KEY ISSUES IN THE HEALTH SYSTEM AFFECTING ACCESS TO EMERGENCY HEALTHCARE IN NIGERIA

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ABSTRACT

The health system is made up of different environmental factors. Environmental issues are a great impediment on the realization of the lofty idea of having access to emergency healthcare in Nigeria. The Nigerian health system comprises of various factors militating against this dream, such as human capital resources, financial resources, infrastructural deficiency, bureaucracy and corruption among others.

In this paper I have been able to take a look at this key health issues in the environment and how they individually and collectively affects access to emergency healthcare in Nigeria with the aid of statistical evidence where available.

The doctrinal method of gathering and analysising of data was made use in the process of carrying out this research work.

The paper ended up by drawing up a conclusion as regards and recommendations made.

Keywords: Health system, Access, emergency health, policy, corruption

INTRODUCTION

A health system comprises of different indices such as the infrastructure, the human capital, the equipment, the financial resources, regulatory agencies and the government policies put in place to deliver or achieve a health services to members of an identified geographical area.

The Nigerian health system is based on the three tier system of primary, secondary and tertiary, where the Local government councils are responsible for the primary health care services, the state ministry of health has the responsibilities of providing secondary level care and the tertiary level of care is the responsibilities of the Federal government. Otu[i]said a health system is the network of organizations, institutions and resources that deliver health services to the public.

The National Health Act[ii] by virtue of the provisions of Section 1, established for the Federation, the National Health System, which shall define and provide a framework for standards and regulation of health services, without prejudice to extant professional regulatory laws and which shall-

- encompass public and private providers of health services;
- promote a spirit of cooperation and shared responsibility among all providers of health services in the Federation and any part thereof;
- provide for persons living in Nigeria the best possible health services within the limits of available resources;
- set out the rights and obligations of health care providers, health workers, health establishment and users; and
- protect, promote and fulfill the rights of the people of Nigeria to have access to health care.

Otu[iii] went further to the effect that the Nigerian Health system is made up of the traditional health care system and the modern health care system. According to him, the traditional health system includes the traditionalist and herbalist or those that are classified as the alternative health care practitioners', while the modern health care system includes the organized health care practitioners.

Section 2[iv] of the National Health Act, list out the classifications of areas, institutions and health care providers captured under the National Health System to includes the ministry of health at the Federal capital territory, the states and the local government areas, parastatals under them, ward and village committees and not living out the private and alternatives health care providers.

It however unfortunate, that despite the existence of the provisions of the National Health Act, 2014, the Nigerian health care system is still faced with lots of problems which has invariable affected the ability of population to have access to emergency health care in the country. In the course of analyzing this health system issues, each of the identified issue will be discussed separately.

ANALYSIS AND ASSESSMENT OF PREVAILING HEALTH CARE PROBLEMS IN NIGERIA

Government Policy And Its Effects On Access To Emergency Health Care In Nigeria

Section (2) (1) of the National Health Act[v], is to the effect that the Federal Government is empowered by the Act to ensure the development of National health policy and issue guidelines for its implementation in collaboration with both the states and the Local government.

The provision of this section of the Act is not ambiguous, as regards who has the power to make policy in relation to health care system in Nigeria.

According to Omoleke and Taleat,[vi] they identified Federal government health policy as the bedrock of the problem with the Nigerian health care system. The argued that most policies put in place are usually Abuja centered, in that the inputs of other state holders in the state are not taken in consideration before the policies are formulated. They traced the history of policy making for health to immediately after independence in 1960 especially as contained in the various National Development Plans till the present day Nigeria.

Omoleke and Taleat concluded that aside the fact that most policies formulated hardly take into consideration, other stake holders, there was also a general lack of coordination, are not related

to any economic target. They also recognizes the influence of politics on the implementation of this policies especially lack of continuity due to change in governance.

Otu[vii] in his submissions traced the history of health policy in Nigeria back to 1987, when the primary health care was launched and to help achieved its objectives, the Federal Government in 1988 promulgated a comprehensive health policy aimed at addressing the issue of access to health, improve health indicators, efficient immunization and increase funding among others. He stated further, that the weakness of the 1988 policy gave room for the 2004 reviewed policy in collaboration with New Partnership for African development(NEPAD), the MDGs and the New Economic Empowerment and Development Strategy(NEEDS), all which culminated in the National Strategic Health Development Plan Framework(NSHDP 2009-2015).

He further stated that most government policies in Nigeria lacked measurable foals and sustainability and is mostly driven by political objective instead of the need to provide services for the generality of the population. In term of accessibility, he opined that most of this policies are put in place without considering its location and place of utilization, in that some of the projects are located in areas where they already available as against areas that really needed them.

Obiajulu[viii] in his write up said the "Health Sector Reform (HSR) Plan of Action was one of the policy introduced by the government to tackle the problems affecting access to health care system in Nigeria. The problems identified by him include duplication of policies and lack of coordination in governance leading to redundancy and waste of resources. He concluded that this led to the apathy on the part of the international community to lend support to the country.

Federal ministry of health has the responsibility for providing policy guidelines and direction for the overall direction for the National health care delivery system. The NHA 2014 put in place alongside the SDGs and the UHC contain different policy objectives aimed at helping improving the health care system in Nigeria. Going further, the National Health Plan is the latest version of the NHA, and the NHP was based on 10 policy trust which includes, governance, financing, medicines, vaccination, infrastructure, data system, research and development, Public-private partnerships(PPP) and community participation. The Federal Government health policy as contained Economic Recovery & Growth Plan 2017-2020 which was aimed at improving accessibility, availability, affordability and quality of health care

services by increasing access to primary health care service and expanding health coverage could not achieve its aim as a result of poor financing, inadequate and inequality in access, human or personnel problem, lack of coordination, lack of cohesion and accountability[ix].

Adeloye in his submission stated that there are growing concerns locally and internationally with respect to the lingering problems affecting access to and the delivery of health care services to Nigerians and according to him this has been attributable to the poor state of governance especially in the health sector.

Human Resources Requirement And Its Effects On Access To Emergency Health Care In Nigeria

Part V of the National Health Act[x] especially sections 1, 2, 3, and 4 was dedicated to addressing the issues related to the provision of adequate human resources for the health care sector, ranging from the provision of, management and utilization of personnel to the formulation of policy guidelines in the training, distribution and retention of this personnel so as to achieve the desired objective of health care for all.

Omoleke and Taleat[xi] in their write up came up with the conclusion that health care personnel are inadequate in Nigeria. That Nigeria falls short of the WHO requirements of one medical doctor to 500 patients (1-500). They said this large gap had made access to health care difficult in the country. According to them, the shortfall in the number of medical doctors have created a long waiting time evidence in the queues which one do see in our major government own hospitals. They also identified the poor or lack of training coupled with poor pay and lack of motivation as a major factor leading to brain drain noticeable in the health sector of the country.

Adeloye et al[xii] said the health workforce is the backbone of any functioning health system without which services cannot be delivered to members of the public. They linked a working governmental system to the overall output of the health workforce.

The continuous brain drain in the health sector had been traced to the general problem in our system of governance especially in the area of funding for the health sector, the remuneration being paid to the health workers, the lack of training and re-training, lack of adequate and

modern equipment to work with. Statistics shows that 1 out of every 4 Doctors and 1 out of every 20 nurses trained in Africa has migrated to the developed countries for better working conditions leaving the African continent to grapple with the crisis. To buttress this the Guardian[xiii] reported that the major cause for the decline in the number of doctors in Nigeria is the migration of Nigerian doctors abroad, according to the repot an estimated 2,000 medical doctors leave Nigeria yearly and no fewer than 5,407 Nigerian trained doctors are currently working with the British National Health Service in the United Kingdom. Dr. Francis Faduyile , the president of NMA attributed high rate of insecurity, unemployment, low remuneration, bad roads, and poor healthcare system as some of the reasons why doctors are leaving the country in search of greener pastures. He noted that 75,000 Nigerian doctors were registered with the Nigerian Medical Association (NMA), but over 33,000 have left the country[xiv]. The unending strike in the health sector is another factor which has been adjudged as a contributory factor to the constant emigration of medical personnel out of the country. The factors responsible for this incessant strike include among others need for improve conditions of service, good remuneration and training inclusive all of which are readily available in the developed countries.

The burgeoning Nigerian population is another factor that has been traced as being responsible for the inability of the health care workers to provide access to emergency services in the country. The increasing population needs a corresponding increase in the number of workers in the health sector, but this has not been the situation in the country.

Adeloye et al, equally recognizes the uneven distribution of the work force as another major setback affecting the manpower need of the health care sector, in that most deployment of workers in this sector are done based on discretion and not on need. The power tussle between medical professional in the academics and those not in academics as regards to the position they can rose to was also another issue that affecting the health manpower sector.

It is however imperative to note that the attainment of goal 3 of the Sustainable Development Goals (SDGs) requires an adequate number of doctors in order to achieve the goal and the Nigerian healthcare system has not shown any visible signs of achieving sustainable development goals, especially in relation to human resources.

Health Care Financing And Its Effects On Access To Emergency Health Care In Nigeria

The Nigerian health system has continuously struggle to meet the yearnings of the population in terms of the provision and access to quality health care need, emergency care inclusive. Health care financing has being attributed to be one of the major hindrances in the process.

Health care financing is a worldwide phenomenon, and because of its implications on the generality of the population, most countries of the world take healthcare financing as a priority. It should be noted that provision of healthcare has been adjudge as one of the fundamental rights which citizens are entitled to[xv], and it was in this respect that various international treaties and conventions had been drawn up which enjoined countries of the world to dedicate a certain percentage of their annual budget to the financing of healthcare. Healthcare is a critical component of the economy. The health of members of a society goes a long way in determining how developed or underdeveloped a nation would be. It is as a result of this, that most countries tend to place maximum priorities on the health of their citizens. In Nigeria and indeed many countries of the world had put in place much legislation to help in the areas of financing of the health sector. According to the WHO, healthcare financing is the function of the health system concerned with the mobilization, accumulation, and allocation of money to cover the health needs of the people, individually and collectively in the health system.[xvi] Healthcare financing also involves the process of raising money to pay for the operation of the health system[xvii]. Healthcare finance can also be said to be a process by which revenue are collected, accumulated in fund pools and shared among people based on their identified health needs.[xviii]

There are various sources of healthcare financing in the world, Nigeria inclusive. They include, tax-based public sector health financing, household out-of-pocket health expenditure, the private sector (donor funding), community-based health expenditure, and health insurances. External financing of health care includes grants and loans from donor agencies like the World Bank, the World Health Organization (WHO) Funds and Foundations among others.[xix] A detailed explanation of these sources is as follows;

TAX-BASED PUBLIC SECTOR HEALTH FINANCING

This source of health care financing is derived from proceeds of tax-based revenue of government across all levels and sectors in Nigeria. At the federal level, the pool of taxes entails crude oil and gas export proceeds, petroleum profit tax, royalties and the component proceeds of domestic crude oil sales/other oil revenues, companies' income tax, customs and exercise duties, Value-Added Tax (VAT), tax on petroleum products, education tax among others[xx]Financing of the healthcare by the government is largely a function of its revenue base. In essence, there is a strong positive relationship between the proportions of tax-based health spending and the progressivity of total health expenditure. Another implication of raising funds through taxes is that contributions are usually spread over a larger share of the population than might otherwise be the case. It is of note that some employers and employees are not captured in the tax net due to the fact that they work in the informal sector; workers in the formal sector are more affected.

HOUSEHOLD OUT-OF-POCKET (OOP) HEALTH EXPENDITURE

Here individuals are charged for the health services they consumed by the service providers. OOP health expenditure could be incurred directly by a patient to a health service provider without reimbursement. The consumer of such services pay on -the spot for health care services received. The payment could include cost of medication, consultations, card fee among others.

Out-of-pocket payment, otherwise known as private health expenditures accounted for more than 90% cost in accessing health in Nigeria. Consequent upon this, it was noted that over-reliance on the ability to pay through OOP has the potency of reducing health care up-take. Thus, limiting access to quality health care[xxi].

A larger proportion of people living in Nigeria still personally finance the consumption of their health. Considering the level of poverty in Nigeria, personal financing of health care services will greatly have a debilitating effect on some kind of illness. Where the OOP expenditure exceeds the household income or its ability to pay for healthcare services received, such portends great danger for the country. Household, or families are then left with little or nothing to meet other household basic needs.

The resultant effect of this type of health care spending is that a larger proportion of the poor may be driven into abject poverty. Medical impoverishment, inability o meet basic household needs and catastrophic health expenditures are the effect of over-reliance on OOP health spending. The after effect of a high OOP health spending is said to be generally greater in the rural areas compared to the urban areas.

PRIVATE SECTOR (DONOR FUNDING)

It should be noted that the government cannot shoulder the enormous responsibility of providing good and high quality health care taking into consideration the Nigeria economy that is tied to the dictates of price of petroleum products culminating in poor budgetary allocation to the health sector. It thus becomes important that the private sector be involved in financing health care services in Nigeria. Private sector health financing include donor funding as well as Public-Private Partnership (PPP). Some of the health donors are UNICEF, the World Bank, WHO, UNDP UNAIDS, etc. The international community's contribution to global health, come in various forms, namely: financial assistance (loans and grants), commodities (drugs medical equipment), technical expertise, training, study tours and fellowship, research funding among others. It is on record that government donations and concession loans that include at least a 25% non-reimbursement component are referred to as official development assistance, and they serve as the major source of external financing for the health sector in the developing world[xxii]. Asides the major donors, there are other global public-private partnership donors who focus on specific diseases or health conditions only. Public-private partnership initiative has helped in expanding the financing of health system in Nigeria taking into consideration the inadequate government statutory allocation to health for a population of around 200 million people.

COMMUNITY-BASED HEALTH FINANCING (CBHF):

This is to provide financial protection from the cost of seeking health care. The CBHF has three components and these are: [xxiii]

- Pre-payment of health services by community members
- Community control
- Voluntary membership.

Community-based health financing is not a new phenomenon in health care financing, some are as old as religious organizations who operates and finances health care needs of their members. Some communities do pay direct subsidies in aid of the health care needs of their members, while some partners with third party insurance providers. This community based health financing scheme are now being run in Nigeria by some registered community based health insurance organizations otherwise known as health management organizations (HMO)[xxiv].

The 1999 Constitution requires the government to make laws for the general well being of Nigerians, provision of health inclusive. However, this constitutional provision only exists as a guide in that its non compliance cannot be enforced in court[xxv].

It is essential at this stage to take a look at some of the legislation put in place by the government in areas of government and private sector health care financing.

Some of the legislations includes:

THE NATIONAL HEALTH ACT, 2014[xxvi]: The lacuna created by the 1999 constitution especially in the area of creating a legal framework for healthcare brought about the National Health Act 2014. It is a common knowledge that before the introduction of the Act, there was no clear definition of the roles and responsibilities for the levels of government and health care personnel. This generally brought about a high level of inefficiency and ineffectiveness in service delivery, in a crisis ridden sector.

The National Health Act 2014 which formally came into law on the 27th of October, 2014 was the most recent legislation put in place to provide the essential framework for the delivery of high quality health care delivery in Nigeria[xxvii].

The National Health Act 2014 was divided into 7 (seven) parts and made up of 65 (sixty five) sections, and each section is carefully set out to take care of different aspect of health care delivery in Nigeria.

The recent happenings in the country has made it inevitable to take a look at the provision of this Act, especially as it affects the financing of the health sector and the assessment of same in light of the present reality .

The National health act makes conspicuous provisions in both its sections 3 and section 11 as regards the categories of individuals that that will benefits from the funding of health care provided by the government and the percentages each tier of government is expected to contribute to the Basic health care funds before they can have access to same.

Section 3 of the Act[xxviii] makes provisions for the categories of people that are exempted from paying for health services in public establishment. Section 3 (2)[xxix] further provides for the categories of exemption currently being enjoyed and the categories of people affected and the impact of such on access to health and the vulnerable groups. Section 3 (3)[xxx] however makes it mandatory for all Nigerians to be entitled to a basic minimum package of health services. Inferably, the outlook of the foregoing provision is that exemption from payment for health services is not even automatically available to the persons falling within the exemption category. This is understandable, as the successful running of the scheme depends on availability of funds. However, it is essential that certain categories of people be given but then certain person's priority even when the effects of exemption calls for suspension of the privilege, such persons should include pregnant women and women with terminal diseases.

Section 3 (3)[xxxi]: does not define the basic minimum package provided for under section 3. This appears to leave the Act without force, lacking teeth. The Act should clearly state what the package is, that the minister ought to have due under the powers granted to it. This would have given this provision the legal effect, since the regulation would be regarded as the subsiding legislation with the attendant's consequences.

The design package, scope, contents and manner of delivery are critical to the universal health coverage.

The implementation strategy must be developed as an integral part of the design package. The basic minimum package will operate within the existing financial framework established by the National Health Act.

Section 11[xxxii] of the Act makes provisions for the establishment of a fund to be known as Basic Healthcare provision fund. Three specific grants are to make up this fund and they are[xxxiii]:

i. Annual grant not less than 10% of the Federal Government Consolidated Revenue fund.
ii. Grant from international donors and partners
iii. Funds from any other source.

Section 11(3)[xxxiv] provides that funds from the above source shall be deployed in the following ways: 50% for the provision of basic minimum package for the citizens through the NHIS, 20% to provide essential drugs, vaccines and consumables, 15% for the maintenance of facilities, equipment's and transport for eligible primary health care facilities, 10% for the development of human resources for primary health care, and 5% for emergency medical treatment. The sources are not certain except for the Federal Government annual grant which may not be less than 1% of the consolidated revenue fund. The success of this type of health system anticipated by the Act cannot be delivered without adequate funding. 5% of this fund is to be applied for the provision of basic minimum package of health services to citizens. It is also salutary that 10% of the fund is to be used for the development of human resources for primary healthcare. The Act provides that any state or local government that wants to benefit from the fund should contribute not less than 25% as their commitment in the execution of healthcare project. Thus, the implication there is that when a state or local government fails to contribute its citizens will irritably be denied access to healthcare which the Act intends to avail them. State contribution should not be optional but mandatory. It is suggested that state as well as local government allocated from the scheme should be deducted from their monthly revenue allocation.[xxxv]

The Act is set to achieve the Universal Health Coverage and meet the Millennium Development Goal (MDGs) target. The Act also provides for the elimination of quacks from professionalism and provides basic health funds needed by Nigerians. [xxxvi] The Act was also enacted for the purpose of providing healthcare insurance to certain class of people who are actually deprived.

THE NATIONAL HEALTH INSURANCE SCHEME ACT

The National Health Insurance Scheme (NHIS) (Act 1999)[xxxvii] and its operational guidelines (2012)[xxxviii] was put in place to protect the health and well being of Nigerians. As a law, it is meant to provide a policy framework to guide Nigerians, especially the vulnerable in access to health services irrespective of their status has the primary objective of ensuring access to good, qualitative and cost-effective health care services to every health care insured Nigerian citizen and a restricted number of his dependents.

The NHIS also has as one of its objective the protection of such insured Nigerian families from exorbitant medical bills arising from their not having any health care insurance cover.

The NHIS, like any other insurance scheme, is required to assist the health care sector in Nigeria to have an equitable distribution of health care standards, facilities and costs among different income groups.

The objectives of NHIS includes:[xxxix]

a) Universal provision of Health care in Nigeria.
b) To control and reduce arbitral increase in the cost of health care services
c) To protect families from high cost of medical bills
d) To ensure equality in the distribution of health care services
e) To ensure high standard of healthcare delivery
f) To boost private sector participation
g) To ensure adequate and equitable distribution of healthcare facilities in the country
h) To ensure equitable patronage of healthcare services at all levels, and
i) To ensure adequate flow of funds for the smooth running of the scheme.

Contributions to the NHIS are voluntary, as any employer with a minimum of Ten (10) employees, may, together with every person in his employment, pay a health care insurance contribution to NHIS, at such rate and in such manner as may be determined from time to time by the Governing Council of the NHIS.

All NHIS contributions are required to be paid into the account of the health-insured's chosen Health Maintenance Organization ('HMO').

Employers' contribution to the NHIS, on behalf of their employees, must not however result in the reduction, directly or indirectly, of the employees remuneration or allowances, on whose behalf the NHIS contribution is, are or was made.

The law establishing the NHIS stated that it shall be managed by a Governing Council, and the Governing Council has among its key functions the registration of all participants in the program; namely Health Maintenance Organizations ('HMOs'), Health Care Providers ('HCPs'), employers, employees, etc. Persons who are not obligated to join the NHIS are allowed to apply to be registered with the NHIS as voluntary contributors; and on registration, to make the specified contributions like other NHIS contributors to the NHIS.

In return for registering with the NHIS, and making contributions to the scheme, insured beneficiaries of the scheme are entitled to such quality of health care services that the contributor or subscriber has paid for.[xl]

At the commencement of the scheme, it only covered formal sector employees, representing less than 40% of the population. Preponderantly, about 60% in the informal sector was not reached.[xli] The problem of the exclusion of the informal sector later led to the scheme's expansion and inclusion of Community Based Health Insurance (CBHI) in 1997. At the 42nd meeting of the National Council on Health (NCH), an approval was given for the re-packaging of the NHIS to include and ensure full private sector participation by providing re-insurance coverage to CBHF and Health Maintenance Organization (HMOs) to form Social Health Insurance (SHI)[xlii]. The scope of NHIS is principally concerned with the contributions paid to cover health care benefits for the employees, a spouse and four (4) biological children below the age of eighteen (18) years; more dependents or a child above the age of 18 years is covered on the payment of additional contributions by the principal beneficiary as determined by the scheme.

Even though principals are entitled to register four (4) biological children each, a spouse or a child cannot be registered twice. In terms of access to good and qualitative health care services, the scheme has developed various programmes to include different socio-demographic segments of the country.

Any registered person who fails to pay any NHIS contribution into the account of any NHIS organization within the time specified; or who deducts NHIS contributions from an employee's wages and withholds such NHIS deductions, commits an offence which on conviction, in the case of a first offender, attracts a fine of N100,000 or 500 per cent of the amount involved, together with accrued interest; this fine could be with or without imprisonment for a term not exceeding two (2) years or less than one (1) year; or to both the fine and the term of imprisonment .For repeat offenders, the above monetary penalties and term of imprisonment are required to be doubled when the repeat offender is convicted.

Where any offender is a corporate body, its Directors and Managers who are or were aware of, connived or consented to the infraction of the provisions of the NHIS Act will be deemed to have committed the offence in their individual capacity, and will be liable to prosecution and punishment in the like manner stated above.[xliii]

One of the benefits that an employer derives from incurring NHIS contributions on behalf of its employees is that the employer will have a healthier and more dependable workforce.

Another benefit to the employer and other independent contributors is that NHIS contributions are tax deductible expenses when computing the tax liability of the NHIS contributor for the relevant tax period.

Also, NHIS contributions are non-transferable to the creditors of a NHIS registered operator, where such operator goes into bankruptcy or insolvency and where a merger or acquisition occurs, the acquiring entity shall take over the NHIS statutory responsibilities of the previous entities.[xliv]

Despite the laws put in place as regards financing of healthcare in Nigeria, some of the following have been identified as the problems associated with the sources. They include;

Corruption: this has been adjudged to be the largest indices in that, most funds which are allocated or earmarked for the health sector are either sidetracked or diverted or squandered or embezzled by the officials in charge of such.[xlv]

Economic recession: It should be noted that Nigeria is largely dependent on revenue from crude oil and other income tax generated from other sources as provided for in the constitution. Once the gross domestic product or revenue from oil falls, health expenditure also falls.[xlvi]

Inadequate budgetary allocation: it is a non fact that the constitution and the National Health Act makes provisions for a certain percentage of the countries budget to be allocated to the health care sector. It is however a common knowledge that there is a loop sided budgetary allocation not only to the health sector but also to the other tiers of government and the lower tiers of health sector.[xlvii]

Inconsistent policy: Nigeria like most other countries do get bilateral and multilateral assistance from foreign countries and donor organizations. Despite this, such donations have not translated into any positive enhancement of the status of Nigerians health wise. Poor strategies and policy implementations coupled with political influence has negatively affected these donors.[xlviii]

No clear court policy direction from government as regards the National Health Insurance Scheme and the limited or lack of encouragement as regards the way the states embrace the Scheme.[xlix]

Large population of out of pocket patients: It's a known fact that majority of Nigerians accessing health care facilities pay for the enjoyment of same from their pockets. And this has a great implication on the type of services they get which in itself is determined by their financial strength or capability[l]

The National Healthcare Act 2014 despite its lofty provisions especially in the area of healthcare financing was bedeviled by the lack of will power to implement its content. The World Health Organization, and the African Union did make provisions as regards the percentage of a country's budget that should be earmarked for health care financing. The World Health Organization provides that every country in Africa should earmark at least 5% of their GDP for the financing of health care.[li] The African Union in 2001 at the African Union head of state meeting tagged the Abuja deceleration asked all countries to earmark and allocate at least 15% of the annual expenditure to health[lii]. In Nigeria budget provisions to the health care sector has been term as the lowest when compared to some African countries, as at 2014, Nigeria was ranked 45 in Africa with a 3.7% GDP.[liii] In 2018, the budget provision for the health sector was just 4%,[liv] while in 2019 a paltry 2% of the total budget was allocated to the health sector.[lv] In 2020, the budgetary allocation to health slightly increased to 4.5%.[lvi]. The 2021 budgetary allocation to the health sector despite the COVID-19 pandemic was

4.5%[lvii].From the above analysis one can see that the budgetary allocations for the last 3years was below 5% and this has been the position in the last 10years. It is obvious that the lack of willingness to fund or finance the health care sector is one of the major problems associated with the legislation.

The in ability to implement the content of the health act is vital to achieving universal health coverage especially where 70% of health care expenditure is borne out of pocket of individual members of the society[lviii].

Aside poor funding, another noticeable shortcoming associated with act is the slow pace of its implementation and this has been attributed to lack of leadership and willingness on the part of the government and supposed ministers of health.[lix]

The supremacy struggle between the national health insurance scheme, the ministry of health and the ministry of finance has generated lack of trust and bad blood among the agencies.

The inability of the act to clearly indicate who should manage its fund has considerably slowed down its implementation.[lx] The inability of the act to put in place a reliable insurance model that could drive the process having regard to the fact that the track record of the national health insurance system is poor[lxi].

The federal government and its federating states have little or no contribution nor participate in the national health insurance care thus making it ineffective[lxii].

The law establishing a national health insurance scheme makes participation in the scheme optional and by implication reducing or restricting the scope of participation especially by civil servant [lxiii]

The national health insurance scheme like every Government project is not adequately funded.

INFRASTRUCTURAL DEFICIT AND ITS EFFECTS ON ACCESS TO EMERGENCY HEALTH CARE IN NIGERIA

Usoro[lxiv] et al said that hospitals in Nigeria is faced with lots of challenges arising from the lack of trust which members of the public have in the available health care facilities, thus

propelling them to seek medical attention abroad. Fallout from the deficit in the provision of adequate financing for the health sector was traced to have a direct impact on the provisions of infrastructural facilities in the sector[lxv]. The structures if available at all are not only obsolete but weak and defective. Most of the hospital buildings are not only old but poorly maintained, lack adequate water supply, with no generating sets etc. Some structures are built with no provisions for emergency wards, no lifts and entry points and exist for the physically challenged. The medical equipment's are themselves an eyesore if they are available at all, the emergency situation thrown up by the COVID -19 Pandemic was an eye opener, with most hospital lacking functional oxygen cylinder and where functional has no oxygen, no personal protective equipment to the extent that the patients themselves or their families have to buy for the use of the health care personnel before they can be attended to, no enough bed space leading to the construction of isolation centres that are ill equipped. Ambulance services are not available in most hospital to address emergency situation, leading to situations where family of the patients or even the hospitals resorted to the use of private cars, taxi or even tricycle to transport the sick and the injured to hospitals for emergency treatment or during referrals.

Another health care infrastructural facility lacking in Nigeria is the drug bank. There is a noticeable shortage of drugs in most government owned hospitals, there is poor management of drugs if available and there are instances where the available drugs are the expired ones.

The huge deficit noticeable in the number of health care facilities and infrastructure in Nigeria has led to an unprecedented rise in medical tourism among not only the rich or political class but also among middle or low income earners as long as they can afford the cost. The long term effect of this medical tourism can be seen in the loss of revenue on the Nigerian economy. The favoured countries to which most Nigerians travel to for medical care include the United Kingdom, United State of America, Germany, Israel, Indian, China, France, Canada, Malaysia among others[lxvi], where they sought medical treatment for various medical issues.

A report by Price Waterhouse coopers in 2016[lxvii]indicates that over $1b was spent by Nigerians on medical tourism, an amount which represents about 20% of the total government spending in the health sector.

Report did show that between the year 2010 and 2020, Nigerians spent the sum of $11.01 billion on health tourism, the highest amount being $2.56billion in 2019 while the lowest was

$17million in 2016[lxviii] . In admitting the menace of medical tourism in the country, the Nigerian minister of health stated that aside lack of equipment and technical deficit, the poor attitude of the health care workers had in no small measure driven away Nigerians from seeking medical care in Nigerian hospitals. In his words, poor sanitation, disrespectful attitude and lack of confidentiality have greatly damaged the reputations of these hospitals thus eroding public confidence[lxix]

BUREAUCRACY AND CORRUPTION AND ITS EFFECTS ON ACCESS TO EMERGENCY HEALTH CARE IN NIGERIA

Bureaucracy has been identified as another major hindrance affecting the effective delivery of health care services, emergency care inclusive. The provision of the National Health Act, centralized within the Federal government, but does not create offices and agencies to coordinate health care delivery at all levels to ensure equitable access at both the state and the local government levels. The operation of the National health insurance scheme is a veritable example of how bureaucratic bottle neck has made the realization of this scheme a tall order especially as it affects seeking approval before treatment can be accessed on this scheme. The waiting time before approval codes are gotten sometimes makes access to emergency health care difficult.

Aside the bureaucratic hindrance, corruption has also be identified as another factor limiting access to emergency health care in Nigeria. According to Omoleke and Taleat[lxx] corruption has permeated all the facet of the Nigerian society and as a result makes policy implementation, monitoring and evaluation a difficult task in the health sector. They argued that with corruption merit had been relegated to the background to the extent that some hospitals do hired temporary staffs of all categories for accreditation purposes and to show to the visitation panel that the hospital in question possess the required human capital resources. They further recognized the situation whereby medical doctors in government owned hospitals divert patients to their privately owned hospitals or that which they have retainership with as a consultant.

At the long run, the indices of corruption makes efficient and judicious utilization of resources difficult, erode into the effective performance of the health care personnel and making it

difficult to deliver the required services and thus making access to emergency health care a mirage.

CONCLUSION

The health system is the aggregation of all elements in the health environment, all working together to achieve the objective of the health system. In this chapter, I have taking a look at these elements from the fact of their existence and how their non-existence can affect access to emergency healthcare services. I have argued in this chapter, that adequate manpower is needed in the health sector and at the right proportion in relation to the population of the country, the need to train health workers handling emergency situation on the required skills needed to excel. I did show that the large population of the country needed to be adequately provided for in terms of the ratio of health worker to the patients. I was able to bring to fore in this chapter the effect of inadequate funding of the health sector, especially the budgetary allocation from the Federal government which falls below the AU agreed 15% allocation. The economic situation of the citizens was also highlighted, wherein I was able to show that lack of economic power do in some cases affects access to emergency healthcare especially where the person is not a subscriber to the NHIS. The precarious nature of most of the healthcare facilities was also looked at, judging from the non-availability of an emergency ward in most of the hospitals and where available, they are usually overcrowded. The impact of lack of drug bank and oxygen tank was also highlighted. The poor number of ambulance services to cater for millions especially in Lagos which was adjudged the best in the country was examined. The uncontrolled and uncoordinated government policies in the area of health were also examined. I finally examined the effect of government bureaucracy and corruption as it affects government officials, health workers and the patients alike in relation to having access to emergency healthcare.

This finding in these areas now leads to the next objective of this research work, and this bothers on the appraisal of the existing legal and regulatory framework on access to emergency healthcare in Nigeria.

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