Chapter

Poor Health Care Access in Nigeria: A Function of Fundamental Misconceptions and Misconstruction of the Health System

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Abstract

Health care access in Nigeria is very limited in all dimensions due to factors within and beyond the health system. Misconception of primary health care and poor leadership resulted in a stunted health system development which has failed to align system structures and processes to the goal of achieving universal health access. Improving financial access through compulsory health insurance will not be enough to reverse this status without a holistic primary health care reform to correct the system misconstruction, achieve high quality health care that is efficient, acceptable to the people and therefore sustainable and capable of driving growth and development for the health system and the country. A primary health care movement consisting of health professionals within the country and the diaspora and other stakeholders is needed to drive this process and overcome the inertia of political leadership in this regard.

Keywords: health care access, primary health care, reform, quality of care, health system organization

1. Introduction

The World Health Organization defines access to health as universal health coverage which means that all people have access to the health services they need, when and where they need them of sufficient quality to be effective, without financial hardship. The goal should include the full range of essential health services, from health promotion to prevention, treatment, rehabilitation, and palliative care and beyond to holistic improvement of well being and quality of life [1]. To achieve universal health care, a nation needs policy-makers committed to investing in universal health coverage, skilled health workers providing high quality, people-centred care in a health system founded on a strong, people-centred primary health care rooted in the communities they serve [1].

This definition encompasses 2 major pillars of health care access: financial access and the quality of the services accessed. The emphasis on quality of care is

very important because it determines the capacity of the service to deliver "health" to the users.

The reformed primary health care is defined as first contact, comprehensive, continuing, coordinated, person centered care delivered to the individual within the context of his family and community through a defined regular provider. It is care delivered by professional health care providers in teams that take primary responsibility for the health of defined population of people and their community. It therefore has the competence to offer effective, appropriate and safe care to all patients for most of the problems they have most of the time at first contact thereby achieving comprehensive care which integrates personal curative, preventive, promotive and palliative with family and community engagement. Responsibility for a defined population of people makes them the regular source of care and entry point into the health system therefore offering continuous care over the life course with increased mutual knowledge and understanding between the patient and providers strengthening provider-patient relationship which facilitates trust, empathy, person-centeredness and therefore efficacy of care. The primary care provider takes responsibility for coordinating the health care needs of the patients when specialist care beyond the first contact is required and maintains on going care after the referral has been accessed. This serves to entrench quality care, efficiency, increased safety, individual utilization and community ownership and participation. It serves as the foundation of the health system. This mode of primary care has been evidenced provide high quality care to the population, achieving the desired health outcomes. The undergirding principle of the reformed PHC is that it serves as a means of providing the highest attainable level of health for all citizens maximizing equity and solidarity, integrating citizens' expectations with structures and processes to attain them i.e. guided by responsiveness [2].

Globally, about 50% of people do not have access to health care and about 100 M people are pushed into poverty every year due to catastrophic health expenditures [1].

All over the world, access to health care and quality of care have been on the increase in a sustained pattern as evidenced by the Global Healthcare Access and Quality Index Scores: from 37.6/100 in 1900 to 42.4 in 2000 and 54.4 in 2016. However, around 7.3 billion people are unable to access all the essential health services that they need, and it is estimated that in 137 countries around 8.6 million excess deaths occurred in 2016 as a consequence of poor access to quality healthcare, particularly in Low and Middle-Income Countries as at 2017 [3].

The concept of access to health care has been variously defined and conceptualised in dimensions by different authors to enable its study, understanding and measurement. The Penchansky definition of access in 5 As is very commonly used and will be combined with the Levesque's framework for this discussion.

Levesque's framework defines access as the opportunity or ability to identify or perceive a health need, seek, reach, pay/obtain, or use healthcare and to ensure the fulfilment of the needs for these services. This framework is chosen because of its' comprehensive approach incorporating factors attributable to the health delivery system, the social determinants of health and the patient. The framework sets out the process of health seeking to include a continuum from the existence of a health need to perception of the need and desire to seek care, the care seeking action, ability to reach the source of care, utilizing care and deriving the desired outcomes.

Ability to perceive a health need is determined by personal factors as health literacy, beliefs, trust and expectations of health facilities. Health system (HS) factors as the delivery of transparency, outreach, information and screening to the populace impacts this capacity. This is equated to the Penchansky dimension of Approachability.

Seeking health care is determined by social determnants of health (SDH) factors as personal and social values, culture, gender and autonomy of the patient. HS factors impacting this include professional values of health care providers norms culture and gender which impact the patient's perception of the available health facility and services. This depicts the Penchansky dimension of Acceptability.

Health seeking action is determined by SDH factors as living environments, transport, mobility and social support and by HS factors as geographic location of services, opening hours, accommodation, appointment systems. This corresponds to the Penchansky dimension of Availability and Accommodation.

Health care utilization or ability to pay is determined by SDH factors as income, assets, social capital and health insurance and by HS factors as direct, indirect and opportunity costs of service utilization and is equivalent to the Penchansky dimension of Affordability.

Deriving appropriate/desired outcomes from health services which includes satisfaction, health and economic derivatives for individuals and populations is determined by SDH factors as empowerment, information, adherence, care giver support and by HS factors as technical and interpersonal quality of services, adequacy, coordination and continuity of care. All these are equated to the Penchansky dimension of Appropriateness.

It is necessary for this discussion to use this comprehensive systemic framework that incorporates the interconnections between SDH factors with HS factors given the fact that due to poor development in all sectors, these factors are generally negative thereby constituting barriers to access to health [4].

2. The Nigeria Health System

- Nigeria population: 217,373,637M [5].
- 36 states and the federal capital territory.
- 774 local government areas.
- 52.0% lives in urban areas [6].
- Health Budget % total budget: 5.97% (2022) NGN3,453/capita [7].
- Health Expenditure % GDP: 3.03% less than Ethiopia and Ghana [8]
- Government Expenditure /capita: Nigeria; 15.95 USD, Ghana: 40.24 USD Ethiopia: 22.70USD, Canada: 70.17USD
- Private expenditure per capita: Nigeria: 71.30%, Ghana:48.48%, Ethiopia:43.19%, Chile 49.08%, Canada:29.83%.

3. Health indices

- Life expectancy in Nigeria: 2021
- Total: 60.87, Males: 59.07, Female: 62.78

- Neonatal mortality (approximately in 2016/2017) 40/1000. Infant mortality: 80/1,000 Underfive mortality: 120/1000 (NSHDP II)

- Maternal mortality rate:800/100,000 (approximate 2015, NSHDP II)

4. Distribution of Health Facilities as at 2015 (NSHDP II)

Type of health facility Public Private Total

- Primary Health Centres: 30,098 (Public: 21,808, Private: 8,290)

- Secondary Health Facilities: 3,992 (Public: 969 Private: 3,023)

- Tertiary Health Facilities: 86 (Public:86, Private: 10)

- **Total 34,176**

5. Distribution of health manpower

- Doctors in Nigeria 2022 [9]

- Doctors 24,600. Population ratio, 1:8,836.

- Dentists: 1,400. population ratio, 1: 155,267. Required at ratio of 1 doctor /600 population: 362,289 doctors. Deficit: 338,289

- Nurses: 249,566 Population ratio 1:1,677 (NHSDP II,2015)

- Senior CHEWs: Total: 42,938 population ratio 1:28,256 (NHSDP II,2015)

- Junior CHEWs: Total: 28,548 population ratio 1: 5,914 (NHSDP II,2015)

The Nigerian health system is organized in three tiers: primary, secondary and tertiary care levels. The primary health centers are deployed at the grass roots in the ward health system which locates a primary health center at each political ward (9,560 wards) to be run by the local government authority. Secondary health care is delivered at the general hospitals run by the state governments and each is deployed to cover several local governments. The tertiary hospitals are run by the federal government and offer tertiary care and health manpower training in teaching hospitals and federal medical centers [6]. NSHDP II.

The primary health care delivery system consists of pyramids of health facilities in the villages/neighbourhoods (health posts covering 500 persons), primary health clinics(one per group of villages covering 2000–5000 persons) and the primary health centers at the apex covering each political ward consisting of 10–20,000 persons. The health providers at these facilities are deployed such that health posts are manned by community health extension workers, clinics are manned by a nurse/midwife and the health centers by a doctor or nurse where available. Linkages to the secondary and tertiary health facilities is effected via a 2 way referrals system. The

system was planned to be the basis of the health system of the country and a foundation for further growth and development of the system. This system was to deliver the ward minimum package of health services (WMPHS) representing the purposed essential package of health services (EPHS) for Nigerians. Health care utilization is designed to begin at the primary health center as entry point and for cases beyond the capacity of the personnel and facilities to be referred upward to the secondary and then to the tertiary care levels as warranted [10].

Generally, majority of the PHC facilities are in deplorable condition. The evidence of the poor structural and process quality of services is widely documented [6]. A review of PHC facilities in 5 states and the federal capital territory provides evidence on the state of the facilities as shown below [11].

Geographical distribution: Only 22% met stipulated catchment population coverage range of one facility to 1–36 communities (1 facility to 20,000 people)) and at a distance from community of 1–49 km.

State of the buildings: 38.4% facilities required major renovations while 34% required minor renovations.

Forty Nine percent had cracked walls, 50.7% had cemented floors, 21.9% had rough floors and a large proportion (58.9%) had leaking roofs.

Security: only 24.7% of the facilities had perimeter fencing.

Power supply: 38.4% were connected to the national electricity grid, Solar power: 8.2%. generator: 23.3% with only few having functional generators or fuel to run them.

Water Supply: only 30% used motorized bore hole, 7 facilities depended on rain, 8 facilities on surface waters like streams, rivers and dams, 16 used wells. Of these only 65% of facilities have a water outlet within 500 m. 5 facilities had zero source of water.

Toilet facilities: 31%: had no toilet facility. 25% used pit latrines, 16% used piped sewer system. Only 23% had a flush system.

Emergency ambulance vehicle: only 5.5% had emergency ambulance, 2.7% had emergency transportation system including motorcycles and car.

Referral system: 11% had referral system.

Majority (79.1%) had access roads, only 24.7% were tarred and in variable conditions.

Accommodation for staff, only 30.1% had some form of accommodation for some staff. All were in deplorable conditions and none met the stipulated regulatory (NPHCDA) standards.

Communication: Only 31.5% facilities had a functional means of communication.

Information technology facilities: only 2.7% facilities had functional computers / internet.

Basic medical equipment like stethoscopes, sphygmomanometers, thermometers, weighing scales and infusion sets were available in at least 50% of facilities but others required for simple emergency care like oxygen cylinders, nebulizers, ambubags, basic suturing etc were not available in majority of facilities.

Non-professional health manpower (CHEWs) was in very short supply obviously limiting service availability and operating hours.

The pattern of utilization and service availability was in favour of immunizations, antenatal care and deliveries in keeping with programmatic interventions for the target populations.

Given the state of these facilities, their capacity to deliver "health care" is obviously questionable. The PHCs are often the only health facilities available in rural areas and 48% of Nigeria is rural, this therefore depicts the health care access to this population.

6. Misconception of Primary Health Care in Nigeria

The ward health system was developed in response to the Alma-ata primary health care (PHC) reform in 1978 and was instituted as the basis of the health system in the first comprehensive national health development policy 1988 and remains the structure for health care delivery till date [10]. The WHO declaration of primary health care as a means of achieving health for all in 1978 was undergirded by the rationale that at that time, the global disease burden was dominated by preventable communicable disease for which low cost interventions had a high impact relative to cost of investment, many countries were yet to define a viable and stable structure for health delivery and investments were skewed towards curative rather than preventive medicine, the importance of social determinants of disease and multisectoral collaboration for health was under emphasised [2].

The Alma Ata declaration therefore aimed to put forward a set of values and principles to guide the development of health systems by placing national and global solidarity for health on the front burner and persuading countries especially in LMIC to take ownership of responsibility for the health of their populations and invest in health. Hence the main thrust of the PHC was development of PHC as the basis of the health delivery vehicle for health systems such as to provide access to services at grassroots with community participation and ownership, and services targeted at community and personal preventive care, maternal and child healthcare, treatment of common diseases and injuries and provision of essential drugs. Globally, countries responded and reformed their health systems in the spirit of primary care. Developed countries reformed and improved on their delivery of holistic care integrating preventive, curative and rehabilitative care attaining high population coverage and improved health indices. Low and middle income countries (LMICs) evolved differently with very poor outcome. In Nigeria as in most LMIC, PHC was fundamentally misconceived as an intervention program to deliver basic health services for priority diseases to the rural poor with the main thrust as community preventive health care and that personal curative care needed was of a basic nature not requiring professional health care providers and technology. The focus was therefore on priority segments of the population: women and children and those suffering from conditions like tuberculosis, guinea worm etc for which donor programs were available. This approach defined the governments' perspective to health system development: intervention to the rural poor using non-professional health workers for priority diseases defined by the global donors thereby denying majority of the population access to health care. This misconceived approach to health care and health system development failed to deliver health to the populations and coupled with poor leadership and massive corruption led to massive waste of resources, stunted health system development and abysmal health indices for the nation.

7. Failure of the PHC

The guiding policy for health delivery in Nigeria, the National Strategic Health Development Plan II (NSHDP II) states that the goal of the policy is "to strengthen Nigeria's health system, particularly the Primary Health Care sub system, to deliver quality, effective, efficient, equitable, accessible, affordable, acceptable and comprehensive health care services to all Nigerians". The PHC system was deployed to the grass roots but geographical access did not translate to access to health care as majority (80%) of these facilities were not utilised by the populations [6]. The myriad of

reasons for this included, perceived poor quality of services, principally due to the fact that available health care providers were not capable of delivering competent care to meet the needs of the populations. The expressed health needs of people that make them seek care (which are mostly curative and beyond the prescribed preventive care) require the expertise of professional care providers: doctors, nurses, pharmacists etc and not the community health extension workers (CHEWs) found in most PHC. Poor utilization consequently resulted in economic unviability of these facilities and abandonment by both the populations and the government and their dilapidation.

This was noted by the WHO PHC review and reform document to be the case in countries utilizing low cadre health care providers. It is unlike in high income countries where primary care was provided by specialist physicians with competence to offer high quality comprehensive first contact care thereby facilitating early detection of diseases and appropriate management, preventing complications and mortality. There is therefore a fundamental mismatch between the needs and aspirations of the people and the services that were provided for them: failure of people centered care. This has been attributed by the WHO as the principal cause of the failure of the progress of health systems in LMICs. It is the fundamental cause of the failure of PHC in Nigeria. Even the poor recognize their need for professional quality health care and are no longer content to be recipients of intervention programs that cater to selected diseases. The NSHDP II acknowledges this and states that despite previous reform efforts and *investments, ..."efforts at health system strengthening have not had the desired effect*, resulting in limited health care coverage and persistently poor health status of the population". The 2018 strategic health plan goal of provision of high quality health care for all Nigerians via the PHC is in itself a contradiction reflecting the lack of understanding of the misalignment of the current concept, structure and reality of the outcome of the PHC system in the country to this goal. There have been two national strategic health development plans since 2008, the 2010–2015 and 2018–2022 in which the system has been reviewed, the failures documented but reform has been only on paper and without addressing the crucial causes of failure. The WHO 2008 report on PHC reform was referenced in these plans but none of its recommendations were included in the plans [2]. Poor leadership and entrenched lack of responsiveness and responsibility have resulted in refusal to reform the system based on local evidence and the WHO reform agenda.

8. Poor leadership

The principle of social justice which makes the right to health a fundamental human right to be guaranteed by government has been neglected in Nigeria due to poor leadership in government and also within the health sector. The Nigerian government did not institutionalise the right to health of citizens until the enactment of the National Health Act of 2014 [12]. The laissez -faire attitude to health care is evident in poor funding, policy enactment and implementation resulting in the persistent approach to health as a commodity for which the populations have individual personal responsibility. The PHCs are statutorily under the governance of the local government authority which is non functional as a tier of government in Nigeria. The NPHCDA at national level has been supervising and funding the PHC through very opaque mechanisms directly and via the state PHCDAs. Poor leadership has left this system uncorrected despite the impact of this misconstruction on the performance and accountability of PHC system.

9. Corruption and mismanagement

There is an endemic pervasive culture of corruption in Nigeria which is largely responsible for the state of the health system and nation. The misconception and failure to reform the PHC in line with the WHO recommendations is based on this. Corruption has made it impossible for the leadership both within the health system and government to walk the talk and altruistically work to build a system that can provide access to health care for the population. The lack of sense of social justice undergirds the misconception that PHC is a program for the poor, and the refusal to reform the system despite the overwhelming evidence of it's failure and rejection and the knowledge of the availability of the WHO strategy for reform. Their knowledge and rejection of the poor quality of care in Nigeria is evidenced by the whopping 1.6B USD capital flight from Nigeria spent on medical tourism annually especially by the political class [13]. Monumental graft in the system has consumed the available funding and greatly accelerated the collapse of the system.

Poor funding: The health budget has been consistently below 5% of national budget contrary to the fact of Nigeria being a signatory to charters recommending more than this (Abuja declaration recommending 15%). This performance is less than most countries of comparable income. The 2022 health budget was 4.3% of total budget amounting to about N3,453 per capita [7]. An amount that is incapable of providing access to health care for anyone. The dependence on donor funding for the priority diseases and programs may be a factor since these conditions are also the ones tracked for health system performance.

Policy development: Government ownership of the responsibility for health of her citizens warrants that health status, risk factors, morbidity and mortality trends are tracked to develop priorities and guide policy development but in Nigeria it is not so. Health priorities are determined by global agencies and donors and implementation is entirely to satisfy the conditions set for the vertical programs. This has often resulted in very poor performance of these programs, inefficient use of resources and poor sustainability. Also, it has contributed to the stunted development of the health system as the focus is on vertical programs targeted at segments of the population to satisfy global concerns but not on holistic health delivery for the entire population. The failure of the numerous vertical programs and their fragmenting impact on the system led to the development of the Primary Health Care Under One Roof initiative [14]. This aimed to integrate the multiple programs under one management, eliminate duplicate funding, staffing, facilities and competition but has not succeeded in achieving better results for the programs or improved performance for the system. Vertical stand-alone programs are expensive and inefficient and need to be mainstreamed into a well- structured PHC system that is capable of offering comprehensive first contact care to all segments of the population [2]. This is also noted by the WHO as a major contributor to the failure of health systems in LMICs [2].

Data management culture and research: poor sense of responsibility for the system and commitment to its development is also evidenced in poor data management culture which has permeated the entire system evidenced by lack of current Nigerian Government date for all indicators within and beyond the health system. Lack of value for the use of data to guide policy and decisions has resulted in a culture of disregard for accuracy, timeliness and sanctity of data collection and management. It is generally regarded as only necessary to be seen to meet program tasks. There is a wealth of research evidence as to the poor performance and community rejection of PHC but this fact has not deterred the government from persisting in its' pursuit

as the basis of health care delivery system in Nigeria. The National Strategic Health Development Plans acknowledge these evidences, the failure of government to implement measures to address the problems and yet insists on "strengthening" the existing PHC system to deliver quality health care to all citizens.

The health indices of Nigeria have remained persistently deplorable, worse than peer countries, among the worst globally and in contradiction to her great potentials. This is well documented in the national strategic health plans (NSHDP II) including the fact that there is no tangible effort to redeem the situation and adopt the WHO reform strategy. This approach to PHC has stunted the development of the health system and thus denied Nigerians access to health care.

10. Misconstruction and misalignments

A health system is defined as all the resources, actors and institutions related to the financing, regulation and provision of activities whose primary intent is to improve or maintain health [15]. The intrinsic goals of a health system are to provide good health, responsiveness and financial fairness for the population. The health of the population as a primary outcome of the system should reflect the health of individuals throughout life including both premature mortality, non-fatal health outcomes and the distribution of these in the population and reduction of inequalities. The health system structure and processes must therefore be aligned to achieve these goals. The key functional components of the system must therefore include institutions to provide for financing, service delivery, resource generation and stewardship with these institutions working in synergy to achieve the goals of the system for society. Policy, strategic design and implementation must therefore be aligned to the achievement of these goals facilitated by a framework for evaluation and reform over time.

The construction of the health system in Nigeria and its capacity to provide health and access to same is discussed in this context.

11. Financial access

National Health budgeting:

- The financing function of the HS in Nigeria is one obvious cause of poor access to care.

- The national budget allocation for health at average of 5% is consistently below the WHO recommendation of 15% and less than many Sub Saharan African countries despite having greater economic means [6].

The National Health Act (2014) established the responsibility of government for the health of Nigerians and instituted the basic health care provision fund (BHCPF) to provide the essential package of health services (EPHS) or basic health care package (BHCP) for the citizens [12]. The BHCPF is derived from 1% of consolidated revenue of the federal government and the EPHS stipulates the minimum package of health services that every citizen is entitled to. The principle of establishing EPHS in a health system is to serve as a tool for guaranteeing equitable access to health. It should be designed with specific funding and delivery mechanism for quality health care,

plans for upgrading of the package and also serves as a means to guide budgeting for health. The EPHS as designed in Nigeria contains the provision of water and sanitation and 6 personal health interventions: 4 maternal and child interventions and one urinalysis and one blood pressure measurement for others not in the maternal and child bracket [16]. The content of this package represents the basic obligation of the government to citizens for health and demonstrates the minimal consideration to achieve health for majority of citizens. In Nigeria water is provided by individual private bore holes and government action in this regard is minimal. Sanitation in urban areas is contracted by government and paid for by citizens. At a birth rate of 37/1000, the estimated number of pregnant women and infants in a given year is 7.6 million mothers and 7.6 million babies approximately, covering only 7% of the population is covered. Also, maternal and child health services are already covered by primary health care services funded by NPHCDA budgets and donors in multiple vertical programs. The provision of the funding of reproductive, maternal, neonatal, child and adolescent health (RMNCAH) services in the BHCPF amounts to a duplication and therefore renders the stewardship of the funds opaque.

The provision of one blood pressure check and one urinalysis for those outside the maternal and child target population cannot be equated to a health care package thereby confirming that the government does not feel obligated to give her citizens access to health care. It is in fact a travesty of responsibility. The content of the EPHS contradicts the principles under girding the design of EPHS as it neither provides health care nor equity for the population [2, 17]. This is unlike developed countries where the EHP content is comprehensive and other countries in LMIC category like Ethiopia which includes curative care for non-communicable diseases (NCDs) in the EPHS and recognizes that water and sanitation are delivered by other sectors outside the health services [18].

The stewardship of the BHCPF further jeopardizes its' capacity to meet its' goals. The fund is designed to be deployed through 3 routes: the National Health Insurance Scheme: (50%) for delivery of EPHS to the poor, NPHCDA: (45% for primary health care) for the provision of vaccines, essential drugs and consumables, maintenance of equipment and facilities and development of human resources for health. Federal ministry of health (FMoH) is allocated 5% of the funds for interventions to reduce mortality from road traffic accidents on 5 most dangerous routes in the country [16]. This is a clear departure from the stated intention of the BHCPF in the national health act. The operationalization document of the BHCPF clearly acknowledged that the entire fund cannot provide the health expenditure per capita and cannot buy any real basic package of health care and should therefore be targeted at providing the EPHS for the poor and yet the fund is split to include the FMOH for provision of emergency services through an unfeasible and opaque mechanism. Also, the funds given to the NPHCDA to cover services already previously provided for creates a duplication which is unaccounted for unlike in Uganda where such overlaps resulted in closure of vertical stand-alone programs for TB and leprosy and their incorporation into mainstream services [18].

Health insurance coverage. The capacity to purchase health is a major barrier to access where financial risk protection is lacking. Out of pocket expenditure for health at 71% is one of the highest among peer countries [8]. With nearly half of the citizens living below the poverty line, significant proportions of the population delay seeking health care, utilize quacks, or forfeit care altogether [19]. Effort at establishing universal health coverage via the national health insurance scheme (NHIS) has been in operation since 2005 but has so far covered only 13.5 million people (7%) [20]. The

NHIS is a social health insurance scheme and has five major schemes targeting the formal sector employees (FSSHIP), students in tertiary institutions (TSSHIP) vulnerable groups (VGSHIP), informal sector via voluntary schemes, (VCSHIP) community based insurance (CBI). The federal government funds FSSHIP and TSSHIP which have gained reasonable coverage among the populations targeted (government employees and corporate organizations staff) for these 2 schemes accounting for the 13.5 M people so far covered. The informal sector and community-based schemes which cover most of the population do not receive any government funds and do not have any specific mechanisms to ensure enrolment. The vulnerable group scheme provides for the same health benefit plan as the FSSHIP to be funded by government but has not gained much traction due to the lack of a clear funding mechanism, no reliable data base and mechanism to ensure their enrolment. However, in July, this year (2022) the Federal Government of Nigeria (FGN) announced the signing into law of a new act making health insurance compulsory for all citizens and residents of Nigeria, the National Health Insurance Act 2022 (amendment) also established the National Health Insurance Scheme as the National Health Insurance Authority. A specific funding mechanism for the VGSHIP was also announced to be derived from telecom tax, the basic health care provision fund (BHCPF) and donations. It is expected to cover 83 million Nigerians (43% of the population) and therefore increase the breadth of health insurance coverage of the population [21, 22]. However, a major challenge to achieving this coverage is the stewardship of these funds and accountability of the process of enrolment.

This concern is demonstrated by the fact that the fund was released for the first time in 2019 to the tune of 56 BN and is said to have been deployed to 7,250 health centers for rehabilitation and to cover the NHIS enrolment of about 1,042,890 indigent people of which 753,999 have started receiving the EPHS [23]. This reflects the contradiction in the operationalisation of the BHCPF aiming to provide EPHS to the poor via the NHIS, at variance with the NHIS provision that vulnerable group (VGSHIP) enrolees will receive same health benefit plans (HBP) entitled in the FSSSHIP. The achievement of financial access to health care for the vulnerable group via this funding is dependent on if their enrolment entitles them to the same health benefit plan as the FSSHIP or limited to the content of EPHS. This clarification is necessary as there is inconsistency in the announcements of the minister for health and the director general of the NHIA regarding this [20, 23].

Operationalizing the VGSHIP necessitates the consolidation of the entire funds into the NHIA to provide HBP cover for the vulnerable group and therefore avoid duplication and improve the efficiency of resource utilization in the spirit of stewardship.

The community based health insurance scheme is targeted at rural dwellers who are also mostly poor. They are required to form contributory groups, engage a health management organization to manage the funds and negotiate their HBP with a health management organization (HMO). This scheme receives no funding from government. Many challenges have impeded the deepening of the coverage of this target population: poverty of the target population, poor knowledge of the existence of the scheme, poor community organization and participation and poor quality of available health services in rural health facilities (primary health centers). The poor funding of this scheme from the contributors makes the scheme unviable business for the HMOs, limits the value of the coverage they can receive and therefore limits access to care. However, the VGSHIP will absorb a significant proportion of this population. The government needs to provide a scheme to subsidise the enrolment of those not covered by the VGSHIP in keeping with government's obligation to meet their right to health especially now that health insurance has been made compulsory and as done in other countries [24].

The coverage for the informal sector workers (Voluntary Contributors Health Insurance Scheme VCSHIP) which includes a significant proportion of the population who are engaged in small and medium scale enterprises has also not gained much breath attributed to poor awareness and knowledge of the scheme.

12. Health delivery system

The reformed PHC system empanels individuals, their families and communities with specific primary health care teams led by specialist physicians [2, 25]. This delivery structure enables the system to be accountable for the health of every citizen, allows for regulation of quality of care and facilitates cost effectiveness and efficiency of the system thereby achieving universal access. The health system of the United Kingdom, France, Canada, Australia, the Netherlands and Germany are structured as such and their health indices are evidence of its' success. The basis of the health system in these countries is the primary care provider team led by the Family Physician, General Practitioner, Primary care Internist, or primary care Paediatrician [2, 26]. They take care of most of the health needs of most of the population most of the time serving as the gateway to secondary and tertiary care in a coordinated approach [26]. Majority of the doctors in these countries are specialists with a high density of other professional health workers working in integrated teams within systems that span from the community to the hospitals [26]. Quality of care is a priority established on evidence-based practices [26]. Commitment to high quality care and population outcomes drives the system to set high standards of care using the most efficient solutions in a responsive and responsible manner ensuring equity and solidarity in the spirit of primary health care. Health manpower planning is prioritized and is coordinated from training to employment, distribution and retention. Health budgets are significant proportions of the total GDP, access in ensured via health insurance and out of pocket expenditures are minimal.

The primary health care performance initiative (PHCPI) framework integrates the components of the health system into a framework showing the directionality and interplay of components leading to the achievement of the goals of the system. It demonstrates that achieving the goal of the system is critically determined by the structures, organization, and processes linking them.

Some critical components of the framework are totally lacking in our system contributing to the misconstruction and poor foundation for development. These components include quality management infrastructure and social accountability mechanisms, Population health management (local priority setting and empanelment) High Quality primary care (first contact accessibility, continuity, comprehensiveness, coordination and person centered care), team-based care organization, performance measurement and management. Some components of the outcomes domain are also lacking (responsiveness, equity, efficiency and resilience of health system) all leading to poor health status of the population. This framework emphasises on the critical importance of the service delivery component which determines the interaction between people and the system thereby leading to outputs.

The misconception of PHC and misconstruction resulting in inability to functionally link system, inputs and service delivery domains of the PHC system to the goal of achieving health for the population made the health delivery system ineffective and inefficient ab initio. The structures including health posts, clinics and primary health centers had at it's core goal the programmatic intervention for a small but vulnerable

segment of the population in response to donor determined priorities and not quality health care for the entire population.

13. Human resources for health

The most fundamental reason for the failure of the PHC was the lack of professional health care providers, especially doctors to render the services needed by the people. In recognition of this the NSHDPII made human resources for health a major objective of the strategic plan with the goal to *"have in place the right number, skill mix of competent, motivated, productive and equitably distributed health work force for optimal and quality health care services provision"*. The NSHDP II also acknowledges that health manpower development: training, deployment and retention have not received any strategic efforts from government.

Health manpower planning: There is no tangible effort at evaluating the health human resources needed and aligning this with training priorities, employment and retention. There is no reliable data on the number of physicians, nurses or other health workers in the country. All available estimates show that there are insufficient numbers of all cadres of workers with provider population ratios far below the WHO recommendations as discussed above and there is no government action in this regard despite clear documentation as a major objective for health sector development.

Training: health manpower training across all cadres is hindered by the general decay in the educational sector. Unfortunately, the educational system is suffering a similar neglect with incessant industrial actions, dilapidated facilities, low quality educational processes and inconsistent graduate turn outs due to major interruptions of the academic calendars. It is estimated that at the rate of 3,500 doctors produced per year, it will take Nigeria over a hundred years to produce the 363,000 doctors required to meet the WHO physician-population ratio of 1:600 at our current population of about 218M. There is a staggering deficit of about 338,000 physicians in Nigeria. Primary health care in developed countries is delivered by specialist physician led teams and majority of doctors in these climes are specialised. In Nigeria majority of doctors are not specialised. There is no correlation between health manpower training output and the needs of the health sector. The only effort at manpower development to fill service needs has been at the level of CHEWs via the task shifting and task sharing policy. The CHEWs are being trained to upgrade their capacity to deliver curative services in the primary health centers using standing order protocols in effort to sustain the failed system. Evidence from the review of the PHC has shown that in a survey of 73 PH centers, not one of them had the standing order and that the accuracy of identification of clinical diagnostic entities was about 37% [11, 27]. Among the CHEWs, major challenges noted to impede their work and cause low morale was the lack of professional clinical support and leadership [27]. The persistence of childhood and maternal mortality indices at deplorable levels does not beg further explanation. The gross deficit of professional health manpower results in low technical quality of care ab initio denying majority of Nigerians access to health care.

Deployment: deployment of health manpower should be based on population density with the aim of having adequate numbers and variety of professionals to provide required services. There is no effort in this direction in Nigeria contrary to the strategic plans which made it a major objective to provide the right mix and numbers of health manpower to provide quality health services to all Nigerians. Also, a dysfunctional work culture in the country has resulted in absenteeism in the workplace

further worsening the manpower availability situation. Health workers across all cadres are well known to be functionally absent from their jobs limiting hours of service, increasing waiting times in health facilities and creating major barriers to access to health services. Rejection of rural postings due to poor conditions of living is another problem and even when these postings are accepted, the workers arrange to live in the urban centers and be available at limited times in the rural facilities resulting in functional shut down of the facilities they serve and limitation of access to care.

Retention: The laissez faire attitude of the government in this regard has been monumentally detrimental to the development of the health system. The misconception of primary care as basic interventions for the poor to be delivered by non-professional work force probably undergirds this attitude. There are frequent protracted industrial actions within the health sector over work conditions with the hospitals crippled, citizens denied access to care with consequent morbidity and mortality [28]. The government assumes very contentious positions in these disputes and their functionaries have often posited that Nigeria has enough doctors even in the face of critical painful evidence to the contrary calling to question their sense of responsibility on their jobs and to the nation. The consequent mass flight of health manpower to the developed countries has worsened in recent times with about 9,000 doctors leaving in the last 2 years and many more seeking to leave [29]. It is estimated that of the over 75,000 registered doctors in Nigeria only about 24,000 are still in the country including retired doctors [9].

14. Quality of care

The WHO has made it clear that low quality care is expensive and dangerous [30]. The national strategic health plans and all other health policy documents profusely make quality health care a central goal to be pursued. This is not aligned to any structures and processes that can evaluate and implement quality of care in the system.

Hitherto in our country, failure of PHC has always been premised on poor funding by the government but another argument presents itself in the widespread rejection of these facilities. This rejection has been premised on the perceived poor quality contingent on the non- professional providers available and their lack of capacity to deal with the health needs of the people and their communities. The facilities failed to offer people centered care.

The mix of non-professional service providers and dilapidated facilities in the health centers are fundamental recipes for poor quality care and expectedly poor outcomes as evident in Nigeria. A fundamental misconstruction of the system is the lack of a quality management framework resulting in lack of a quality management mindset and culture among the health care providers and other workers across all strata within and beyond the health system. This is unlike in developed countries where the institutions for managing quality of care are in built critical components of the system empowered to set and enforce standards eg. the Care Quality Commission, and NHS Improvement in the UK [26]. These bodies engage professionals, conduct research and develop evidence which are used to guide clinical care and health care priorities. This is critically absent in our system. There is no synergy between the health professionals and the government in this regard. Standards of care are not set within our local realities and resources and the ones copied from developed countries are not monitored or enforced. There is no data on safety of care and it is well known that majority of Nigerians receive inappropriate or even dangerous or unsafe care in hospitals. There are no reliable data on these problems and there is no action in the

government or professional organizations to address this. Standards are set only in the regulation documents for registration or periodic reaccreditation for which the facilities are well "informed and prepared." The quality of provider patient interactions and clinical care delivery is completely at the discretion of the provider and only the clients who are empowered seek redress in formal complaints and litigations in a slow and cumbersome judicial system. Quality of care management is critical for the efficiency of the system in attaining its goals. Quality of care frameworks facilitate the development and scaling of best practices ensuring that benefit is equitably distributed, harm is minimized and cost is contained.

Technical and process quality standards setting and regulation are necessarily a function of professional governance enshrined in the professional codes. In Nigeria, the health professions have not been active in engaging, setting and monitoring of the quality of care and practice. Currently there is an unfortunate mistrust of the professions by the populace resulting from multiple factors including the existing exploitative private practices, frequent strike actions with hospital shut downs, poor provider patient interactions and numerous anecdotal reports of questionable care. This has been attributed to the widespread disillusionment and breakdown of ethics in society. However, of note is the significant lack of quality of care and system-based practice as important entities in the curricula of training of health professionals, compounded by lack of quality management framework in the health system. This has resulted in the production of health manpower that is not oriented to the goals of the system, their responsibility and critical leadership roles in its' development, sustenance and outcomes. It is reflected in the endemic subsidiarity in the attitude of individuals, each specialty and professional group with deeply entrenched rivalries that hinder team work and jeopardize quality of care [31]. It has had very adverse impact on the development of the professions limiting their capacity to study disease conditions and develop modalities of care that are suited to our local experience, problems and resources. This is a crucial fundamental building block for effective and efficient care systems as exists in developed countries. The professionals are left with the sense that copying the protocols of care from developed countries is impossible given our limitations but yet unable to develop sustainable alternatives further increasing job frustration and professional unfulfillment. These factors contribute to emigration of health workers. They also result in large performance gaps in the quality of care delivered, development of expertise in care and failure to lay foundations for the system to develop. The performance gaps exist because, due to lack of commitment to a quality management culture, the available limited resources are not put to the best possible use thereby delivering outcomes that are worse than need be. This is a function of professional governance but given the endemic lack of leadership culture in the country, resistance to innovation and poor work culture, the development of professionalism has been stunted.

User perception of quality has also resulted in inefficient use of the system resources. Rejection of PHC services and lack of coordination of care results in self-referral to tertiary institutions in search of quality and ethical care. Most tertiary hospitals are inundated with primary and secondary care conditions leading to overcrowding, long waiting times and underutilization and development of specialist resources [32].

15. Timeliness

User perception of poor quality of care is an important determinant of choice of provider and facility. Waiting time is a major barrier to access to health. Studies have

shown that waiting time in Nigerian hospitals can be as long as 6–9 hours [33, 34]. Long waiting times are the result of poor management of patient arrival patterns and coordination of service points. Most public hospitals receive large patient turnouts which overwhelm the available staff and result in long waiting times. Patients decry this scenario and it is one of the major reasons for non- utilization of teaching hospitals hindering access to care. This is despite acknowledging that reliable higher technical quality care is available in teaching hospitals. Unfortunately, due to very poor commitment to responsiveness there is no systemic effort to address this. Simple appointment systems to manage patient arrivals have not been instituted. There is scarcely any public hospital with a telephone number on which they can be reached for anything including emergencies. The COVID-19 experience has failed to change this despite the Nigerian Center for Disease Control (NCDC) protocols requiring that patients with symptoms should call their health care providers before going to the hospital. Long waiting time also contributes to delayed presentation to hospital increasing morbidity and mortality.

Access has so far been discussed with reference to primary care as it is the basis of the health system. The situation with secondary and tertiary care is not more favourable and is largely impeded by similar factors. Availability of highly technical care for such conditions as cancer, stroke, myocardial infarction etc is very poor in public tertiary hospitals and when available is often in poor working conditions and offered in such cumbersome and unresponsive processes that clients do not benefit or choose to seek private care. This is the predominant reason for the large economic burden of medical tourism in Nigeria [13]. Access to emergency care is also very limited. Very few hospitals have facilities and personnel for medical evacuation and when available, the cost excludes most of the population. At the tertiary care level, the main factors responsible for this is poor leadership, poor funding, lack of development of health manpower and consequently, brain drain.

16. PHC as the foundation for health system development

The WHO reform of PHC has as one of its' major thrusts the achievement of UHC via the PHC system and therefore the establishment of PHC as the basis for health system design, development and growth. The misconception and misconstruction of PHC in Nigeria has on the contrary had adverse effect on the system in this regard resulting in stunting of the development of the health system.

Health and social justice: Health as a social good and means to equity and social justice and a responsibility of government: this concept is highly underdeveloped in the psyche of leaders and managers in and beyond the health system and evidenced by the policies and strategies instituted for the system. The misconception of the PHC and persistence on this course despite awareness of its failures and the WHO reformed PHC makes this evident [6]. This is reflected in the fact that public hospital managers are not performance driven and the quality of the services in the facilities do not determine management decisions. Responsiveness to clients is not a core goal of hospital managers. There are no road maps for the development of facilities as there is fundamentally no defined goals and responsibilities of these facilities to the communities they serve. Management goals and priorities are completely at the discretion of the extant manager and there is no obligation to continue good initiatives into succeeding administrations resulting in poor development, waste of resources and entrenchment of the culture of systemic laissez-faire attitude to population health.

The endorsement of the non-professional workforce as competent to deliver care has resulted in a total devaluation of the quality of care in the health system providers and users alike. CHEWS Chemists, nurses, pharmacy shops, fake doctors and all manner of charlatans are allowed to render care. Due to the prohibitive waiting time, direct and opportunity costs of hospital visits, patients seek convenient but unsafe and inappropriate care from these sources resulting in late presentation to the hospitals, increased morbidity and mortality. The misconception and devaluation of quality of care and life has been entrenched to the extent that non-professional health manpower are now licensed to run private health facilities based on standing orders and the task shifting and task sharing strategy [6]. The lack of a quality and data management culture renders this toll on health and life unmeasured and unaccounted for. The government does not take responsibility for this since it is considered good enough for the poor.

Quality management culture: The non-existence of quality management framework in the system has resulted in the stunted development of this all important component of the health system. Quality of Care as a concept and important metric in the structures and processes of care delivery is alien to even the professional health providers. Knowledge and implementation of evidence based best practice is entirely left to the discretion of individual practitioners without any systemic efforts at evaluation of practice and outcomes. There is a culture of resistance to innovations to implement improvement based on primordial egotistic tendencies [35]. The appropriateness, efficacy, efficiency and safety of care delivered even in professional settings in tertiary hospitals is often questionable and unaccounted for. There is therefore no framework for responsibility, accountability, development and reformation of the care system towards achieving high quality care and performance resulting in stunting of development.

Gate keeping and coordination: Unlike the non-professional manpower for the existing PHC, the professional PHC provider in the reformed PHC, has the capacity to provide coordination functions managing gatekeeping to secondary and tertiary care resources. In developed countries this has resulted in more efficient use of health system resources allowing for focusing of high technology care on those most in need of it. Also, secondary care function is mostly integrated with the primary care physicians with most problems being effectively addressed at primary care. The poor capacity for quality care and coordination in the PHCs in Nigeria has resulted in the self-referral of patients to secondary and tertiary care facilities resulting in overcrowding and long waiting times in these facilities and limiting access to care [32]. This in addition to poor funding and equipment of tertiary facilities, contributes to deterring the development of the capacity of these providers for tertiary care. A systemic lack of understanding of these concepts has resulted in confusion of the emerging role of Family Physicians in the Nigerian health system. The terminology primary care in the teaching hospitals where most Family Physicians are trained is irreconcilable with the primary care synonymous with non-professional workforce. Currently there is no coordination of care in the system and consequently patients are receiving very fragmented care with all the attendant adverse impact on quality of care, outcomes, cost and quality of life.

17. Way forward

There is an urgent need to correct these fundamental errors in our health system as the current situation is not only ineffective but constitutes a perpetual journey to poor development.

The time to reform the health system of Nigeria is now more than ever to create a new path to health care access and the desired health outcomes. This will put the country on the right course to a health system that can hope to serve its purpose, build a foundation for development and growth and bring the system in line with the twenty first century.

This reform must be holistic involving all stakeholders: politicians, health manpower including the private sector, general public, community leaders, civil society organisations, global partners and others to ensure buy in, ownership and sustainability. It must include the 4 reform pillars of the WHO reform: leadership and governance, public policies, universal health coverage and service delivery.

Political leadership must own the responsibility for the health of the citizenry and therefore embrace the evidence based WHO reform agenda. They must engage all stakeholders synergistically in the reform process. However, the capacity of our political leaders as currently constituted to effect this reform is perceived as limited. A major reform to generate the necessary political will to effect the reform can only come from a positive change in the political actors in the country. This will also include major reforms to curb the monumental corruption that exists in the health sector as in other sectors generally in the country. The major critical areas that must be attended to include the PHC policy reform, the urgent holistic restructuring of the health manpower management: increasing the availability and quality of training sites, good work conditions and incentivization of specialization especially for primary care specialists, rural appointments, positive change in the engagement of professional organizations in disputes and high quality manpower data management.

There is need for development of a primary care movement whose primary goal will be to educate and mobilize all stakeholders to understand the new PHC and drive the momentum to overcome the inertia of political leadership to reform. The movement should be led by health professionals and include civil society organizations, community leaders, the general public, Nigerian health professionals in the diaspora and global actors [2].

The tasks required include:

Education and conscientization of all stakeholders to understand the critical need to build a health system with the capacity to deliver health while creating a foundation for growth and development of the system. A major thrust of critical importance in the process is the reform of the value system of all stakeholders to achieve a prevailing spirit of solidarity, responsibility and accountability without which the nation cannot survive.

Health professional organizations: A multi-faceted engagement is required to achieve a wide range of empowerment covering leadership training, health system organisation, dynamics, goals and management, health system regulation, professionalism, interprofessional relationship, team work, data based management, quality of care, health system advocacy, and the PHC reform.

There is need to engage and achieve a renewed commitment to the responsibility for the health of society as a social contract of the professions with society so as to encourage positive change in the sector at all levels. Also, there is need to craft a more functional approach to engagement with the political leadership and mitigate the incessant industrial actions that cripple the system. This will require engagement of the professionals and the political actors to reorient their approach to leadership and management of the system and create a synergy between them. All these are expected to yield dividends in improved interprofessional relations, reduced strike actions, acceptance of innovation, development of quality framework and extension of these into the health professions training.

The Nigerian health professionals in the diaspora have an important role to play as they can share their experiences from developed countries and mentor their home organizations thereby supporting human resources reform which is critical to the

strengthening of the system. The health professional bodies can apply a bottom up approach to effect change in the health system from the professionals to the policy makers and catalyse the process of reform. The health professionals as a body have a critical role to play in developing health priorities and designing best practices as in other countries but this is grossly lacking in Nigeria. This has to be corrected and will require actions generated by the professional organizations with commitment to the best interest of the system and advocacy to establish this structure in the health system.

18. Research and innovation

The health professionals need to reform the existing poor ethical research culture. Research and evidence based innovation in the system cannot happen without this. The support of government and donors is very important in this regard but requires the reform of research culture. All areas are important but system-based practice, quality of care and outcomes are needed urgently to generate evidence to guide system development and practice. This will increase the culture of innovation and its acceptance and improve ownership, quality of services and efficiency of the system.

Regulatory Framework: There is a critical need to develop and entrench a strong effective regulatory framework in the system. There is generally poor culture of regulation in the country but the consequence in the health sector is grievous. The system cannot achieve its goal without an effective regulatory framework as obtains in developed countries. The health professionals and their organizations have a critical role to play here and must champion this cause. Continuing professional development, renewal of licencing, reaccreditations through credible processes, periodic relicensing examinations etc are critically important in ensuring that professionals and facilities are up to date to assure technical quality of care. The proliferation of charlatan practices needs to be curbed. The practice of consultations, prescriptions and dispensing of drugs from all manner of sources needs to be regulated to curb the level of unsafe, poor quality care abundant in the system.

Global Partners: Donors should channel donations and aid less to vertical programmes embedded in the old PHC and channel it to structures and processes that support the development of the reformed PHC and health insurance coverage as done by health fund in Sokoto state. Also, they can create incentives to retain health workers in Nigeria especially rural areas to support the reform process. There is need for the global community to take measures to address trans-border migration of health workers especially from poor resource countries to high resource nations in the interest of global health equity. Donations and aids to poor nations cannot translate to desired cost-effective health outcomes if the critical input of health professionals required for success is unavailable. The training of health professionals in Nigerian public universities has hitherto been almost entirely borne by the government and the brain drain represents not just a flight of human capital but of developmental resources used in their training and the consequent impoverishment of our health system.

19. Health human resources management

The most critical input in any system is the human resources and the failure of the current PHC system has clearly demonstrated this. The challenge of health human resources development in Nigeria is indeed daunting, given the current state of socioeconomic,

political, security and health system contexts. However, this challenge must be addressed to stop further waste of resources and retrogression of the health system and the country.

The reformed PHC requires that primary care be delivered by specialist primary care physicians especially family physicians and other health professionals working in teams with the populations empanelled to those teams.

The challenge of manpower management requires a positive change in government's sense of responsibility and investments for all sectors especially the education and health sectors to improve quality and quantity of training. Manpower employment and retention requires that government must change its' contentious posture that mismanages industrial disputes in the health and education sectors. There must be a synergy between government and health professionals as allies in constructive engagements in design, regulation and management of the health system and in particular to address issues relating to work conditions for health manpower. The existing number of physicians (and all other health professionals) is abysmally poor and cannot meet the required placements. A creative and committed roadmap must be drawn as fundamental to the reform plan on how to efficiently deploy available manpower in the short term and extend same in the future. Majority of the physicians in the country are not specialised. The National Post Graduate Medical College of Nigeria has a diplomate programme in Family Medicine which can be harnessed to increase the number of physicians trained to deliver care in the context of primary care ensuring that all physicians in the primary care space are better prepared to offer quality first contact care. This would then facilitate their deployment in empanelled systems as would be designed to directly offer care, supervise and support care teams and increase available sites for training of house officers who would also be integrated into the scheme. Also, at undergraduate level, family medicine training should be mandated in all medical schools to ensure that all graduates are prepared for primary care on graduation. This approach has worked very well in a LMIC like Cuba [36].

20. System reconstruction

The national health insurance scheme offers a mechanism for transforming the health system and implementing the reform of the PHC. Currently the NHIS and the PHC system under the NPHCDA are the two health delivery pathways in the system. The new NHIA Act that makes health insurance compulsory in Nigeria demands that the service delivery must extend to everywhere and everyone mandating universal access to health and thereby mandating only one delivery system. The critical issue then is how to create a system that is capable of achieving this mandate by aligning structures and processes to the goal. The WHO PHC reform provides the pathway to achieve this by organizing the NHIS on the reformed PHC model. The resource limitations in deploying the remodelling across the entire system is obvious. The proposal here is therefore to create a road map wherein the remodelling can start where resources permit and extend to others over time so as to commit the system in the right direction to development and growth.

21. NHIS

The NHIS coverage in urban areas suffers the challenge of quality and efficiency more than availability of facilities and personnel unlike in rural areas. The reform should

be to reorganize the delivery system to achieve empanelment, physician led primary care approach offering, comprehensive, continuing, coordinated, person-centered quality care. This would involve professionals training in family medicine, quality of care, quality management system and regulation of all practices including public and private. The quality and responsiveness of services need to be improved especially, timeliness to remove the barrier of long waiting time and improvement in patient information access.

The role of the private sector is critically important as they control a significant proportion of the service delivery system and must be properly harnessed into the system. Lessons can be learned from the British system where the primary care is delivered entirely by private providers under regulation from the quality systems of the NHS [26].

Empanelment requires the mapping of the population into segments to be served by defined health teams. The existing ward health system has already mapped the population and defined teams of nurses and CHEWs to cater for them. These teams should be further developed and empanelled to defined providers to incorporate them into the NHIS delivery system. This therefore requires that all PHC services covering vertical programs should be mainstreamed into the NHIS services and duplicate funding redeployed to other needs.

The NHIS program available for rural dwellers is the community based scheme which has so far not gained much traction due to the lack of government support, strong community health development committees, ignorance, poverty and also lack of functional health facilities. Rebuilding of dilapidated facilities, government subsidisation of CBI and mobilisation of community awareness will increase ownership of community based insurance scheme and utilization of the PHC facilities in rural areas. This will also be facilitated by the implementation of the VGSHIP reducing the burden of indigent people in the communities. The shortage of professional health manpower can be mitigated by incentivising rural posting of doctors and other professionals and use of telehealth and other adaptations of information technology to provide clinical care and supervisory support to the existing non-professional manpower in empanelled teams. Where unhindered by security considerations, incentivised rural exchanges for urban based professionals could also alleviate the shortage.

The NHIS coverage for the informal sector needs to be deepened by government subsidy, increasing awareness and enrolment of the population in this bracket as done in other developing countries like India and Chile [2].

These steps would set the reform into motion harnessing the available resources to achieve efficiently, both geographical and quality access to those in areas that can be covered now and set a template for growth to cover other areas in the future. A commitment to the road map for development of the system is necessary ensuring that system growth is sustained from one political administration to the next. The NHIA should therefore be conscientized and empowered to perform their role in ensuring the health of the population by taking charge of all health service delivery driven by a quality management culture and responsiveness. Regulatory authorities must be built into the new system structure to regularly set standards, monitor performance, regulate compliance, research system dynamics and performance and provide guidance as done in developed countries [26].

Leadership and Governance: reform in this domain requires whole country effort to reduce the level of corruption and irresponsible leadership that permeates and destroys the whole system. As regards the health system, reconstruction of the system should include streamlining the structures for funding, financing and purchasing of health services into structures that are transparent and aligned to performance and goal achievement. The current system is so convoluted and opaque that funds and its deployment cannot be tracked. The essential package of health services needs to be

upgraded and reformed to correspond to basic health plans of the NHIS which is the minimum required to offer a health coverage. The reformed EPHS should therefore be the basis for determining the health budget in order to create appropriate alignments of goals, budget and delivery structures and processes.

The government must raise health budgets to meet the recommendations of at least 15% of national budget

The NPHCDA services should be mainstreamed into the basic health plans of the NHIS and therefore the funds for RMNCAH services should be mainstreamed into the NHIS via the state health insurance authorities. All donations and grants for these should be tracked through the NHIS ensuring delivery of services and shifting of funds from BHPs to deepen coverage of other services where BHP offers duplication of RMNCAH services.

The statutory domiciliation of governance of PHC under the local government authorities needs to be changed as this level of government has not been allowed to function and so is incapable of managing PHC. Again, even if they were to be strengthened, the responsibility for the successful funding and management of a professional led reformed PHC is beyond the capacity of a local government authority. The current legislation on health as a responsibility of the three tiers of government therefore needs to be amended in line with the realities and for ensuring a successful health system. The state health insurance authorities should be in charge of the NHIS services deployed through a reformed PHC model.

Conclusion: In Nigeria, access to health care in all its dimensions as a function of structure and function of the health system and its interaction with people is very poor.

Poor leadership perpetuated the misconception of Primary health care and stunted the development of the health system.

New paths to improvement require system reconstruction and a reform of the primary health care system now more than ever.

Conflict of interest

The author declares no conflict of interest.

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References

[1] World Health Organization. Universal Health Coverage. Available at http://www.who.int [Accessed August 29, 2022]

[2] World Health Organization. Primary Health Care. Now More Than Ever. WorldHealthReport2008. Available at http://www.who.int [Accessed June 23 2012]

[3] Cu A, Meister S, Lefebvre B, Ridde V. Assessing healthcare access using the Levesque's conceptual framework–a scoping review. International Journal for Equity in Health. 7 May 2021;**20**(1):116. DOI: 10.1186/s12939-021-01416-3. PMID:33962627; PMCID:PMC8103766

[4] Adedini SA, Odimegwu C, Bamiwuye O, Fadeyibi O, Wet N. Barriers to accessing health care in Nigeria: Implication for child survival. Global Health Action. 14 Mar 2014;7:23499. DOI: 10.3402/gha.v.7.23499

[5] Nigerian Population. 2022

[6] Federal Government of Nigeria. National Strategic Health Development Plan II (2018-2022). Available at https://ngfrepository.org.ng [Accessed September 22, 2021]

[7] Amata D. Budget: N3,453 per Capita for the medical care of Every Nigerian in 2022. 2022. Available at https://www.dataphyte.com [Accessed August 8, 2022]

[8] Nigeria- World Bank Data. 2022 [Accessed August 28, 22]

[9] Number of Doctors in Nigeria from 2017 to 2019. Available at www.statista .com

[10] National Primary Health Care Development Agency. Minimum Standards for Primary Health Care in Nigeria. Available at https://ngfrepository.org.ng [Accessed September 10, 21]

[11] Christian Aid. Assessment of Primary Health Centres in selected States of Nigeria. E: nigeria-info@christian-aid.org, www.christianaid.org.uk/Nigeria

[12] Federal Republic of Nigeria. National Health Act 2014. Available at https://nigeriahealthwatch.com [Accessed August 25, 22]

[13] Adeyemi S. Nigeria Set to become Destination for Medical Tourism, Reverse Brain Drain-Minister. 2022. Available at www. fmic.gov.ng [Accessed August 25, 22]

[14] National Primary Health Care Development Agency. Integrating Primary Health Care Governance in Nigeria. Available at https://ngfrepository.org.ng [Accessed August 19, 22]

[15] Murray CJL, Frenk J. A framework for assessing the performance of health systems. Bulletin of the World Health Organization. 2000;**78**(6):717-731

[16] Guidelines for Administration, Disbursement, Monitoring and Fund management for Basic Health Care Provision Fund. 2016. Available at https://www.health.gov.ng [Accessed April 25, 20]

[17] WHO. Essential health Packages: What are they for? What do they Change? Draft Technical Brief No. 2. 2008. WHO Available at http://www.who.int [Accessed September 25, 2021]

[18] The Essential Health Service Package in Nigeria. Tropical Health Matters. 2018. Available at https://www.hfgproject.org/essential-package-of-health-services-country-snapshotnigeria/ [Accessed June 5, 2021]

[19] The World Bank. Deep Structural Reforms Guided by Evidence Are urgently Needed to Lift Millions of Nigerians out of Poverty, Says New World Bank Report. Press Release No. 2022/052/AFW March 22, 2022

[20] Popoola N. 22 years after, NHIS suffer slow patronage amid complaints, corruption others. Available at www.punchng.com [Accessed August 4, 22]

[21] National Health Insurance Authority-Act-2022. 2022. Available at https:// nhis.gov.ng [Accessed August 4, 22]

[22] Ismaila Chafe Health Insurance. Vulnerable Group Fund to cater for 83 m Nigerians. 2022. PM NEWS. Available at www.pmnewsnigeria.com [Accessed August 4, 22]

[23] Biriowo K. FG disbuses N56bn Basic Healthcare Provision Funds to 36 States, FCT. Tribune Online. African Newspapers of Nigeria PLC. 2022. Available at www.tribunronlineng.com [Accessed August 19, 22]

[24] Dutta A, Hongoro C. Scaling Up National Health Insurance in Nigeria: Learning from Case Studies of India, Colombia, and Thailand. Washington, DC: Futures Group, Health Policy Project; 2013

[25] The Primary Health Care Performance Initiative. The PHCPI conceptual Framework. Available at www.improvingphc.org [Accessed August 5, 22]

[26] Tikkanen R, Osborn R, Mossialos E, Djordjevic A, Wharton GA. International Health Care System Profiles: England. 2020

[27] Uzochukwu BSC. Primary Health Care Systems (PRIMASYS): Case study from Nigeria. World Health Organization alliancehpsr@who.int http://www.who.int/alliance-hpsr

[28] Adeloye D, David AR, Olaogun AA, Auta A, Adesokan A, Gadanya M, et al. Health workforce and governance: The crisis in Nigeria. Human Resources for Health. 2017;**15**:32

[29] Adebayo A, Akinyemi OO. What are you really doing in this Country?: Emigration Intentions of Nigerian Doctors and their Policy Implications for Human Resource for Health Management. Journal of International Migration and Integration. 2021. DOI: 10.1007/s12134-021-00898-y

[30] WHO. Low Quality Health Care is increasing the burden of illness and health costs globally. 2018. Available at http://www.who.int/servicedeliverysafety/quality-report/en/ [Accessed April 3, 2017]

[31] Uchejeso OMI, Etukudoh NS, Chongs ME, Ime DM. Challenges of Inter-Professional Teamwork in Nigerian Healthcare

[32] Koce F, Randhawa G, Ochieng B. Understanding healthcare self-referral in Nigeria from the service user's perspective: A qualitative study of Niger State. BMC Health Service Research. 2019;**19**:209

[33] Ogunfowokan O, Mora M. Time expectation and satisfaction: Patient's experience at National Hospital Abuja, Nigeria. Afr j Prm Health Care. Family Medicine. 2012;**4**(1):a398-a404. DOI: 10.4102/phcfm.v4i1.398

[34] Ogaji DS, Mezie- Okoye MM. Waiting Time and Patient Satisfaction: Survey of Patients Seeking Care at the General Outpatient Clinic of University of Port Harcourt Teaching Hospital Port Harcourt. Medicine Journal. 2017;**11**:148-155

[35] Asakitikpi AE. Healthcare Coverage and Affordability in Nigeria: An Alternative Model to Equitable Healthcare Delivery

[36] Suarez IRM, Sacasas JAF, Garcia FD. Cuban medical education: Aiming for the Six-Star Doctor. MEDICC Review. 2008;**10**:4