

CRC 1342 No.36

Social Policy Country Briefs

Nigeria



Joseph Abiodun Balogun
The Health Care
System in Nigeria



Global Dynamics
of Social Policy CRC 1342



Deutsche
Forschungsgemeinschaft

Joseph Abiodun Balogun

The Health Care System in Nigeria

CRC 1342 Social Policy Country Briefs, 36

Edited by Lorraine Frisina-Doetter, Julian Götsch and Mai Mahmoud

Bremen: CRC 1342, 2024



SFB 1342 Globale Entwicklungsdynamiken von Sozialpolitik /
CRC 1342 Global Dynamics of Social Policy

A04: Global developments in health care systems and long-term
care as a new social risk

Contact: crc-countrybrief@uni-bremen.de

Postadresse / Postaddress:

Postfach 33 04 40, D - 28334 Bremen

Website:

<https://www.socialpolicydynamics.de>

[DOI <https://doi.org/10.26092/elib/2742>]

[ISSN 2700-4392]

Funded by the Deutsche Forschungsgemeinschaft

(DFG, German Research Foundation)

Projektnummer 374666841 – SFB 1342

Joseph Abiodun Balogun

The Health Care System in Nigeria

CRC 1342
No. 36

THE HEALTH CARE SYSTEM IN NIGERIA

Joseph Abiodun Balogun*

Content

1. COUNTRY OVERVIEW (LATEST DATA AVAILABLE)	3
2. SELECTED HEALTH INDICATORS	3
3. DEVELOPMENTS IN HEALTH CARE PRIOR TO POLITICAL INDEPENDENCE IN 1960.	4
4. CHARACTERISTICS OF HEALTH CARE SERVICES DURING THE COLONIAL PERIOD.	4
a. Organizational structure	4
b. Coverage.	5
c. Provision.	5
d. Financing	5
e. Regulation	5
5. LEGAL BEGINNINGS OF THE HEALTHCARE SYSTEM POST-INDEPENDENCE	6
a. Major reform I.	6
b. Key developments shaping the context of healthcare system reform in Nigeria	7
c. The significance of the National Health Insurance Scheme, then and now	8
6. DESCRIPTION OF CURRENT HEALTHCARE SYSTEM 2016 –2023	9
a. Organizational structure	9
b. Coverage.	9
c. Provision	10
d. Financing	10
e. Regulation of dominant system.	11
f. Co-existing Systems	11
g. Role of Global Actors.	11
h. List of Additional Relevant Legal Acts.	12
REFERENCES	12

* jbalogun@csu.edu

1. COUNTRY OVERVIEW (LATEST DATA AVAILABLE)



Source: <https://ontheworldmap.com/nigeria/> (Accessed January 23, 2024)

- » Sub-Region: Sub-Saharan Africa
- » Capital: Abuja
- » Official Language: English
- » Population size: 211.401 million in 2021
- » Share of rural population: 52,2 % in 2015
- » GDP: 440.83 billion US \$ in 2021
- » Income group: Lower middle income
- » Gini Index: 35.1 in 2018
- » Colonial period and independence: Great Britain annexed Lagos in 1861 and established the Protectorates of Southern Nigeria in 1900 and Northern Nigeria in 1903. The areas were united in 1914 to form the Colony and Protectorate of Nigeria, which became independent in 1960.

Source: World Bank (2021); UN (2021); Encyclopedia Britannica (2023)

2. SELECTED HEALTH INDICATORS

Indicator	Country	Global Average
Male life expectancy	52 (2021)	69 (2021)
Female life expectancy	53 (2021)	74 (2021)
Under-5 mortality rate	111 per 1,000 live births (2021)	38 per 1,000 live births (2021)
Maternal mortality rate	1047 per 100,000 live births (2020)	211 per 100,000 live births (2017)
HIV prevalence	1.3% (15-49 age range) (2021)	0.7% (15-49 age range) (2021)
Tuberculosis prevalence	219 per 100,000 people (2021)	134 per 100,000 people (2021)

Source: World Bank (2021)

3. DEVELOPMENTS IN HEALTH CARE PRIOR TO POLITICAL INDEPENDENCE IN 1960

Before the arrival of Europeans on the Continent, Africans received health care primarily from native healers and herbalists. World War I strongly affected healthcare delivery services in Nigeria because of the high number of European and African medical personnel conscripted to serve in Europe. After the War, Nigerian physicians, including those who were trained in Europe, were banned from working in government hospitals unless they served Africans. This policy led to protests and frequent involvement by physicians and other medical personnel in the nationalist movements of that era (Coutsoukis 2005). The nationalist movement after World War I pressured the colonial administration to provide more social and economic services for Nigerians (Anaemene 2016).

In response to nationalist agitation after World War II, the British colonial government extended the country's orthodox health and education facilities to Africans and developed a Ten-Year Plan of Development and Welfare for Nigeria in 1946 (the health section of the plan is also known as the "Walker-Harkness Plan", referring to the responsible Director of the Medical Services Dr. J. W. P. Harkness and his Deputy Dr. G. B. Walker), which completely revolutionized the history of health services in Nigeria. The Walker-Harkness Plan, 1946-1956 recognized that healthcare services in the country were inadequate and of poor quality (Callaway 1987: p.101). Subsequently, the government allocated funds to build hospitals, health centers, a medical school in Ibadan (1948), and nursing schools in Lagos, Aba, Kano, and Ibadan (Coutsoukis 2005). Moreover, the Walker-Harkness Plan established the country's first Ministry of Health. Closer to political Independence in 1960, training nurses, medical assistants, and physicians became a priority at all levels with the goal that the trained personnel would take over the running of the healthcare system (Callaway 1987: p.101).

Name and type of legal act	A Ten-Year Plan of Development and Welfare for Nigeria 1946 (The health section is also known as Walker-Harkness plan) launched by the British colonial administration
Date the law was passed	1946
Date of <i>de jure</i> implementation	1946 – 1956
Brief summary of content	The Walker-Harkness 10-year health plan established the Ministry of Health to coordinate health services provided by the government, private companies, and missions. The programs in the plan were the progressive developments of environmental hygiene services, provision of adequate water for all, expansion of hospitals, maternity, child welfare, and dispensary services at the grassroots level (Anaemenem 2016). The plan identified malaria as the leading cause of morbidity and mortality.
Socio-political context of introduction	The Walker-Harkness Plan disregarded the politics of revenue allocation and was utterly insensitive to the health needs of distinct regional and ethnic groups and their accessibility to care. For instance, the preponderance of health services, hospitals, and rural clinics was concentrated in the southern region. It was only after the 1950s that hospitals and dispensaries were extended to urban centers in the northern region, and rural areas began to have dispensaries within a radius of 100 miles.

4. CHARACTERISTICS OF HEALTH CARE SERVICES DURING THE COLONIAL PERIOD

a. Organizational structure

The full implementation of the Walker-Harkness Plan was aborted by the introduction of regional governments, an outcome of the Macpherson Constitution of 1951. The regional governments launched different health plans in their respective areas of jurisdiction. In addition, a federal system of government was adopted in October 1954, upending the 10-year health plan with the introduction of the Economic Development Plan that covered the years 1955-1960. The plan was revised in 1958 and extended to 1962. It contained regional health plans launched by the newly established regional governments and a health plan by the federal governments. Regional and federal health plans were implemented in tandem.

b. Coverage

The percentage of the population covered by any formal healthcare scheme during this period is unknown. The first available data on the Nigerian population was recorded in 1950 at 37,859,748. Unlike the missionary health establishments, the colonial government medical facilities initially provided health services solely for Europeans but later extended healthcare to Africans employees “of European concerns” (Anonymous. (n.d.). The colonial states initially focused on providing health care for European soldiers, administrators, and settlers, particularly vulnerable to the tropical climate and its unique diseases. However, by 1900, they started paying more attention to diseases common among Africans, whose health and population growth were now deemed crucial for economic development and the legitimacy of colonial rule (Coghe, 2020). As Europeans expanded their activities inland, government hospitals and clinics broadened to other areas of the country (Balogun 2020). Unfortunately, the 10-year Walker-Harkness Plan primarily emphasized curative medicine with little attention to preventive and primary care, as no funds were budgeted for immunization, sanitation, and health education. Accessibility to health care was limited to only a few urban centers.

c. Provision

The *health service package* during the colonial period was “far below the average in the colonial empire and in some respects as bad as anywhere in the world” (Mejía et al. 1979). The Medical Examining Board record in 1789 contained only the names of Europeans, mainly Dutch, Danish, and British nationals. By 1961, there were 382 Nigerian *physicians* on the Medical Council register to serve 45,855,507 Nigerians. The number of *physicians* rose to 1,382 by 1970 (Mejía et al. 1979), when the population was 55,982,144. Colonial registered nurses (RNs) in Nigeria gained official recognition in 1946 - only 80 RNs were in the country that year, and 90 at Independence in 1960 (Callaway 1987). The University of Ibadan was founded in 1948 and included the first medical school and University College Hospital. The 1955–1962 Walker-Harkness health plan emphasized training health personnel at all levels, from specialists to laboratory assistants. The plan established 54 new training institutions, which produced medical personnel for hospitals, dispensaries, and rural health services (Anaemene 2016). By 1960, there were 65 government nursing or midwifery training schools (Coutsoukis 2005). Furthermore, by 1979, there were 562 general hospitals, 16 maternity and pediatric hospitals, 11 armed forces hospitals, six teaching hospitals, and three prison hospitals. Altogether with 44,600 *hospital beds*. Ownership of health establishments was divided among federal, state, and local governments, and there were privately owned facilities. Most health establishments were government-owned. By 1985, 84 health establishments were owned by the federal government (13% of hospital beds); 3,023 by state governments (47% of beds); 6,331 by local governments (11% of beds), and 1,436 privately owned establishments accounted for 14% of hospital beds (U.S. Library of Congress (n.d.).

d. Financing

The 1946 Walker-Harkness Plan budgeted funds for hospitals and clinics - concentrated in the main cities, with little funding for developing rural health centers. No quantitative data on healthcare funding is available. However, before orthodox medicine arrived in Nigeria, traditional medical practitioners charged “fees” in barter and reciprocity. With the Western-style health system, services were monetized and provided at a standard fee. The missionary hospitals and maternity services charged nominal fees for services. Thus, through the years, Nigerians became acquainted with paying for health services, and many were willing to pay when the federal and state governments could not sustain their welfare health scheme in the 1980s (Balogun 2020).

e. Regulation

The trans-Atlantic slave traders came with their physicians and surgeons who attended to their healthcare needs and that of enslaved Africans. The Portuguese were the first allopathic physicians to arrive on the shore of Nigeria in 1472. A Medical Examining Board recorded Dutch, Danish, and British physician’s names on its register in

1789. During that era, physicians of the Dutch West Indies Company treated the local people in Benin. Some of the physicians include David Livingstone, Mungo Park, Schnister and John Kirk. The Royal West African Frontier Force formed the West African Medical Service and the Medical Departments of the British Colonies in West Africa (Nigeria, Gold Coast, Gambia, Sierra Leone) were established in 1902. Subsequently, in Nigeria, the regulation of the conduct of medical and dental practitioners started with the formation of the Medical Practitioners Disciplinary Board in the Colonial Department of Health for physicians already registered with the General Medical Council in England (Medical and Dental Council of Nigeria 2022). The Director of Medical Services chaired the Medical Practitioners Disciplinary Board, the statutory regulator of medical and dental professions until independence in 1960. The indigenous statutory provisions evolved through the efforts of the first Nigerian Inspector of Medical Services, Sir Samuel Manuwa.

The Nursing Council of Nigeria was established by the Nurses Ordinance of August 1947 and charged with regulating and controlling the education and standards of the profession. The Nigerian Medical Association was established in 1951. The Medical and Dental Practitioners Act that became operational in 1963 established the Nigeria Medical Council - the first regulatory board for Medicine and Dentistry in independent Nigeria (Medical and Dental Council of Nigeria 2022).

5. LEGAL BEGINNINGS OF THE HEALTHCARE SYSTEM POST-INDEPENDENCE

a. Major reform I

Rather than one big policy bang, the legal beginnings of what is now the healthcare system in Nigeria are characterized by a series of incremental and protracted steps that began in 1975 with the introduction of the Basic Health Services Scheme (BHSS) and which would go on to span the course of four decades. These steps, which have mainly focused on establishing primary health care (PHC) in the country, represent fleeting and often failed attempts at de facto healthcare system reform. De jure, however, they represent effective translations of political will into the formulation and passing of health legislation, thus signaling significant, albeit nascent state responsibility in health care.

More specifically, three significant attempts at developing and sustaining the PHC system came to pass between the years 1975 and 2011. The first, the abovementioned BHSS, formed an integral part of the Third National Development Plan (1975–80) during the Murtala Muhammed and Olusegun Obasanjo military government. Its passing marks the very first successful legislative undertaking in health post-Independence. A second attempt led by the late Professor Olukoye Ransome-Kuti began in 1986 and followed the recommendations of the WHO's Alma Ata declaration. He developed 52 PHC pilot programs in the 774 local government areas (LGAs) that are credited as Nigeria's most successful PHC programs and formed an integral part of the National Health Policy and the Strategy to Achieve Health for all Nigerians in 1988. A vital result of this pilot program was attaining 80% immunization coverage for children under five. The success recorded was attributed to the active participation of the community stakeholders and focus on issues relating to strengthening health systems (Aigiremolen et al., 2014). Professor Olukoye Ransome-Kuti's PHC approach placed emphasis on preventive care and healthcare services at the grass root, ensured exclusive breastfeeding, provided free immunization to children, made compulsory the recording of maternal deaths, promoted nursing mothers' use of oral rehydration therapy, encouraged nationwide immunization and pioneered effective HIV/AIDS campaign. The National Primary Health Care Development Agency was established in 1992 to ensure the PHC agenda continued and was sustained. Sadly, the military takeover of the government in 1993 by General Sani Abacha ended the giant strides achieved under Professor Ransome-Kuti from 1985 to 1992 (Aregbeshola et al., 2017). The third initiative was launched during General Sani Abacha's regime, which established the Primary Healthcare Development Agency (NPHCDA). A less reported fourth attempt that is referred to as the Primary Healthcare Under One Roof Program was launched in 2011 by the Goodluck Jonathan administration and addressed the fragmentation in PHC services.

Name and type of legal act	The Basic Health Service Scheme (BHSS)
Date the law was passed	1975
Date of <i>de jure</i> implementation	1975-1985
Brief summary of content	The BHSS was the first attempt at implementing PHC in Nigeria. The program was introduced in 1975 as an integral part of the Third National Development Plan (1975-80) to extend free medical treatment to the whole nation as provided under previous plans (Aigiremolen et al., 2014). The stated objectives of BHSS were to 1) increase access to appropriate health services by 1980, 2) integrate prevention and health promotion services with curative services, 3) establish basic health units to achieve full integration, and 4) train a new cadre of primary healthcare workers to work at the healthcare facilities to be constructed. Unfortunately, the program did not meet the stated objectives because it focused primarily on building health facilities and training health workers with little attention to developing community participation and intersectoral collaboration. The program relied on unsustainable structures and high-tech equipment. The training of health workers was institutionally based, and workers could not adapt to life in rural areas but preferred to work in urban centers. Their selection was based on political expediency (Eshemokha, 2022).
Population coverage	The BHSS was structured along the “basic health units,” consisting of one comprehensive health facility at the apex, backed up by four primary health care centers consisting of 20 health clinics spread across each LGA, and supported by five mobile clinics serving approximately 150,000 people (Eshemokha, 2022). The total amount spent by the governments for the health sector during the plan period was 20% below the planned expenditure of N760 million. The budget shortfall adversely impacted the PHC services. For example, only 84 mobile clinics out of the planned 1,410 had started operating by the end of the plan period (Lambo, 1982).
Type of benefits	The PHC implemented between 1975 and 1985 aims to improve the collection and monitoring of health data, improve workforce development, ensure the availability of essential drugs, and improve immunization. It also aims to promote the prevention and treatment of epidemic diseases, improve food supply and nutrition, improve maternal and childcare and family planning, and curtail prevailing health problems. Unfortunately, the PHC plan did not significantly impact the accessibility to healthcare, as the system suffered major infrastructural and personnel deficits and poor public health management (Welcome 2011).
Socio-political context of introduction	While this intervention may have been sustainable under the unitary military dictatorship, its sustainability was challenged by the advent of democracy in 1999 (Aigiremolen et al. 2014). Though well-conceived, building model health centers for the LGAs was odd to the newly initiated principle of devolution of healthcare under the democratic system. The drawback of this effort was the non-involvement of local communities who were the beneficiaries of the services. The scheme could not be sustained at the end of the fourth national development plan period (1980-85).

b. Key developments shaping the context of healthcare system reform in Nigeria

Notably, in 1962, the first Social Health Insurance Program was proposed by Dr. Moses Majekodunmi, Minister for Health (1960–1966) to revitalize the nation’s worsening state of healthcare. This was met by stiff opposition from the Nigerian Medical Association when the bill was presented in parliament for its enactment in the Lagos area (Course Hero 2023). Health care has never been high on the national political agenda in Nigeria. At Independence in 1960, Nigeria adopted a federal Westminster system constitution. Between 1963 and 1966, the country was ruled by leaders representing their regions (northern, western, and eastern) as Premiers within the federation, with each geopolitical zone dictating its priorities. The federal government led by President (Dr.) Nnamdi Azikiwe and Prime Minister (Alhaji) Tafawa Balewa (1963-1966) never prioritized health care at the national level.

Sir Ahmadu Ibrahim Bello, an elementary school English teacher who later became Premier of the Northern region (1954-1966), served with a mishmash of religious, traditional, and modern values. He initiated plans to modernize traditional Koranic education and build a school in each province but had no healthcare initiative. Ironically, Michael Okpara, a physician and the Eastern region’s Premier (1959-1966), focused on agriculture and jettisoned health care.

On the other hand, Chief Obafemi Awolowo, a lawyer and Premier of the Western region (1954-1959), provided universal primary education, free health care for children, and increased health services delivery in

rural areas (Balogun 2022: pp. 62-67). Awolowo financed all his programs from agricultural products (primarily cocoa), the region's economic mainstay.

The Second Republic (1978-1983) ushered in the United States-type presidential system constitution instead of the parliamentary system. The new government led by President Shehu Shagari (1979-1983) of the National Party of Nigeria at the National Assembly disapproved the national insurance program and universal health care (UHC) because of the price tag and the global slump in oil prices. The Nigerian economy heavily depends on the oil sector, which accounts for over 95% of export earnings and about 40% of government revenues.

At the same time, the Unity Party of Nigeria (1978-1983), led by Awolowo, was dominant in the western region and the only one of the five registered parties in the country - the National Party of Nigeria, the Nigerian People's Party, the Great Nigeria People's Party, and the People's Redemption Party - to implement free health care and accessible education in the five states (Lagos, Oyo, Ogun, Ondo, and Bendel) that they govern. Having achieved so much with limited resources, many analysts wondered what Awolowo would have done as Nigeria's President at the peak of the oil boom in the 1970s. Awolowo's critics believe he would have successfully implemented UHC as Nigerian President.

By 1988, a Committee set up by Professor Olikoye Ransome-Kuti, the Minister of Health serving in the General Ibrahim Babangida administration, recommended a health insurance scheme for the country by mid-1991. Unfortunately, this proposal did not see the light of day until eight years later, when the National Health Insurance Scheme (NHIS) was launched in 1999 by the civilian government of Olusegun Obasanjo (Course Hero 2023).

c. The significance of the National Health Insurance Scheme, then and now

The NHIS launched under President Obasanjo (1999–2007) was widely acclaimed but did not achieve its primary goals due to a myriad of reasons, but most importantly because the successive Nigerian leaders after him - Alhaji Umaru Musa Yar'Adua (2007 - 2010), Dr. Goodluck E. Jonathan (2010-2015), and Alhaji Muhammadu Buhari (2015-2023) – failed to use the bully pulpit of the presidency to advance the UHC policy agenda vigorously. Several other reasons account for the lack of meaningful progress in implementing the NHIS: a dismal annual health budget, which over two decades is always less than 10% of the GDP, ineffective Ministers of Health, the lack of public awareness of the benefits of health insurance, the high consumer co-pay, the tepid support from the state governments and private employers, and dominant informal sector economy (Balogun 2022: pp. 407-444). Today, Nigeria's healthcare system has one of the world's poorest health outcomes: a high infant mortality rate, poor maternal care, extremely low life expectancy, and periodic outbreaks of various infectious diseases (Welcome 2011; Balogun 2022: pp. 299-338). For instance, 145 Nigerian women die daily from pregnancy-related causes, and 2,300 children below age five suffer the same fatal fate daily. Lassa fever, cholera, measles, meningitis, smallpox, and yellow fever infected 20,375 people and killed at least 1,084. Nigeria is ranked sixth with tuberculosis globally, with Africa's highest TB burden. Nigeria has over 400,000 TB cases annually, but less than 30% are detected. These horrific statistics are among the highest globally, yet over 70% of the deaths are preventable (Adejoro 2023).

Name and type of legal act	NHIS corporate body under Decree 35 launched in 1999
Date the law was passed	Launched on June 6, 2005 with a presidential mandate to achieve UHC
Date of <i>de jure</i> implementation	The new National Health Insurance Act (NHIA) was signed into law on May 19, 2022, aiming to ensure the effective implementation of a national health insurance policy and the attainment of UHC.
Brief summary of content	The objectives of NHIS were to ensure every Nigerian has access to healthcare services, protect citizens from the financial burden of medical bills, and limit the rise in healthcare costs. The plan also aims to maintain a high standard of care, improve and harness private sector participation in health care services, ensure adequate distribution of health facilities, ensure funding of the health sector for improved services, and ensure efficient and equitable distribution of health services (Welcome 2011).
Population coverage	The NHIS presently covers less than 5% of the population; it covers primarily individuals in the formal economy – mainly public civil servants, and employees of elite private establishments.

Available benefits	Outpatient/preventive/dental care, annual check-ups, hospital care up to 21 days a year, and maternity care throughout all stages of pregnancy which also applies to still-births and premature childbirth.
Socio-political context of introduction	<p>As of 2023, Nigeria has had nine military and seven civilian governments since its independence in 1960. Between 1966 and 1999, the military-ruled without interruption, apart from a brief return to democracy in the Second Republic (1979 to 1983), and the most recent coup occurred in 1998 by General Abdulsalami Abubakar (1998-1999). There have been no coup d'états in the Fourth Republic, which restored multi-party democracy in 1999. Many analysts attribute Nigeria's underdevelopment in all sectors, including healthcare, to political instability and a lack of visionary and pragmatic leadership at the national level.</p> <p>The military government of General Yakubu Gowon (1966-1975) had the best opportunity to provide UHC at the peak of the oil boom but wasted the nation's money on white elephant ventures. The subsequent military and civilian administrations of General Murtala Mohammed (1975-1976), Major General Olusegun Obasanjo (1976-1979), President Shehu Shagari (1979-1983), Major General Muhammadu Buhari (1983-1985), General Ibrahim Babangida (1985-1993), interim President Ernest Shonekan (1993), General Sani Abacha (1993-1998), and General Abdulsalami Abubakar (1998-1999), had no health insurance program and did not consider UHC a priority.</p> <p>The successive governments failed to capitalize on President Obasanjo's (1999-2007) administration's health care achievements. Hence, the objectives and functions of the NHIS have yet to be attained as the healthcare delivery continues to be limited, not equitable, and does not meet the needs of most Nigerians.</p>

6. DESCRIPTION OF CURRENT HEALTHCARE SYSTEM 2016 –2023

President Muhammadu Buhari's administration developed three different health plans – The "Revitalization of Primary Healthcare for Universal Health Coverage," "WHO Revised Third Generation Nigeria Country Cooperation Strategy," & the "National Strategic Health Development."

a. Organizational structure

The three government levels (federal, state, and local) share healthcare responsibilities nationwide. The burden of implementing PHC lies within the purview of the local governments. Secondary healthcare belongs to state governments, while the federal government is responsible for tertiary healthcare. The private sector also plays a critical role in providing medical services. In addition to providing technical assistance to local government health programs and facilities, the state Ministry of Health trains nurses, midwives, medical laboratory technicians, and sanitarians at the general hospitals in their locale. The federal government provides policy guidance, planning and technical assistance, and coordinating the national health policy's implementation. Although there is input at the state level, the federal government is primarily responsible for disease surveillance, drug regulation, vaccine management, and healthcare professionals' education.

b. Coverage

No definitive quantitative data are available on the percentage of the population covered by the government social insurance and private schemes. Sadly, 24 years after the launching of the NHIS, the goals remain a pipe dream, as less than 10% of Nigerians have access to health insurance needed to access healthcare services. The low enrollment is due to the population's peculiar demographics. Nigeria has a population of 219,463,862, of which 52% are urban dwellers, while 48% are rural dwellers. The population is mainly young; 42.54% of Nigerians are between 0–14, and over 60% are less than 25 years old. Nigeria is a multi-ethnic nation with over 300 ethnic groups, and cultural beliefs and practices vary. However, while specific cultural practices may vary, geography and socioeconomic status influence health behaviors. Rural dwellers tend to have less appropriate health-seeking behaviors than those in urban areas and higher socioeconomic status is associated with better health-seeking behaviors. Private vendors provide about 70% of healthcare, the government offers only 30%, and over 70% of the drugs dispensed

are substandard (Welcome 2011). About 40% of Nigerians live in poverty and social conditions that create ill health. Despite the various reforms to increase healthcare provision, access is only 43.3%

A revised NHIS (NHIA) law was signed in 2022 by President Muhammadu Buhari's administration to provide UHC coverage (Abubakar et al. 2022). The NHIA is vested with the regulatory responsibility for all participants under the health insurance arrangement, including state health insurance agencies, healthcare providers, health maintenance organizations, third-party administrators (intermediaries to facilitate claims between the insurer and the insured), and even banks and insurance companies that wish to participate in the health insurance sector. The federal government pays the premium for federal civil servants under the NHIA law. Others entering the program through group, individual, and family social health insurance program pay N45,000 or N15,000 per person as a group (The Nation 2022).

c. Provision

As of 2011, Nigeria had 17,038 hospitals unevenly distributed among the 36 states. By 2021, there were 33,303 General Hospitals, 20,278 PHC centers, 59 University Teaching Hospitals, and Federal Medical Centers. 27% of the health facilities are privately owned, and 73% are public facilities. However, the country's number of health professionals and facilities is speculative because many private hospitals are not registered with the government. Often government records are inaccurate due to employee misconduct (Balogun 2022). Health care is provided through a network of facilities at different levels of care - primary, secondary, and tertiary institutions. 85.1% of health facilities are primary, 14.5% are secondary, and 0.4% are tertiary (Physiopedia 2022). The healthcare delivery system continues to face several challenges: underfunding, dilapidated health facilities, inadequate modern equipment, regular commodity stock-outs, poor remuneration, poor working conditions, heavy workload, insecurity, and workforce shortage from migration abroad in search of better work and professional opportunities. At least 75,000 Nigerian nurses and midwives have relocated abroad in the last five years, and 11,273 physicians have relocated to the United Kingdom (Adejoro 2023). On July 8, 2021, the *density of physicians* in Nigeria was 4 per 10,000 and 16.1 *nurses and midwives* per 10,000. The WHO recommends one physician to 600 patients with the critical threshold of 23 physicians, nurses, and midwives per 10,000 patients (Ogune 2021).

d. Financing

A constant feature of Nigeria's budget is the inadequate healthcare funding by federal, state, and local governments since independence. Healthcare expenditure recorded the highest value of 9.2% in 2007 and the lowest at 3.7% in 2002. However, in the last decade, spending rose from a meager 3.9% in 2010 to 6% by 2012. Unfortunately, the health budget decreased to 4.0% in 2013, a paltry 2.6% in 2014, 3.7% in 2016, and 4.2% in 2017. It declined further to 3.9% in 2018 and 3.8% in 2021 during the COVID-19 pandemic - the total expenditure on health amounts to only 4.6% of the GDP. About 60% of all health spending is financed directly by families without insurance. High out-of-pocket payments (OOPs) account for over 76% of health expenditures. OOP spending constitutes nearly 90% of private health spending, placing a significant burden on households (The World Bank 2021).

Healthcare is financed through different sources, including but not limited to tax revenue, OOPs, donor funding, and social and community health insurance programs. The revenue for financing healthcare is collected from pooled (budget allocation, direct and indirect taxation, and donor funding) and unpooled sources - both contribute over 70% of total health expenditure. The unpooled sources include OOP payments (informal or formal direct payments to healthcare practitioners following service provision) and payments for goods (medical products such as bed nets or condoms). Despite the health-financing options, spending is still disproportionately distributed, with regional inequality in expenditure. The persistent and significant weakness of the health system's funding is due to the large informal sector economy, low public spending, high levels of OOP expenditures (one of the highest in the world), and impoverishment due to healthcare costs and increased incidence of catastrophic health spending (Balogun 2022). The uneven distribution of resources has affected healthcare financing, particularly OOP expenditure. Compared with countries of similar income levels in Africa, Nigeria's health outcomes are poor, with national statistics masking drastic differences between rich and poor, urban and rural populations, and different regions.

e. Regulation of dominant system

The National Health Bill provides a legal framework for regulating, developing, and managing the healthcare system and sets standards for licensing and regulating healthcare professionals (Enabulele & Enabulele 2016). Nigeria currently has 14 recognized health professional regulatory boards: Medical and Dental Council of Nigeria, Nursing and Midwifery Council of Nigeria, Medical Rehabilitation Therapist Board, Radiographers Registration Board of Nigeria, Optometry and Dispensing, Optician Registration Board of Nigeria, Dental Therapist Registration Board of Nigeria, Institute of Public Analyst of Nigeria, Health Record Registration Board of Nigeria, Community Health Practitioner Registration Board of Nigeria, Pharmacists Council of Nigeria, Institute of Chartered Chemist of Nigeria, Medical Laboratory Scientist of Nigeria, National Institute of Pharmaceutical Research and Development, and National Primary Healthcare Development Agency.

The board's primary purpose is to protect the public by assuring that all practitioners are competent and public safety is not at risk by quacks. The regulatory boards ensure practitioners' credentialing processes are maintained according to stated standards, periodically update the code of conduct, and make it desirable for its practice. The boards impose penalties for the code's infringement of conduct by admonishment, suspension for a stated period, or deleting the practitioner's name from the register. The regulatory boards also periodically review the academic standards to conform with global best practices and oversee examinations in the discipline(s) by awarding certificates to candidates who complete clinical specialist or fellowship training. It also accredits academic programs and clinical sites where students have preceptorship and internship training. The boards eliminate quackery by screening new members' credentials and maintaining an up-to-date register of all licensed members. Regulatory boards also ensure members are lifelong learners by mandating continuing professional development education to enhance practitioners' knowledge and clinical skills. The services rendered by private health centers are also regulated by professional regulatory bodies to ensure they maintain operational registration and licensing from the federal and state governments.

f. Co-existing Systems

The health system's operation is a triad delivery system consisting of conventional Western orthodox medicine, complementary and alternative medicine, and traditional medicine. The three methods are recognized and regulated by the federal government and operate in tandem. The evolution of traditional medicine in Nigeria led to various categories of healing methods. Traditional medical practitioners also specialize and practice referral healthcare like their conventional counterparts. The primary specialization includes herbalists, traditional birth attendants, surgeons, bone setters, rehabilitation, medicinal ingredient dealers, psychiatrists, and therapeutic occultism (Balogun 2022). Today, 80-90% of Nigerians still receive healthcare from traditional medicine practitioners and pay out of pocket for the services provided. They are the primary or sole healthcare providers in many rural communities. Their services are easily accessible, affordable, and culturally accepted. Orthodox healthcare remains inaccessible due to the prohibitive cost, and the facilities are concentrated in urban centers.

g. Role of Global Actors

Nigeria is a benefactor of the largesse of several international donors. Between 2003 and 2009, several grants were received through the Global Funds for HIV/AIDS (\$677,565,797), tuberculosis (\$147,354,856), and malaria (\$679,125,620). In 2011, the HIV/AIDS relief emergency program committed \$488.6 million to support prevention and treatment programs. The Carter Foundation funded the fight against eliminating *Dracunculiasis* (guinea worm infection), trachoma control, river blindness, schistosomiasis, and lymphatic filariasis in Nigeria. Nigeria's annual budgeting for health care delivery relies heavily on international assistance. In 2011, Nigeria received \$528 million in *health aid* (measured in 2004 constant dollars) for financing PHC to combat communicable diseases and attain the health-related Millennium Development Goals. In 2012, Nigeria was among the top 13 recipients of aid by 139 countries that received development assistance (Shaw et al. 2015).

In 2021, international donors such as USAID, EU, OSIWA, and Ford Foundation raised about \$6 billion to support activities combating the COVID-19 pandemic in Nigeria. Additional support came through materials and campaigns to strengthen the COVID-19 response. For instance, Ford Foundation donated vehicles to the Lagos

state government to provide a contact tracing process. In 2020, the foundation raised a \$1 billion social bond in the United States to help strengthen nonprofit organizations hit hard by the COVID-19 pandemic (Ojekunle 2020).

h. List of Additional Relevant Legal Acts

Aside from the 1945-1955 First Colonial Healthcare Development Plan launched by Queen Elizabeth's administration, other significant national health policies exist:

1956-1962.....The Second Colonial Healthcare Development Plan by Queen Elizabeth

1962-1968.....The First National Healthcare Development Plan by President (Dr.) Nnamdi Azikiwe and Prime Minister (Alhaji) Tafawa Balewa (1963-1966)

1970-1975.....Second National Healthcare Development Plan by General Yakubu Gowon

1975-1980.....The Third National Healthcare Plan by General Olusegun Obasanjo

1981-1985.....The Fourth National Healthcare Plan by President Shehu Shagari

2004-2008.....The NHIS Development Strategic Plan by President Olusegun Obasanjo

2010-2015.....Primary Healthcare Under One Roof Plan by President Goodluck Jonathan

2015-2023.....National Health Insurance Authority Bill and Mental Health Bill

On January 23, 2018, President Muhammadu Buhari signed the *Discrimination Against Persons with Disabilities (Prohibition) Act* or *Nigerian Disability Act* (Aka & Balogun 2022: pp. 96-100). Unfortunately, like most of Buhari's white elephant projects, the law is not expected to improve the quality of life of persons with disabilities. Five years after enacting the *Disability Act*, the implementation has been slow. Only nine of the 36 states have passed the law (Ezigbo 2023). Critics claimed that Buhari "has no plan for any implementation for the less privileged, not to talk of people with disabilities" (Martinez & Vemuru 2020). Before assuming office in 2015, Buhari made many pledges that could significantly impact health care. Sadly, his performance falls far short of the promises. His administration was mired by underfunding, poor implementation, and public health crisis, leading to calls by Nigerians to declare a state of emergency in the health sector. During his tenure, Buhari left the country for more than 200 days seeking medical treatment abroad, while Nigerians struggled to access care during his eight-year tenure (Adejoro 2023).

REFERENCES

- Abubakar, I., DalGLISH, S.L., Angell, B., et al. (2022), The Lancet Nigeria Commission: investing in health and the future of the nation. *The Lancet Commissions*, 399, 10330, P1155-1200. [https://www.thelancet.com/article/S0140-6736\(21\)02488-0/fulltext](https://www.thelancet.com/article/S0140-6736(21)02488-0/fulltext)
- Adejoro, L. (2023). Eight years after, Buhari bequeaths dying health sector to Tinubu. <https://punchng.com/eight-years-after-buhari-bequeaths-dying-health-sector-to-tinubu/>
- Aigiremolen, A.O., Alenoghena, I., Eboreime, E., Chukwuyem, A. (2014) Primary health care in Nigeria: From conceptualization to implementation. *Journal of Medical and Applied Biosciences*; 6. 2277-0054. https://www.researchgate.net/publication/269703981_Primary_Health_Care_in_Nigeria_From_Conceptualization_to_Implementation
- Aka, P.C., Balogun, J.A. (2022) Improving disability laws under Nigeria's fourth republic: Ten measured steps into the future (Lexington Books). <https://rowman.com/ISBN/9781666914184/Improving-Disability-Laws-under-Nigeria's-Fourth-Republic-Ten-Measured-Steps-into-the-Future>
- Anonymous. (n.d.). Health: Nigeria. In: Helen Chapin Metz, ed. *Nigeria: A Country Study*. Washington: GPO for the Library of Congress, 1991. Available at: Nigeria - HEALTH (countrystudies.us). Accessed January 13, 2024.
- Anaemene, B.U. (2016) Health sector reforms and sustainable development in Nigeria: A historical perspective. *Journal of Sustainable Development in Africa*, 18, 4. <https://jsd-africa.com/JsdA/Vol18No4-Fall21016/PDF/Health%20Sector%20Reform%20and%20Sustainable%20Development%20in%20Africa.Benjamin%20Uchenna%20Anaemene.pdf>
- Balogun, J.A. (2022) The Nigerian healthcare system: Pathway to universal and high-quality healthcare. Springer Nature. <https://www.springer.com/gp/book/9783030888626>

- Callaway, H. (1987) *Gender, culture, and empire: European women in colonial Nigeria*. MacMillan Press, Oxford. https://www.google.com/books/edition/Gender_Culture_and_Empire/yjSwCwAAQBAJ?hl=en&gbpv=1&dq=how+many+physicians+and+nurses+in+Nigeria+in+1946%3F&pg=PA101&printsec=frontcover
- Coutsoukis, P. (2005) Nigeria history of modern medical services. https://photius.com/countries/nigeria/society/nigeria_society_history_of_modern_me-10005.html
- Coghe, S. (2020). *Disease control and public health in colonial Africa*. Oxford Research Encyclopedias <https://doi.org/10.1093/acrefore/9780190277734.013.620>
- Eshemokha, U. (2022). Primary health care, definition, goal, principles, and strategies. *NIMED Health*. Primary Health Care Definition, Goal, Principles and Strategies - Nigerian Health Blog (nimedhealth.com.ng)
- Enabulele, O., & Enabulele, J. E. (2016) Nigeria's National Health Act: An assessment of health professionals' knowledge and perception. *Nigerian Medical Journal*, 57(5), 260–265 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5036296/>
- Ezigbo, O. (2023) Only nine states have enacted disability protection law, Says CAN. *ThisDay Newspaper* <https://www.thisdaylive.com/index.php/2022/12/08/only-nine-states-have-enacted-disability-protection-law-says-can/>
- Lambo, E. (1982). Basic health services programme The Nigerian experience. *Sage Journals*; 1, 2:119-128
- Basic health services programme The Nigerian experience (sagepub.com)
- Martinez, R.M., Vemuru, V. (2020) Social inclusion of persons with disabilities in Nigeria: Challenges and opportunities. *World Bank, Blog*. <https://blogs.worldbank.org/nasikiliza/social-inclusion-persons-disabilities-nigeria-challenges-and-opportunities>
- Medical and Dental Council of Nigeria. (2022) History of Medical and Dental Council of Nigeria. <https://www.mdcn.gov.ng/page/about-us/brief-history>
- Mejia, A., Pizurki, H., Royston, E. (1979) Physician, and nurse migration: Analysis and policy https://www.google.com/books/edition/Physician_and_Nurse_Migration/u1ZrAAAAMAAJ?hl=en&gbpv=1&bsq=how+many+physicians+and+nurse+in+Nigeria+in+1960%3F&dq=how+many+physicians+and+nurses+in+Nigeria+in+1960%3F&printsec=frontcover
- Ogune, M. (2021) Nigeria to suffer shortage of 50,120 doctors, 137,859 nurses by 2030. *The Guardian Newspaper*. <https://guardian.ng/news/nigeria-to-suffer-shortage-of-50120-doctors-137859-nurses-by-2030/>
- Ojekunle, A. (2020) Donor community has raised \$6 billion for COVID-19-related responses in Nigeria. <https://www.dataphyte.com/latest-reports/development/donor-community-has-raised-6-billion-for-covid-19-related-responses-in-nigeria/>
- Physiopedia, (2022) Nigeria patient access to physiotherapy services/entry point. https://www.physio-pedia.com/Nigeria#cite_note-13
- The Nation. (2022) Controversy over health insurance contributions. <https://thenationonlineng.net/controversy-over-health-insurance-contributions/>
- U.S. Library of Congress. (n.d.) <http://countrystudies.us/nigeria/50.htm>
- Shaw, RP., Wang, H., Kress, D., Hovig, D. (2015). Donor and domestic financing of primary health care in low-income countries. *Health Systems & Reform*; 1:1, 72–88, DOI: 10.1080/23288604.2014.996413
- Uzochukwu, BS., Ughasoro, MD., Etiaba, E., Okwuosa, C., Envuladu, E., Onwujekwe, OE. (2015). Health care financing in Nigeria: Implications for achieving universal health coverage. *Nigerian Journal of Clinical Practice*; 18(4), 437–444 <https://doi.org/10.4103/1119-3077.154196>
- Welcome, MO. (2011). The Nigerian health care system: Need for integrating adequate medical intelligence and surveillance systems. *Journal of Pharmacy & Bioallied Sciences*; 3(4), 470–478. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3249694/>