many forms within the health sector and occurs at all organizational levels from government agencies to the direct provision of care. Likewise, the motivations underlying health sector corruption vary by country, therefore, it may challenging to adapt corruption-mitigating strategies that were successful in one health

system to another system with completely different incentives, accountability structures, enforcement mechanisms, and socio-economic and political contexts, that is the heterogeneity and dynamic nature of health systems, sustainable reductions in corruption and resultant improvements in health care delivery require a systems thinking approach, (Scharbatke-Church et. al., 2019).

Impact of corruption on population and health systems

Pervasive corruption has the potential impact on the health of populations. Countries with high levels of corruption spend less on health care as a percentage of gross domestic product. In addition, high levels of corruption correlate with poor health-related outcomes. This includes higher infant and child mortality rates, lower life expectancy and lower immunization rate. Moreover, corruption has a negative effect on the mental health of citizens, with individuals who experience high levels of corruption reporting a lower perception of their overall health (Factor & Kang, 2015). According WHO (2019), the current situation of Nigeria health care which is due to corruption affect the improvement in quality of health care, reduce expanded infrastructure, reduce insurance coverage and reduction in health care personnel.

Improper financial relationships

Improper financial relationships are associations between actors within the health system that have the potential to create a conflict of interest. Specifically, they foster situations where individuals are motivated by financial enrichment over medical indication, patient well-being, and/or public health. At the highest level of service delivery, improper financial relationships can occur between government officials and for-profit entities within the health sector such as pharmaceutical, medical device, insurance companies. Other potential manifestations of improper relationships at the highest level of government include deregulation of the health sector to benefit specific interest groups, influence over health-related recommendations or guidelines, expediting approval of pharmaceuticals or medical devices, etc. (Williams & Horodnic, 2017).

Improper financial relationships in Nigeria has exerted inappropriate influence at the level of direct service delivery. Two common business relationships that fall within this category are self-referrals and kickbacks. Self-referrals occur when providers refer patients for medical services performed by an entity with whom the provider or family member has a financial relationship. Although they may be legal, these financial relationships have the potential to result in medical profit which may enrich providers at the expense of patients or payers. Kickbacks at the service-delivery level are similar to those at the government or payer level. For example, a pharmaceutical company may pay inducements to providers to preferentially prescribe their company's medication (Lio & Lee, 2016).

Fraudulent billing and claims

Fraudulent billing refers to the act of obtaining reimbursement for services or items that were either not provided, more complex than what was provided, or medically unnecessary. The actors involved in fraudulent billing can vary depending on how health care was financed.

In countries like Nigeria with social health insurance programs, fraudulent billing occurs primarily between providers, government, or private payers. Also in Nigeria who lacks well-established health insurance systems where out-of-pocket payments predominate, providers may fraudulently obtain reimbursement from patients, and same providers may also defraud the government for services or items related to certain diagnoses, patient populations, or conditions that are provided by government at no charge to patients (HIV, tuberculosis, prenatal or pediatric care). Fraudulent billing is a relatively common form of health sector corruption in HICs. In OECD countries, fraudulent billing in the form of overprovision or overbilling for services were among the most common forms of corruption (Li et. al., 2018).

Theft and diversion of resources can occur at all levels of a health system, especially at government or payer level, theft often takes the form of embezzlement, where government officials or insurance company employees siphon health-related funding for personal use (U.S. Department of Justice, U.S., 2020). Moreover, large-scale theft of donor funding allocated to LMICs by government officials has also been reported (US, 2020). At the provider level, health care workers may divert supplies, medication, equipment, or official fees for financial enrichment. The extent of theft and diversion at the provider level is challenging to precisely measure. Relative to other forms of corruption, theft and diversion is perceived to be less common in countries. However, qualitative studies from sub-Saharan Africa, indicate that theft may be a larger concern in this region where public health systems have historically been weak, (Couffinhal, et. al., 2017).

Absenteeism

Frequent, unauthorized absenteeism is regarded as corrupt when public sector workers “choose to engage in private pursuits during working hours”. Although absenteeism can occur at the highest levels of government, this review will focus on absenteeism of health care workers in Nigeria and its impact base directly on provision of care. Factors driving absenteeism include low or unreliable salaries in the public sector, lack of monitoring and accountability and substandard work environments that includes demanding workloads partially induced by frequent absenteeism. In Nigeria, public sector health care workers report being unable to cover basic necessities with their salaries, including food, clothing, transportation, etc. Some of these employees report going one to two years without being paid a salary (Agwu et.al., 2020). Poor remuneration promote absenteeism when health care workers engage in dual-practice, or the provision of clinical care in the public and private sector concurrently.

Informal payments

Informal payments are defined as “payments to individual and institutional providers, in kind or in cash, that are made outside of official payment channels or are purchases meant to be covered by the health care system”. They can involve actors at all levels of the health care system from government officials, suppliers, and providers. Informal payments can be illegal or legal and encompass a broad range of unofficial exchanges including overt bribes, favors, substantial gifts, and payments solicited under the guise of an official transaction or

fee.cultural and societal norms around gift-giving, the marketization of health care, and prevalence of bribery in other sectors of society are also cited as reasons for informal payments (World Health Organization, 2019).

Counterfeit medical supplies

Counterfeit therapeutics, medical devices, and other medical supplies represent an important form of corruption that disproportionately impacts health systems in LMICs. According to a report by the World Health Organization (WHO, 2017), 20% of malaria medications, 17% of antibiotics, and 9% of anesthetics/analgesics circulated globally were either substandard or falsified. Although these substandard or falsified products were reported in numerous countries of all income levels, the problem is particularly acute in Africa, which represented 42% of the total reports. Another study evaluating medications in Latin America identified a negative correlation between the quality medications and the level of corruption within the country. It is important to note that while producing and distributing intentionally falsified supplies represents a form of corruption, substandard products may be a result of technical inexperience or weak capacity (WHO, 2017).

This regulation is further complicated by the fact that many of these supplies are the product of complex multinational supply chains. Regulation may be even more challenging in LMICs without a national insurance program and where patients are paying for these supplies out-of-pocket. Moreover, those who are suspicious of the efficacy of the medication or device may be reluctant to voice their concerns out of fear of reprisal from criminal enterprises involved in trafficking, (WHO, 2017).

Raising salaries

Investing resources in health systems of LMICs, specifically to improve wages of health care workers in the public sector, may itself represent an anti-corruption strategy. Despite increased spending on health care globally over the past 2 decades, there are significant disparities in per capita spending between in Nigeria and HICs ($5,252 USD) and LMICs ($40–81 USD). This disparity in funding may underlie the aforementioned pattern seen in LMICs of health care workers engaging in corruption to supplement unsustainably low public sector salaries. Adequate investments in health sector infrastructure, equipment, and guarantee of supply chains for therapeutics and consumable supplies can improve access to services, which could also deter perpetuation of an unregulated private sector within health systems in Nigeria (National Academies of Sciences Engineering and Medicine Health and Medicine Division Board, 2018). According to Scharbatke-Church, et, al., (2019) report, Nigeria has to address those likely issues such as healthcare reform, political trust, political economy and political bias in order to ensure good quality of health care systems for all the population at large.

Conclusion

A healthy nation is a wealthy nation. Good public health does not come by chance. It is often the result of well articulated plans emanating from public institutions. This informs the effort of government in articulating programmes to boost the health system. Such efforts are

usually associated with challenges and prospects as is the case with the Nigerian healthcare system. It is heartwarming to reveal that while the challenges are obvious, these prospects are certain. Thus, shortage of medical professionals (doctors, nurses, pharmacists etc) are being addressed. However, the rate at which these challenges are being addressed is quite low and calls for more concerted efforts, to improve the health care system. The following measures are suggested to improve the current healthcare delivery system in the country,

1. Conducive working environment should be in place to stem the tide of emigration on the part of health professionals. Better salaries, allowances and decent accommodation should be introduced to beef up the welfare package for such professionals.
2. Efforts should also be made by government to further enhance adequate training for nurses and doctors, includes other health professionals in the system
3. The National Drug law enforcement agency must learn to do more to address the issue of the use of adulterated and fake drugs.
4. Facilities and other equipments should be provided particularly at the local government and community levels to enhance the door step delivery of health services. This will make the primary health care delivery services more effective.
5. There should be a greater public enlightenment on the need to consult well trained medical practitioners rather than quacks at road side drug peddlers.
6. The roles of each tier of government in the health care delivery system should be spelt out more clearly to eradicate the present confusion arising from duplication of such functions.
7. Reforms in the health sector should be a more regular phenomenon that is presently the situation on ground especially in Nigeria where a lot of health problems and challenges exist.

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