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Research Paper

Healthcare Delivery System and Preventive Health: A Review of Sojourn of Lagos State

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ABSTRACT: *Lagos State is distressed with hosts of environmental and health difficulties; among which are: irregular urban development and indiscriminate waste disposal, air and water contamination, poor drainage services, insufficient infrastructural facilities and services. These environmental issues are negatively affecting the health of the inhabitants. This review overview the historical trend of healthcare delivery system in Nigeria, with particular reference to Lagos State. Literature review and key Informant Interview were employed to generate information for discussions in mainly descriptive approach. The review discussed the healthcare systems in Lagos State, mapped the healthcare facilities, identified challenges of healthcare delivery and suggest possible solutions. To improve the liveability of Lagos city and access to medical services, there is urgent need to resolve the challenges associated with healthcare services.*
KEYWORDS: *Healthcare Delivery, Preventive Health, Lagos State*

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I. INTRODUCTION

In recent times, renewed interest and increasing concern by both local and global bodies over the health of key cities of the emerging nations is increasing. 'Health' as a term is not easy to define. By WHO's (1961) general definition, health is a state of complete physical, mental and social well-being and not a simply absence of disease or infirmity. This description of health suggests that health is certain only when specific fundamental needs are met: these include housing, water and a contamination free environment (Egunjobi, 1993). Environmental health is the subdivision of public health that is bothered with the various aspects of the natural and built environment that may touch human health. World Health Organization (1961), defines environmental health as those aspects of the human body, human health and illnesses that are determined by influences in the surroundings. Housing standard is in most cases a pointer of health conditions. This implies that poor housing conditions can have a lot of effects on health. Poor neighborhood conditions can be defined as having abandoned buildings, vacant lots, no access to quality schools, and high levels of poverty.

Agreeing further, Agbola et al (1993) posit that housing and health challenges in the emerging countries are varied and multifaceted and are principally severe in the urban centers due to gravity of urbanization. In addition, Patrick et al (2003) states that there is an increasing body of scientific literature signifying that children in America and around the world suffer from health challenges from poor housing conditions and security hazards. Health according to WHO (1961), including those fundamentals of human health that are affected by physical, chemical, biological, social and emotional factors in the environment. Therefore, the World Health Organization emphasizes that housing remains the most important environmental factor associated with diseases and life expectancy for human beings. Today, in many emerging nations such as Nigeria, the urban setting is categorized by risky housing conditions, deficiency, overpopulation, corruption, disgraceful hygiene, insufficient water supply and low health status (Verhasselt, 1985). Supporting this fact, it is observable that in slum areas where there are substandard houses, pitiable air quality, disproportionate heat and unavailability of infrastructures in place, the subsequent special effects is the health hazard and the costs to the people has become noticeable over the years (Okafor, 2013).

Additionally, in Nigeria, quick urbanisation has overtaken the capability of governments to offer satisfactory housing and basic facilities for the urban poor (Payne, 1977; Mabogunje et al and Mistra, 1978; Lewin, 1981) consequential in serious urban poverty, growth of slums and squatter settlements which is

categorised by undesirability resultant from the joint effects of factors like natural ageing of buildings, lack of preservation and abandonment, incorrect use of structures, wrong development of land, poor hygiene in the removal of dirt and solid wastes, and cumulative worsening of the normal landscape (Omole, 2006). The extraordinary rate of lack of many urban households makes the obtainable housing stock out of their economic reach. Many of the households often find alternative to construction by making shift houses with all kinds of garbage resources in unlawfully occupied land. Rendering from Olotuah's findings (2010), the occurrence of quick urbanisation happening in Nigeria, accounts as a chief influence answerable for population outburst in urban centres and the subsequent housing scarcities and ruined urban environment. The scarcity of inexpensive and decent housing for the urban underprivileged is therefore a foremost housing difficulty and public health issues in Nigeria.

1.1 Health and Healthcare System

The World Health Organization (WHO) defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." This definition, no doubt, is bedevilled by concerted criticisms based on the use of the phrase "complete physical, mental, and social well-being." Some critics contend that no person could be in the state of "complete" health in the strict sense of the word. They argue that health is a matter of one's ability to adjust to one's condition. What it implies is that when an individual is not able to adjust to one's condition, that individual suffers from ill-health. Consequently, this adjustment is a matter of urgency and should be regular. This is because "achieving and maintaining health is an ongoing process, shaped by both the evolution of health care knowledge and practices, as well as personal strategies and organized interventions for staying healthy."

Health may also be defined as "a state whereby one is not perturbed by either physical, or spiritual (mental) illness, or by injury of any kind." The underlying supposition of this definition is that man is a composite being with two complementing aspects-body and soul-either or both of which may be affected by ill-health. That is why as we talk about physical health, we should not lose sight of the fact that mental health a necessity without which man's life will be atrophied is. We can see why the WHO defines health as "a state of complete physical, mental and social well-being."

Health care is the provision of suitable environment which is aimed at the promotion and development of man's full potentials. It is simply "the identification of the health needs and problems of the people,and promoting them with the requisite medical care." Health care facilities are those basic equipment, stock of drugs, vaccines, portable water, constant supply of energy (power), medical record tools, ambulances for mobility of patients, solar freezers, availability of qualified health officers and medical personnel, etc., which make it possible for the improvement of the patients' healthy living. Health care facilities also include "hospitals, clinics, dental offices, out-patient surgery centres, birthing centres and nursing homes." In considering these facilities, it should be noted that the environment is an important factor influencing the health states of individuals. Here, we may mention three categories of environment, viz, natural, built and social environment. It is in the context of this environment that we consider the determinants of health. These determinants of health, like clean water and air, adequate housing and safe communities, good roads etc., contribute to good health, and as such, they are rightly to be including among health care facilities. It has, therefore, to do with a person's well-being so long as he is alive, for a dead man cannot be said to be healthy. In order that the Nigeria population achieves its well-being in all its ramifications, certain health care facilities must be put in place.

II. HISTORY OF HEALTHCARE SYSTEM IN NIGERIA

At the time of the country's independence in 1960, the health care system was largely engaged in curative care and modern healthcare was found to be almost exclusively in urban areas. The 1970's and 1980's brought about large changes in health care in Nigeria with a dramatic expansion of the public health system. The setting up of Health Management Boards (HMBs) for both Federal Government and State Government controlled health institutions in the 1970's arose partly from the need to rescue healthcare delivery from the claws of civil service bureaucracy (Ogunbekun, 1991). The National health Policy developed in 1986, promulgated in 1988 and later reviewed in 1996, set up a health system, which defines much of what remained today. It recommended four main strategies for effective primary health care implementation. It was not until August 1987 that the Federal Government launched its Primary Healthcare Plan, which was announced as the cornerstone of health policy. In the early 1990's, a community-level component was established as part of the health strategy, including training of primary healthcare workers. Subsequently, in 2004, the Revised National Health Policy was developed by the Federal Ministry of Health (Ogunlela, 2012). Primary Health Care (PHC), as defined in Alma Ata declaration of 1978, refers to essential health care based on practical and socially acceptable methods and technology made universally acceptable to individuals and families in the community through their full participation, and at a cost the community can afford.

There have been 3 major attempts at PHC implementation in Nigeria. The first attempt (1975-1983) was by the Federal Ministry of Health through the Basic Health Services Implementation Agency. Schools of Health Technology were built for the training of middle level health manpower to form the PHC Team with doctors. In the absence of doctors (who were inequitably distributed) Community Health Officers (CHOs) or Community Health Extension Workers (CHEWs) were to head the Team. A committee of the FMOH developed a National Health Policy that identified PHC as the cornerstone to the National Health System. Even though the strategies were promotion of community mobilisation, involvement of other sectors, functional integration and strengthening of managerial processes, there were problems with implementation. The main problems of this attempt were identified as poor community participation (100% of resources provided by government), faulty citing of health facilities, stolen equipment, lack of political commitment as well as inadequate orientation and distribution of the health workforce. Consequently health indices and primary health care coverage and quality remained poor.

The second attempt, the District Health System (1986-1992) started with the development of "Project Formulation Documents" or Action Plans that were funded by the Federal government in 52 selected pilot LGAs. Village and District Health Committees were formed but the problems identified for this attempt were similar to the first. Communities did not have ownership of their PHC facilities and did not participate actively in the development of the Action Plans for their communities. Poor funding, lack of appropriate infrastructure, equipment, drugs and materials persisted. This system was strengthened by the Bamako Initiative activities in 1988 when PHC facilities had seed drugs to operate Drug Revolving Funds jointly administered with their Community Development Committees.

However, guidelines for the formation of Community/Village Development Committees were not followed, there was paucity of basic health statistics and inequitable distribution of manpower and poor logistics persisted. Even though the Law establishing the National Primary Health Care Development Agency (NPHCDA) was enacted and the agency with 6 zonal and 36 state the FCT offices were set up in 1992, there was no similar law backing community structures for health. Consequently, Community Committees became dysfunctional, PHC facilities were bypassed and health indices, primary health care coverage and quality remained poor. In response to recommendations of international partners (3rdattempt) the District Health System was replaced by the Ward Health System (WHS) in the Year 2000. The objectives of this attempt were to improve knowledge, attitude and practice on health issues, encourage self-reliance, reduce maternal and infant mortality by 25% in target wards within 2 years, improve immunisation coverage by 20% in 2 years, improve nutritional status by 20% especially among under-fives, make essential drugs available, affordable and accessible, encourage collaboration between stakeholders as well as promote poverty alleviation activities.

Two hundred PHC facilities were built in 200 model wards, a ward being the smallest geopolitical unit from which a councillor is elected. In the spirit of community ownership, the facilities were handed over to the Community Development Committees (CDCs) whose capacities were enhanced for effective management of the facilities and community-based intervention programmes. Over a period of 12 years (2000 to 2012), several programmes including the Minimum Health Care Package, Integrated Management of Childhood Illnesses (IMCI), Expanded Programme of Immunisation (EPI), National Immunisation Days (NIPDs),

Integrated Maternal, New-born and Child Health (IMNCH) Services etc have been introduced to strengthen the WHS which is still not fully operational in any part of the country. Attempts have also been made at Community based financing, National Health Management Information System based on measurable indicators, equitable use of resources, and the development and use of relevant manpower has continued. However, "Lack of effective stewardship role of government, fragmented health service delivery, inadequate and inefficient financing, weak health infrastructure, mal-distribution of health workforce and poor coordination" key players continue to be identified as the major impediments to the establishment of an efficient, effective health (PHC) system in the country. Up to date, health is on the Concurrent List and there is no specific fund for PHC. The proposed National Health Bill (2008) that is yet to be signed is expected to correct inadequate/inefficient management of available resources, a major factor responsible for the slow pace at which the country is moving towards the achievement of the MDGs.

2.1 Nigeria's Health Sector in Perspective

The health sector in Nigeria is deeply fragmented, with only a small fraction of the healthcare coming from a unified and organized centre. The health ministry provides policies and regulations meant guide the implementation of healthcare, but this is mostly bureaucratic posturing that gets lost as you drill down to the core of healthcare practices in the country. Private hospitals provide at least 70 per cent of the healthcare in the country, with the rest coming from federal, state, local government, and even, community-funded health institutions.

The organization of health care services in Nigeria is complex and includes numerous providers in both the private (private for profit providers, not-for-profit and community-based organizations, religious and

traditional care providers), and public sectors. In the public sectors, Nigeria operates a decentralized health system in the three tiers of government namely: Federal Ministry of Health (FMOH), State Ministry of Health (SMOH), and Local Government Health\Department (LGHD). The FMOH is responsible for the co-ordination and implementation of national health policy. It oversees health activities in the 36 States of the Federation, Abuja (Federal Capital Territory) and 774 Local Government Areas (LGAs). FMOH also provides tertiary care through the teaching hospitals and federal medical centres.

The SMOHs provide secondary health care through the state hospitals and comprehensive health centres, while the LGAs provide PHC services through the primary health care centres. However all the three tiers of government and agencies also participate in the management of the PHC; resulting sometimes in duplication and overlap of responsibilities, conflict and waste. Several small communities have evolved primary health care services, with active community participation. The capacities of facilities installed years back were overstretched and infrastructure in various states of disrepair.

The common man seems to be reverting to the traditional care providers, because of problems of access and affordability. Moreover the demography of Nigeria shows that about 55% of the total population lives in the rural areas while about 45% live in urban areas. Primary health care is currently catering for less than 20% of the potential patients. The goal of National Health Policy (1987) later revised in 2004 was to actualize a comprehensive health care system based on primary health care that is preventive, protective, restorative and rehabilitative to all Nigerian citizens, as well as ensuring health promotion within the available resources, so that individuals and communities are assured to productivity, social well-being and quality of life.

Lack of basic amenities in the rural areas where majority of Nigerians are living has driven some to the urban areas. Probably deluded by this migration, the government ended up situating many of her infrastructures in the urban areas. this resulted in a spatial inequality with regard to situating health care facilities, thus abandoning a vast majority whomust still live in these rural places with little or no medical presence. Consider that the Federal ministry of health usually spends about 70% of its budget in urban areas where only a shabby 30% of the population resides, what an existential irony.

Successive governments have tinkered with some health policies in the past. For instance, Primary Health care was the cornerstone of the Ibrahim Babangida regime's health policy. Many Nigerians would want President Jonathan to pay more attention to primary health care which has almost gone into extinction. The present sad situation of the health sector in Nigeria, taking references from World Health Organization, United Nations Development Programme, the National Bureau of Statistics, National Population Commission and the Demographic Health Survey, can be further gleaned from these highlights:

- Nigeria has an estimated population of about 145 million people
- Healthy life expectancy at birth male / female: 41/42
- Probability of dying under fire (100 have birth): 191
- Probability of dying 15 and 60 years male/female (per 1000 population) 447/399
- The under-five mortality rate is presently put at 157 children per thousand, meaning that 1 out of 6 children born die before their fifth birthday- half of this number actually involve those less than one year old.
- Another points of interest have are the health indices that concern the adult female population, which is equally noted to be among the very worst in the world.
- On the average, some 800 per 10,000 women die in Nigeria every year due to pregnancy related causes. In some regions, the figure is actually more than twice the quoted average.
- Three quarters of all material deaths occur during delivery and the immediate post-partum period (Akinrogunde, 2011:1, 4).

Although a large portion of Nigeria's population uses the private sector and consumers pay a high out-of-pocket share for health expenditures, much of those funds go toward low-quality products and services. Too little regulation is being enforced to ensure that minimum quality standards are met. Although there is no shortage of well-trained providers (doctors, nurses, midwives, and pharmacists), they are not being encouraged to open their own private practices. The main barriers are poor infrastructure, no access to credit, and unfair competition with unregulated, less-skilled providers. Furthermore, nurse and midwife practices are constrained by the requirement for physician supervision.

Nowhere is the neglect during the Abacha regime more apparent than in the health sector. The mortality of children under 5 years old is estimated at 201 per 1,000 live births, maternal mortality is about 800 per 100,000 live births, total fertility is 5.7 children per woman, modern contraceptive methods have an 8 percent prevalence rate, adult HIV prevalence is estimated at 5 percent, and immunization rates are low with only 13 percent of 1 year olds receiving all of their recommended vaccinations (World Bank 2005).

These outcomes suggest that the health care system is struggling. When one looks at service and consumption indicators, it is clear that neither the public- nor private-sector health systems are functioning effectively. According to World Health Organization (WHO) National Health Account analysis from 2003, consumers pay a high share of health expenditures—67 percent of health expenditures come from out of their

pockets versus 26 percent from the government and 7 percent from the private sector (that is, private insurance and employers). Too often consumers forego treatment or pay for medical care from unskilled providers. No treatment is sought for 31 percent of children with a fever or who have symptoms of an upper respiratory infection (Demographic Health Survey 2003). Twenty percent of children with diarrhea receive no treatment (Demographic Health Survey 2003), and 66 percent of deliveries occur in the home with a skilled provider only attending 35 percent of them. While this behavior is especially true for the poor, unassisted or using unskilled providers for deliveries occur in all income groups. As shown in Figure 1, even in the richer quintile of the population close to 50 percent of deliveries are occurring with unskilled providers.

2.2 Nigeria's Health Goals

High-performing PHC systems will be important for reaching the health-related SDG targets, such as "end preventable deaths of newborns and under-five children." The global goal of Universal Health Coverage (affordable access to quality health care for every person, everywhere) rests on a pillar of strong PHC, as do the aims of the Every Woman Every Child movement to help mothers, children, and adolescents survive and thrive. Progress—or lack thereof—in Nigeria, by far the most populous African country, will play a major role in determining whether these global goals are met. Achievement of the ambitious goals Nigeria has set for itself, too, is dependent on improvements in PHC. For example:

The Nigerian National Strategic Plan for Tuberculosis (TB) Control 2015-2020 set a goal of providing Nigerians with universal access to high-quality, patient-centred prevention, diagnosis and treatment services for TB, TB/HIV and drug-resistant TB by 2020. To support Every Woman Every Child, Nigeria committed in 2012 to achieving the goal of a contraceptive prevalence rate of 36% by 2018 to enhance maternal and child survival (in 2013, its rate was 11%10); and also achieving zero malaria-related deaths by 2020, a stated goal of Nigeria's National Malaria Strategic Plan 2014-2020, hinges on proper diagnosis and treatment at the PHC level (Revised National Health Policy. 2004)

III. METHODOLOGY

3.1 The Lagos Metropolis

Lagos State has 20 Local Government Areas (LGA), out of which 16 Agege, Ajeromi-Ifelodun, Alimosho, Amuwo-Odofin, Apapa, Eti-Osa, Ifako-Ijaiye, Ikeja, Kosofe, Lagos Island, Lagos Mainland, Mushin, Ojo, Oshodi-Isolo, Shomolu, and Surulere) make up the metropolis. Lagos metropolis lies within latitudes $6^{o}23'N$ and $6^{o}41'N$ and longitudes $2^{o}42'E$ and $3^{o}42'E$ in Lagos state. The metropolis is bounded in the north and north-east by Ogun State and Ikorodu LGA respectively; east by Epe and Ibeju-Lekki LGAs, in the west by Badagry LGA and the south by the Atlantic Ocean/Gulf of Guinea.

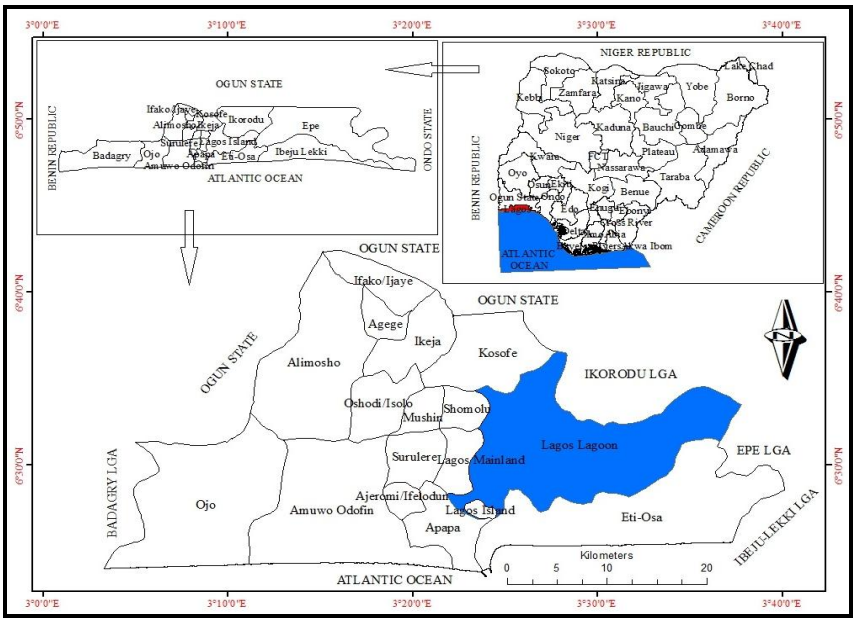

Figure 1.1: The 16 metropolitan LGAs of Lagos State in National and State context.
Source: Lagos State Ministry of Physical planning and Urban Development, 2017

3.2 Research Approach, Data types and sources

This study adopted literature review and Key Informant Interview (KII) approaches. We use secondary data to corroborate discussions of findings. The secondary data were sourced during KII at Lagos State Ministry of Health and from published and unpublished books, dissertations, journals, internet websites and seminar papers of selected authors. Relevant maps and other information were collected from Lagos State Ministry of Physical Planning and Urban Development.

IV. OVERVIEW OF HEALTHCARE SYSTEM IN LAGOS STATE

The most significant ingredient of life is health. No wonder the oft–spoken slogan: "Health is wealth", has remained evergreen in our memory. This is why inasmuch as life is the greatest gift of God to man, the provision of health care facilities is needed in superfluity in order that life may be sustained on earth. Unfortunately, in Nigeria today, the provision of health care facilities seems to be at low ebb as many Nigerian are vulnerably exposed to the danger of death. The state of healthcare system in Nigeria over the years had been and still remains less than desirable. A worrisome statistic shows that although Nigeria accounts for only 2 percent of the world's total population, she accounts for some 10 percent of the world's infant and maternal mortality (Ogunlela, 2011). Consequently, the Federal Government of Nigeria has made attempts to rehabilitate the health sector through a series of reforms. Deliberate efforts have been made to initiate and sustain health sector reforms over the past years.

The reform of the sector is predicated upon the fact that the sector is characterized by poor quality of public sector health services, resulting in poor health outcomes when measured against basic health indicators (ADF, 2002). The current state of the country's healthcare system can be said to be quite worrisome, judging by the health indicators and statistics that are abysmal as noted earlier. In fact, Nigeria's health indicators have stagnated or even deteriorated in the past decades (Gustafsson-Wright et. al., 2008). A distinct feature of the country's healthcare service delivery and management is its decentralization at the three-tier levels involving the primary, secondary and tertiary institutions, managed by the local, state and national governments, respectively.

Both the public and private sectors are participants in healthcare delivery. Health infrastructure, being a part of a larger health system, includes the health policy, budgetary allocation implementation and monitoring (Adebanjo and Oladeji, 2006). The discussion of the healthcare infrastructure in sub-Saharan Africa and Nigeria in particular, has recognized the existence of different types and practices. Regarding Nigeria's situation, the picture offers little to cheer about. The management of any health care system if it is to be successful should be typically directed through a set of policies and plans adopted by the government, private sector business and other groups in areas such as personal health care delivery and financing, pharmaceuticals, health human resources and public health. The Federal government purportedly created the National Health Insurance Scheme in May 1999, but evidence showed that this as only fashioned to suit the government employees. The organized private sector and the informal sectors and probably the general public have no need of it.

Speaking at a presidential summit on Universal Health Coverage in Abuja, President Jonathan said we have suffered substantial capital flight to this development and that this is unjustifiable. We still have the largest number of people in Africa and the developed world, travelling out of the country to seek health services. The scale of capital flight lost to medical tourism is enormous, not justifiable, and needs to be speedily addressed for the survival and development of our local health practitioners and industry, he said at the event, at which he was represented by Vice President Namadi Sambo (Ejim, 2014).

4.1 Organisational Structure of Health Systems in Lagos

The political/executive headship of the Ministry is reposed in the Honourable Commissioner for Health and the Special Adviser to the Governor on Primary Health Care. Through them, policy matters affecting health in the State are channelled to the State Executive Council and the Governor. The Permanent Secretary is the accounting officer/head of the Ministry's civil service, through whom all the directors report to the Honourable Commissioner and the Special Adviser to the Governor on Primary Health Care.

There are nine Directorates viz:

- Health Care Planning, Research & Statistics
- Primary Health Care: Disease Control & Family Health/Nutrition
- Hospital Services: HEFAMAA & LASAMBUS
- Occupational Health & Staff Clinic
- Pharmaceutical Services
- Medical Administration & Training
- Nursing
- Accounts
- Finance and Administration
- Public Affairs Unit

List of Primary Healthcare Centres (PHC) in Lagos Nigeria and their spatial concentration (Fig. 1)

1. City Hall PHC, Lagos Island
2. Lafiaji PHC, Lagos Island
3. Lafiaji PHC, Lagos Island
4. Sura PHC, Lagos Island
5. Adeniji PHC
6. Oko Awo PHC
7. Olowogbowo PHC
8. Alade Health Post, Ikeja
9. Alausa PHC, Ikeja
10. Onilekere PHC, Ikeja
11. Ijora PHC
12. Oluwole Market Healthcare centre
13. Apakin PHC
14. Folu PHC
15. Idasho PHC
16. Ide HP
17. Idotun HP
18. Igbo Olomi HC
19. Igbogun PHC
20. Lekki PHC
21. Magbon Segun PHC
22. Okunraye PHC
23. Osokoro PHC
24. Ajah PHC
25. Badore PHC
26. Ogombo PHC
27. Okun Mapo PHC
28. Owode PHC
29. Sangotedo PHC
30. Ajiran HC
31. Alpha Beach HC
32. Igbon-Efon PHC
33. Ikota PHC
34. Maiyegun HC
35. Akerele PHC, Surulere
36. Gbaja HC, Surulere
37. Festac PHC
38. Igbo Ologun PHC
39. Mile 2 PHC
40. Sagbokoji PHC
41. Abule Nla PHC
42. Ondo West PHC
43. Otto PHC
44. Simpson PHC
45. Ajeromi General Hospital
46. Military Hospital Awolowo Road Ikoyi
47. Apapa Comp. Health Centre
48. Lagos state university teaching hospital
49. Badagry General Hospital
50. Onikan Health centre
51. Ebute-Metta Health Centre
52. St Nicholas Hospital
53. Epe General Hospital
54. 68 Nigerian Army Reference Hospital Yaba
55. Gbagada General Hospital
56. Lagos University Teaching Hospital
57. Igando-Ikotun PHC
58. 445 Nigerian Air force Hospital Ikeja

59. Ikeja Primary Health Centre
60. Harvey Road Health Centre Yaba
61. Ikorodu General Hospital
62. Holy Family
63. Isolo General Hospital
64. Agege LGA Sango
65. Lagos Island Maternity Hospital
66. Ojodu PHC
67. Mushin Primary Health Centre
68. Ifako Ijaiye General Hospital
69. Oriade Primary Health Centre
70. Ibeju Lekki General Hospital
71. Orile Agege General Hospital
72. St Kizito Hospital
73. Oshodi Primary Health Centre
74. Tolu Primary Health Centre
75. RAPAC
76. Surulere General Hospital
77. Regina Mundi Clinic
78. Otto PHC
79. Alimosho GH
80. Lagoon Hospital
81. Mushin GH
82. Nigerian Navy hospital, Ojo

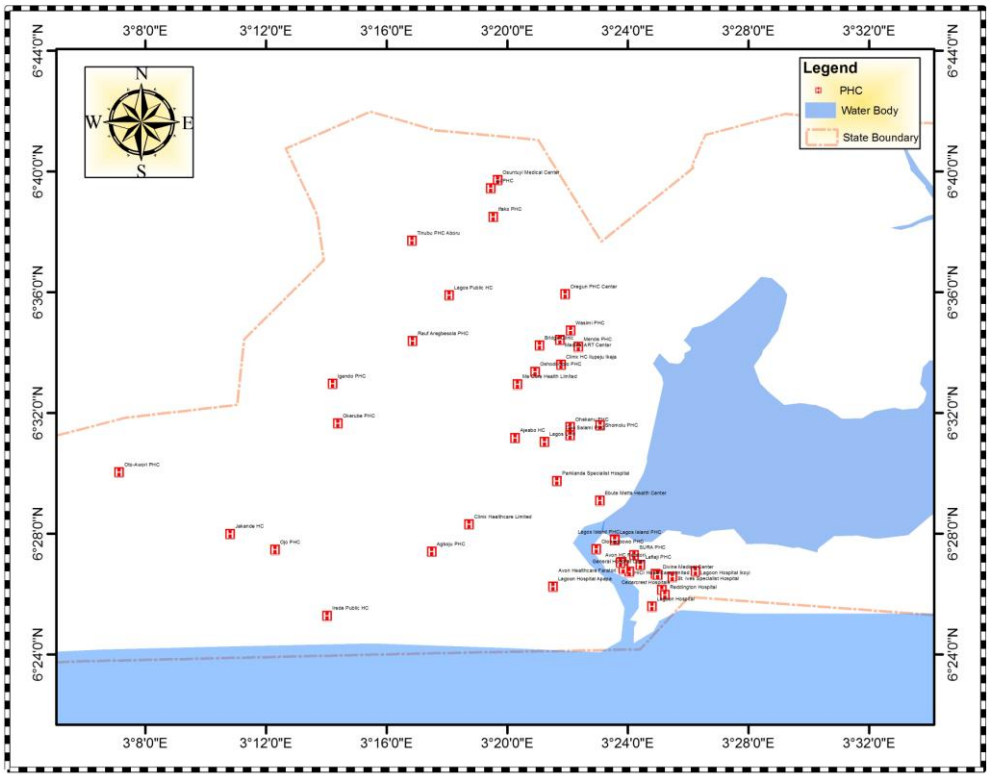

Fig. 1: Spatial distribution of health centres in metropolitan Lagos
Source: Authors' Analysis, 2018

4.2 Challenges of the Healthcare System

A health care system comprises all medical care services involved in the prevention, diagnosis, treatment, and rehabilitation (services for the restoration of function and independence); the institutions and work force that provide the services, and the government, public and private organizations and agencies that fund the service delivery. A four-level model of the health care system comprises: the individual patient, the care team, the organization, and the political and economic environment of operation. Sustainable health care is

a complex system of interacting approaches to the restoration, management and optimization of human health that has an ecological base, that is environmentally, economically, and socially viable indefinitely. It should function harmoniously both with the human body and the nonhuman environment and should not result in unfair or disproportionate impacts on any significant contributory element of the health care system.

Sustainable health care stems from well-articulated and implemented health plans based on the National Health Policy. Evaluation of all operations is paramount to ensure effectiveness and efficiency of the programs. The federal government of Nigeria provides directly or indirectly over 90% of the funds for health services, and allows states and local governments some freedom in the way they disburse the allocated funds. Availability of funds and timely disbursement are therefore closely tied to health care performance and sustainability. Achieving successful health financing system in Nigeria is challenging due to limited institutional capacity, corruption, and unstable political and economic context.

In Nigeria health care is financed by a combination of tax revenue, donor funding, user fees, and health insurance (social and community). Most economies adopt a mixture of various methods. The success of these financing methods is measured by the overall impact on equity of access and health outcomes, revenue generation and efficiency, and the effects on the provider and user behavior. Since launching National Health Insurance Scheme (NHIS) in 1999 till mid 2012 the scheme still covered only about 3% of the Nigerian population (five million people) with mixed success, while the recent launch for rural community-based social health insurance program to cover more Nigerians recorded low up-take. Health systems vary widely in performance, and countries with similar levels of education, income and health expenditure differ in their ability to attain key health goals.

Saying that the Nigerian health sector is in shambles is tantamount to saying the sky is up above. This is the unadulterated truth, fact, reality, and right-in-your's-face that Nigerians have to contend with, in addition to the other litany of inconveniences. Despite having some of the very best healthcare professionals in the world, the lack of development of the public healthcare system has eroded the little confidence the general population have in the Nigerian healthcare system. Even the leaders who ought to lead by example are most guilty of this lack of faith in the Nigerian healthcare system, which is why they excel at flying themselves and their cronies to other countries with highly developed healthcare systems at the slightest sign of any health issues.

The health sector in any economy forms the backbone of its growth and development. Factors affecting the overall Nigerian health system performance include: inadequate health facilities and structures, poor management of human resources, poor motivation and remuneration, inequitable and unsustainable health care financing, skewed economic and political relations, corruption, illiteracy, decreased government spending on health, high user fees, absence of integrated system for disease prevention, surveillance and treatment, inadequate access to health care, shortage of essential drugs and supplies and inadequate health care providers. Bilateral and multilateral assistance, and government spending on health (26.40 billion Naira or 26% of total annual budget for 2004) have not translated into enhanced health status of average Nigerians. Policy reversals and other inconsistencies over the years tend to undermine some health reforms of the past. Strategies developed for the effective implementation of national health programs in the three tiers of government (federal, state, and local government) are poorly implemented due to the politics of federalism (autonomy and resource control). High disease burden and population explosion have culminated in a vicious cycle of poverty, insecurity and uncertainty.

There is uncertainty in how health care will look in the future. There are multiple meanings and varieties of uncertainty in health care (Sommers LS, Launer J. 2013) Uncertainty is not a monolithic phenomenon, but has multiple varieties. A new integrated conceptual taxonomy characterizes uncertainty in health care according to its fundamental sources, issues and locus. Han et al.(2011) developed an organizing conceptual framework that categorizes these varieties in a coherent, useful way to add value to clinicians, researchers and health policy makers. The three sources of uncertainty in health care are as follows: Probability (indeterminacy of future outcome) - clinical uncertainty could arise from an individual clinician's limitations in medical knowledge or policy and/or in cognitive and affective functioning. It can also apply to other health professionals who could face uncertainty in the course of carrying out their professional roles.

Ambiguity (lack of evidence, contested evidence or imprecision in estimates) - uncertainty could arise from how individuals interact and form relationships. These include clinician-patient, clinician-clinician, or clinician-non-clinician staff. Other members of the health team face similar problems at work, and could be classified the same way. Complexity (multiplicity of causal factors and interpretive cues) Uncertainty could also be a problem resulting from living within complex adaptive systems where varying mixes of natural and man-made systems interact and resist control. Collaborative engagement with case-based uncertainty in small groups of clinicians, and other health professionals are faced with initial trial and error process of false starts and blind alleys during investigation of a disease condition. Over time and repeated effort, the investigating clinicians finally gain better understanding that inform their subsequent decisions on the disease management.

Langham et al. challenged the wide spread notion that multi-professional care is best supported by the rational approach of standardized protocols, strictly delineated roles and an electronic record system that assures quality through coded entries, templates, etc. When uncertainty is high in primary health care, quality emerges through adaptive relationships, collective sense-making and on-the-job learning from one another. Plsek and Greenhalgh also emphasized limitations in reductionist thinking and the clockwork universe metaphor for solving clinical and organizational problems. They posit that coping with complexity involves abandonment of linear models, acceptance of unpredictability, respect (and use) of autonomy and creativity, and flexible response to emerging patterns and opportunities - to enhance sustainability. Unlike the management thinking of machine metaphor, complexity thinking suggests that relationships between parts are more important than the parts themselves, that minimum specifications generate more creativity than detailed plans. Treating health care organizations as complex adaptive systems allows a new and more productive management style to emerge. Moral issues play a significant role in the way health and pharmaceutical businesses are executed. The expectations that physicians would always put the interests of their patients and clients above their own self-interests, the role of not for-profit organizations, professional licensing and many other forms of government regulation – could be viewed as adaptations to the existence of uncertainty in the incidence of disease condition and its management.

Constitutional Impediments

The Nigerian Health System though has its inherent complexities and is unnecessarily cumbersome. For example, the prevailing system has outlined in the 1999 Constitution place health on the concurrent list, meaning that all tiers of government have a defined role / responsibility to play at providing for the health needs of the populace. Generally, it is noted that the primary level of health care delivery is taken as the responsibility of local councils; the secondary level of care is noted as the responsibility of the state governments while the federal government is in change of the tertiary level of health care delivery.

Of course, for multifarious reasons, the outlined responsibility above have a lot of intermingles with respect to who is in charge at certain levels of health care provision. For example, a number of state governments have their own tertiary health institutions like teaching hospitals, while the federal government itself has created a number of institutional intervention agencies to come in at the primary level of health care. It is however, disappointing that such tertiary levels institution within the primary purer of the federal government such as the teaching and specialist hospitals and centers are not truly centers of excellence as a number of them are far from in reality. In Nigeria today, even the "expertise" is said to be available in respect of these so called centers of excellence are lacking in tools that make them truly worthy of being referred to as tertiary health institutions (see Adebayo, 2014).

Brain Drain

While it is conceded that the salary and welfare packages of the federal government employed health practitioners have improved considerably when matched with their counterpart in other sectors elsewhere, thanks to the doggedness of their agitations for improved emoluments, this alone will not avert the collateral trend towards brain drain outside the country of the appropriate tools to function effectively are not put in place.

Slow Implementation of NHIS

Another area of health care challenge is the role the NHIS plays . . . The National Health Insurance scheme which has been in place per enactment for more than 12 years now. To date, less than 5% of the populace had been keyed into the scheme, and that percentage comprise mostly federal government employees; very few state employees and organized private sector employees have signed on. The rest of the populace are not involved and there are no signs in view that there will be a radical change soon. Even the Presidency /MDGs office's NHIS free Medicare programme initiated two years ago for pregnant women and under five children in some local council in 12 states is already faltering due to paucity of found. For the health insurance scheme, this balance sheet screams failure and not a crawling success as the operators of the scheme and the profiteers from it went the populace to believe.

Corruption

While the agitation for more funds is very sign relevant, many also posited that even when conceded that very little get appropriated to health sector than understand by desired, the budgetary allocation for this sector hardly get to the target layers envisaged during budget implementation. Most of these funds get embezzled by corrupt officials and their collaborating suppliers and contractors (see NdenleGrang& Igbo). Prior to the global economic crisis, allocation to healthcare as a share of the national income in Nigeria fell far below the 2001 Abuja Declaration by African countries to commit 15 per cent of their national budget to health sector. Between 2002 and 2008, the sectoral allocation to health had oscillated between 3 and 6 per cent with the high point being in 2002, just immediately after the Abuja declaration.

The crisis nonetheless resulted in a reduction in the sectoral allocation to health in relation to 2008 (the 2008 allocation was done before the crisis became pronounced). While it could be argued that the percentage drop in the allocation to the health sector in the 2009 budget is marginal in relation to 2008, it is to be noted that the drop broke a trend of upward movement that began in 2004 after a low in 2003. Also, given the contraction in the national GDP in the same period, the drop is more significant in real terms than the statistics show. Also, there is diminution in the GDP of most countries in the African zone following the crisis. This brings into relief the dilemma of these countries in a global system in which they are utterly dependent on the 'prosperity from abroad' and are therefore highly vulnerable to the dynamics and the contradictions inherent in the global capitalist system. But even more telling is the World Bank projection that a decline in GDP of one or more points increases average infant mortality by 7.4 per 1000 births for girls and to 1.5 per 1000 births for boys (The World Bank cited in Adekanye et al, 2009:7).

The third point to note is that the global economic crisis appears to have impacted more on the HIV/AIDS subsector than any other social sector with global resource mobilization for the pandemic being in serious jeopardy. This is due, in large measure, to the dependence of countries of the SSA on external funding to combat the pandemic. The fourth point is that contrary to the general expectation that the crisis would result in a drastic reduction in the quantum of Official Development assistance (ODA) from the world's industrialized and developed nations to the less developed nations, there was in fact a marginal increase in the volume of such assistance in 2009 compared to 2008.

Ordinarily, this would have constituted a piece of cheering news by for certain implications that flow from it. One such implication is the contrast between the stability in the ODA flow from developed nations and the instability in the domestic revenue source of the recipient nations. It immediately raises concern over, for instance, how the leadership of these recipient countries, particularly in the African region would have hoped to carry on with the business of service provisioning had the global crisis persisted and the ODA eventually fizzled out? What safety nets are in place for the citizens of these nations to access in the event of a recurrence of such crisis?

Of more serious concern though is the implication of aid dependence for the recipient countries. The point here is that the primary responsibility for service provisioning in any country lies with the government of such country. Or put differently, it is the responsibility of such government to ensure that such basis services are provided. When such government fails in the discharge of this basic responsibility, or increasingly depends on other countries, or even multilateral agencies, to discharge this basic responsibility, the legitimacy of such a government is often called to question and, over time, the sovereignty of such a state is gradually under-mind and eventually eroded. Hence, the categorization of some countries as 'ungoverned territories'.

Environmentally, many citizens are yet to realize the health benefits of clean environments. The rate of both traffic and human congestion in our other big cities cry to the stake holders for immediate action. Environmental and noise pollution and general lack of sensitivity towards nature stares government in the face and the consequences of these or to show apathy. One insensitivities are always fatal. Just between March and June 2010, a series of lead poisoning in Zamfara state, Nigeria, led to the death of at least 163 people including 111 children. The ongoing can only prove that the system has gone down, this house has indeed fallen, things have fallen apart. The worst demeanour to be put up by anyone concerned in this situation is to delay or to show apathy.

4.2.1 The way forward

Healthcare system in Nigeria began to deteriorate in the 1980s when our medical experts and other medical personnel left the country in droves in search of the proverbial greener pasture abroad. That was when our hospitals were no better than glorified consulting rooms. Two reasons accounted for this exodus; one was lack of tools for the doctors to work and second, we could not match the mouth-watering offers being made to them abroad, including countries like Saudi Arabia. Since there was no job satisfaction, it was only a matter of time for use to lose many of our consultants in the health sector to the countries where their services were better appreciated. The government in partnership with the citizenry must rise up to the current challenges facing the health sector. Failure to do so is an easy access to a disastrous consequence in the future.

Remote areas and rural communities are almost relegated to the background and have to fend for themselves. Some of these areas are not even connected to the national grid, and so have no power whatsoever. The federal government has no say in how states utilize their allocations, and cannot mandate them to spend a certain amount on healthcare, making it difficult to gauge the effectiveness of any campaign for improvement on a cohesive nation-wide level.

Also, the lack of medical intelligence nullifies any effort to identify sectors with disease outbreaks in a timely manner, to contain and treat incidences of infectious disease outbreaks, and reduce the frequent occurrence of such in the country. The manner of drug supply is also cause for concern. Most of the pharmacies in the country are not regulated, and even the tomato seller could also sell medication like pain killers,

multivitamins, tetracycline, antibiotics and so on. A complete overhauling of the healthcare sector is long overdue and will help alleviate the suffering of the masses.

Government spending on health and donor funding have reduced, which caused uncertainties in resource allocation and spending in the three tiers of government. Tighter control of available funds and operations should be used to enhance the quality of services. Health policy should be in line with the changing environment, aimed at achieving health for the vast majority of the people. Abandoned immunization programs in many health centres across the federation should be resumed with vigour. Problems of access, poor community participation, and underfunding, should be given top priority in the best interest of the people. Supply of solar-powered refrigerators in rural communities without electricity would enhance vaccines potency. Massive national and community mobilization/participation, and the adaptation of Chinese model would help in ensuring that health care gets to the grassroots. However fiscal discipline, social mobilization, substantial government investment on health, and high sense of nationalism are required to make a land-mark success. The core of Chinese 2009-2011 reform program includes: establishment of the basic medical insurance coverage; establishment of national essential drug system at all local levels; upgrading the primary healthcare services at the grass-roots level; expanding the coverage of basic public health services; and facilitating pilot reform programs in public hospitals.

Government should put policies in place and back them up with legal muscle to ensure that the earlier target of 90%coverage is kept in focus through high performance and quality improvements. The federal Government should plough more money into health care, knowing that the health of the population is a measure of the country's wealth. Donor funding towards enhanced PHC activities in Nigeria should be put to the best use, to minimize the multiplicity of uncertainties that accompany poor resource utilization. Many Nigerians embark on medical tourism to India, South Africa and other foreign countries. Government and entrepreneurs should take advantage of the growing demand, to develop top class healthcare institutions to serve this niche of health seekers. The US model that emphasizes safety, effectiveness, timeliness, efficiency, equity and patient-focus, with a number of care plans, should be adapted in combination with the Chinese health reform model. Regulatory agencies have vital roles to play in ensuring that standards are met in various aspects of the health system.

The implementation of the Health Reform Laws has started a revitalisation of PHC with more appropriate involvement of the people, improved resource management (human, financial, data/logistics, drugs/supplies) as well as an apparent higher level of service utilisation. The expected impact of these is general improvement of health status and better health indices for the country.

- **Political commitment**

The apparent commitment of federal, some states and some Local Governments to PHC must be sustained. Also, their commitment in terms of funding, community involvement in policy decisions and employment of adequate human resource is crucial to the sustenance of a stable PHC system foundation. Most PHC facilities in the country as in Lagos State do not have adequate staff to provide 24 hour services or take deliveries because required staff has not been employed or the conditions of service are poor and not acceptable. Consequently, access to services is limited and communities patronise available alternatives; secondary and tertiary hospitals or expensive private clinics, patent medicine sellers and traditional practitioners or resort to unsafe self-medication. This is also one major reason for overcrowding, long waiting times and reduced quality of care at the higher tiers of health care.

- **Infrastructure**

There is hardly any ward in the country without infrastructure that can be utilized for PHC services. Multipurpose community halls can be used as long as relevant staff, equipment, materials and drugs are available. Also private facilities are available even where there are no government ones, so, logistics could be worked out for private-public partnerships especially for the National Health Insurance Scheme.

Renovation of existing infrastructures is cost-effective and promotes better coverage indicators and use them for managing the health system. In addition, it is designed to ensure equitable distribution of facilities and resources as well as to correct misconceptions e.g. PHC is for the poor, concern only children and women, is only for immunization, family planning / antenatal, lack; qualified people etc.

A study done three years after the commencement of the WHS in Nigeria found that, high percentages of the stakeholders, especially WHC/WDC were not well informed. In countries like Ghana where community structures are well established, intervention programmes e.g. Malaria project are being sustained and have wide coverage. The Composition of Governing Bodies may vary with countries. One major health reform in Nigeria is the creation of State Agencies/Boards. The Law for Lagos State made provisions for the establishment of community structures that are fully backed by the law (first in the country) while executing programmes with

drastic measures for resuscitating PHC in the state. The strategy was Integration of all PHC services delivered under one authority.

- **Human resource and capacity building**

There are human resources with health knowledge and potentials for effective leadership in the Ward Health System. Their performances in the pre-tests on management of the WHS showed some degree of baseline knowledge especially among the health professionals (some retired) and the PHC staff who had been recently trained by the Board. They scored high in the pre-test and there was no significant difference between their pre and post test scores. However overall, there was significant improvement in knowledge after the training workshops. The increasing trend of movement of educated retirees and younger ones to suburbs and rural areas in search of cheaper accommodation is a welcome development. Emphasis should now be on effective, appropriate knowledge transfer.

A major challenge to health manpower is brain drain to other countries. Nigeria has adequate training facilities for high, middle and low health manpower training and has trained more than adequate medical, dental and paramedical workers. Almost all the states have medical/dental colleges and Schools of Health Technology. The health system is relatively rich in human resources compared to many other African countries with 2 health care professionals/1000 populations (WHO benchmark is 2.5/1000). Many are unemployed yet the PHC system suffers from inadequate staffing of health facilities. Of the 277 PHC facilities in Lagos State, less than 20 have full complement of staff for 24 hours service.

One major evolving challenge is unionism. Instead of the PHC team spirit and intersectoral collaboration, some professional unions are at logger-heads with one another. Also, there still exist controversies over the relevance of Traditional Birth Attendants' functions. Even in urban Lagos State where there are more than enough health facilities, TBAs still take more than 50% of deliveries. The state's Traditional Medicine Board has registered and trained more than 4000 of them. Evidence of their usefulness is described in the report on the Bill and Melinda Gates Maternal and Neonatal Project in Gombe, northern Nigeria where TBAs over a period of 6 months visited 54946 women, conducted 7150 deliveries, transported 985 women in labour and referred to health facilities 41775 maternal and neonatal patients (Adebanjo A.A &Oladeji S.I 2006).

- **Funding of PHC**

The sources of funds are still the Federal Government through the NPHCDA, State Governments, LGs/LCDAs and Development Partners. Even though some states like Lagos have started experimenting with community-based insurance scheme, payment for service is still mostly through Fee for Services and Drug Revolving Funds. Even though the National Health Insurance Scheme is still in a rudimentary stage it has potentials to improve coverage if the National Health Bill becomes operational. The bottlenecks with LG administrative staff will be drastically reduced. For sustainability, WHCs must not rely solely on funds from government or partners (Olakunde OB, 2012). They must generate funds as counterpart to any from other sources. Commitment, rather than pumping of money into programmes may be more relevant in ensuring impact and sustainability.

- **Eradication of the challenges of community governing bodies for health**

The initial challenges of lack of take-off grant, office accommodation, conflicting roles will be minimized when the National Health Bill becomes operational. Reluctance of LGs/LCDAs to fund their LGHAs and WHCs may be because they are seen as rivals competing for allocations with existing staff and uncertainty about the time the Bill will become operational.

V. CONCLUSION

This chapter has been able to present a review of existing literature on housing poverty, healthy housing, and connection between housing condition and health conditions of residents of Lagos metropolis. The chapter also touched on the concept of theoretical framework in a research. In addition, attention was given to significance of certain hosing factors in connection to corresponding health situations in metropolitan Lagos.

There are positive outcomes from commencement of the implementation of the country's Health Reform Laws and Strategic Development Plans. States (Lagos State as index) are taking positive steps towards community ownership by enabling community governing bodies to assume leadership roles and take active part in the planning, implementation, monitoring and evaluation of their communities' health interventions. The challenges are still basically inadequate financing of health, non-engagement of trained manpower, inadequate and poor distribution of available human resource, and inadequate community mobilization resulting in sustainability problems (Gupta MD, Gauri V, Khemani S, 2004).

For a sustainable PHC system in Nigeria, each ward needs to develop costed Annual Operational Plan of Action based on community diagnosis, prioritize the problems, assess available resources and utilise them optimally. Ward Action Plans from all the wards in an LG/LCDA approved by the LGHA should constitute the LG/LCDA PHC Operational Action Plan while Action Plans from all the LGHAs in a state approved by the State's PHC Board/Agency should constitute the State Operational Action Plan. Plans should be funded by all relevant stakeholders in addition to allocations from government.

It is therefore important to develop an integrated health system that will be accessible to the vast majority of the people, at affordable costs, and a disease surveillance and information system that monitors out-breaks, with a view to providing early response. Given the problems of numerous uncertainty factors, the federal and state governments should channel their energy to the grassroots (LGAs) and evolve a new, workable health system in the face of shrinking global economy. Since the trouble with Nigeria was identified as simply and squarely a failure of leadership, committed and proactive health leaders are the imperatives to turn rhetoric into action.

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