PROPOSALS FOR THE FULL IMPLEMENTATION OF THE NATIONAL HEALTH ACT

(Proposed by Centre for Social Justice)

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ABBREVIATIONS

BHCPF	Basic Health Care Provision Fund
FMoH	Federal Ministry of Health
MTSS	Medium Term Sector Strategies
NCH	National Council on Health
NHA	National Health Act
NHHRP	National Health and Human Resource Plan
NHIA	National Health Insurance Authority
NHIAA	National Health Insurance Authority Act
S.	Section
UHC	Universal Health Coverage

1. INTRODUCTION

The National Health Act (NHA) was made to provide a legal framework for the regulation, development and management of the National Health System and to set standards for rendering health services in the Federation and for related matters. The National Health System established under the Act has as part of its objectives the protection, promotion and fulfilment of the right of Nigerians to have access to health care services as it seeks to provide for persons living in Nigeria, the best possible health services within the limits of available resources.

The National Health System sets out the rights and obligations of health care providers, health workers, health establishments and users. It promotes a spirit of cooperation and shared responsibility among all providers of health services in the Federation. These provisions of the Act are in tandem with Nigeria's treaty obligations (especially, under the International Covenant on Economic, Social and Cultural Rights) to take steps, to the maximum of available resources, with a view to achieving progressively the full realization of the right to health.

The NHA has a number of other provisions which potentially will improve the realization of the right to health of Nigerians. These include the mandate of the Federal Ministry of Health (FMoH) under S.2 (2) to prepare strategic medium-term health and human resource plans annually for the exercise of its powers and the performance of its duties under the Act. The FMoH is to ensure that the national health plan forms the basis for budget preparation and other government planning exercise as may be required by law. The FMoH is to ensure the continuous monitoring, evaluation and analysis of health status and performance of the functions of all aspects of the National Health System; promote adherence to norms and standards for the training of human resources for health; conduct and facilitate health systems research in the planning, evaluation and management of health services; collaborate with the states and local governments to ensure that appropriate mechanisms are set up for the implementation of the National Health Policy; determine the minimum data required to monitor the status and use of resources; etc.

The National Council on Health (NCH) established by the NHA has the responsibility for the protection, promotion, improvement and maintenance of the health of the citizens of Nigeria; ensure the delivery of basic health services to the people of Nigeria and prioritize other health services that may be provided within available resources; advise the Government of the Federation on technical matters relating to the organization, delivery and distribution of health services; issue, and promote adherence to norms and standards, and provide guidelines on health matters, and any other matter that affects the health status of the people; identify health goals and priorities for the nation as a whole and monitor the progress of their implementation; offer advice to the Government of the Federation, through the Minister, on matters relating to the development of national guidelines on health and the implementation and administration of the National Health Policy; etc.

The NHA established the National Tertiary Health Institutions Standards Committee with the mandate to prepare periodic master plans for balanced and coordinated development of tertiary hospitals in Nigeria; establish minimum standards to be attained by the various tertiary health facilities in the nation and also to inspect and accredit such facilities; advise the Federal Government on the financial needs, both recurrent and capital, of tertiary health services and in particular investigate and study the financial needs for training, research and services and make appropriate recommendations for these; set standards and criteria for allocation of funds from the Federal Government to tertiary health institutions and monitor their utilization, source for grants as laid down by the Committee; monitor and evaluate all activities and receive annual reports from the tertiary hospitals and supervise annual peer reviews; etc.

The above and other provisions of the NHA if fully implemented will go a long way to promote the realization of the right to health of Nigerians. Improving the realization of the right to health of citizens and residents is perhaps one of Nigeria's greatest developmental challenges. Under national and international standards, Nigeria is under obligation to use the maximum of its available resources for the progressive realization of the right to health. This is based on the understanding that the right to health is integral to the right to life, which is the fulcrum upon which other rights revolve. Consequently, full implementation of the NHA should not be negotiable because it is directly proportional to the realization of the right to health of Nigerians.

Some of the benefits of full implementation of the NHA include:

a. ***Universal Healthcare Coverage:*** The NHA emphasizes the principle of universal health coverage (UHC), which means inter alia that everyone should have access to the health care services they require, at the time and place they require them without financial hardship. This involves the full spectrum of health services according to need; financial protection from direct payment for health services when consumed and coverage for the entire population. By fully implementing the NHA, the government will be working towards achieving UHC, ensuring that no one is left behind and reducing health disparities in the population.

b. ***Improved Health Outcomes:*** The NHA includes provisions for the establishment of healthcare standards, guidelines, and protocols to ensure the delivery of high-quality health services. By implementing these provisions, healthcare providers will be held accountable for the quality of care they deliver, leading to improved health outcomes for Nigerians.

c. ***Health System Efficiency:*** The NHA promotes the integration and coordination of healthcare services, aiming to create a more efficient and streamlined healthcare system. By fully implementing the NHA, barriers to effective healthcare delivery, such as fragmented services and lack of coordination, can be addressed. This can lead to reduced healthcare costs, optimized resource allocation, and improved patient experiences. Full implementation can lead to three dimensions of value for

money vis; less money for same health outcomes, same amount of money for greater health outcomes, and greater amount of money for greater health outcomes.

d. ***Patient Rights and Protection:*** The NHA emphasizes the rights and protection of patients, including their right to access healthcare services, informed consent, privacy and confidentiality. Full implementation of the NHA will ensure that these rights are respected and upheld, empowering patients and improving doctor-patient relationship.

e. ***Health Workforce Development:*** The NHA recognizes the importance of a skilled and motivated healthcare workforce. By fully implementing the NHA, initiatives for healthcare workforce development, including training, retention, and equitable distribution of healthcare professionals, can be effectively implemented. This will strengthen the healthcare workforce, ensuring adequate supply of qualified healthcare professionals to meet the needs of the population.

f. ***Health Promotion and Disease Prevention:*** The NHA emphasizes the importance of health promotion and disease prevention strategies to improve the health of the population. By implementing these provisions, the government can invest in preventive measures, such as vaccination campaigns, health education programs, and early detection initiatives. This proactive approach can lead to a healthier population and reduce the burden on the healthcare system.

g. ***Stakeholder Engagement and Participation:*** The NHA encourages active participation and engagement of stakeholders, including patients, healthcare providers, and civil society organizations, in healthcare decision-making processes. Full implementation of the NHA will create mechanisms for meaningful engagement, allowing diverse perspectives to be considered and ensuring that policies and programs are responsive to the needs of the population.

2. KEY GAPS IN THE IMPLEMENTATION OF THE NATIONAL HEALTH ACT

2.1 NATIONAL HEALTH AND HUMAN RESOURCE PLANS AS THE BASIS OF THE ANNUAL HEALTH BUDGET

Section 2 (2) (a) and (b) of the NHA states that:

Without prejudice to the foregoing functions, the Federal Ministry of Health shall -

(a) prepare strategic medium-term health and human resource plans annually for the exercise of its powers and the performance of its duties under this Act;

(b) ensure that the national health plans referred to in paragraph (a) of this subsection shall form the basis of-

(i) the annual budget proposal as required by the Federal Ministry of Finance; and

(ii) other government planning exercises as may be required by any other law"

In the spirit of the policy, plan and budget continuum, the budget of the FMoH should not be a stand-alone document. The budget is meant to provide resources for the implementation of plans, policies and laws. In the context of the above provision, this refers to the medium-term sector strategies (MTSS) for the health sector. This should be prepared by a sector team including representatives of the FMoH headquarters and agencies under the ministry, professional associations, organized labour, private sector and civil society, etc. This provision has been obeyed in the breach.

Some of the consequences of misalignment between plans and policies and the budget include:

a. ***Inadequate Resource Allocation:*** The national health and human resource plan (NHHRP) serves as a blueprint for allocating resources effectively and efficiently to address the country's healthcare needs. If there is no plan, there is a risk of inadequate funds being allocated to essential areas, such as preventive care, infrastructure development, healthcare workforce training, and the procurement of necessary medical supplies and equipment. This can lead to a shortage of resources, impacting the quality and availability of healthcare services.

b. ***Lack of Strategic Focus:*** The NHHRP provides a strategic direction for the healthcare system. It outlines priorities, targets, and specific strategies to achieve desired health outcomes. The absence of a plan can result in a lack of focus and coordination in addressing key health issues. This may lead to fragmented efforts, duplication of services, and inefficiencies within the healthcare system. Furthermore, expenditures will not be aligned to key policy goals such that there will be a disconnect between public spending and key policy objectives.

c. ***Suboptimal Health Outcomes:*** The NHHRP is designed to improve health outcomes by addressing prevalent health challenges, reducing health disparities, and promoting population health. Failure to plan or adhere to the plan may hinder progress in achieving these objectives. Without proper funding and strategic implementation, it becomes difficult to tackle important health issues effectively, resulting in suboptimal health outcomes for the population.

d. ***Increased healthcare Costs:*** Adhering to the NHHRP facilitates cost reduction and efficient resource utilization. Budgeting without a plan can lead to haphazard spending and inefficiencies within the healthcare system. This can result in

escalating healthcare costs without corresponding improvements in health outcomes, putting a strain on the overall health budget.

e. ***Diminished Public Ownership:*** The NHHRP facilitates transparency, accountability and popular participation in healthcare decision-making. The participation of stakeholders in the MTSS formulation builds public confidence and ownership of the budget thereby improving the chance of realizing programme results and meeting milestones.

Section 41 of the NHA is on the development and provision of human resources in the National Health System. It states:

> *(1) The National Council on Health shall develop policy and guidelines for, and monitor the provision, distribution, development, management and utilisation of human resources within the national health system.*
>
> *(2) The policy and guidelines stated in subsection (1) of this section shall amongst other things, facilitate and advance:*
>
> > *(a) the adequate distribution of human resources;*
> >
> > *(b) the provision of appropriately trained staff at all levels of the National Health System to meet the population's health care needs; and*
> >
> > *(c) the effective and efficient utilisation, functioning, management and support of human resources within the national health system".*

By S.43. detailed provisions are made on human resources for health:

> *The Minister shall make regulations with regard to human resources management within the national health system in order to:*
>
> > *(a) ensure that adequate resources are available for the education and training of health care personnel to meet the human resources requirements of the national health system;*
> >
> > *(b) ensure the education and training of health care personnel to meet the requirements of the national health system, including the prescription of a re-certification programme through a system of continuing professional development;*
> >
> > *(c) create new categories of health care personnel to be educated or trained in conjunction with the appropriate authority;*
> >
> > *(d) identify shortages of key skills, expertise and competence within the national health system, and prescribe strategies which are not in conflict with any other existing legislation, for the education and training of health care providers or health workers in the Federation to make up for any shortfall in respect of any skill, expertise and competence; and*

(e) prescribe strategies for the recruitment and retention 'of health care personnel within the national health system and from anywhere outside Nigeria;

(f) ensure the existence of adequate structures for human resources planning, development and management at national, state and local government levels of the national health system in conjunction with the National Council on Health;

(g) ensure the availability of institutional capacity at state and local governments levels of the national health system to plan for, develop and manage human resources in conjunction with the National Council on Health;

(h) ensure the definition and clarification of the roles and functions of the Federal Ministry of Health, state ministries of health and local government health authorities with regard to the planning, production and management of human resources in conjunction with the National Council on Health; and

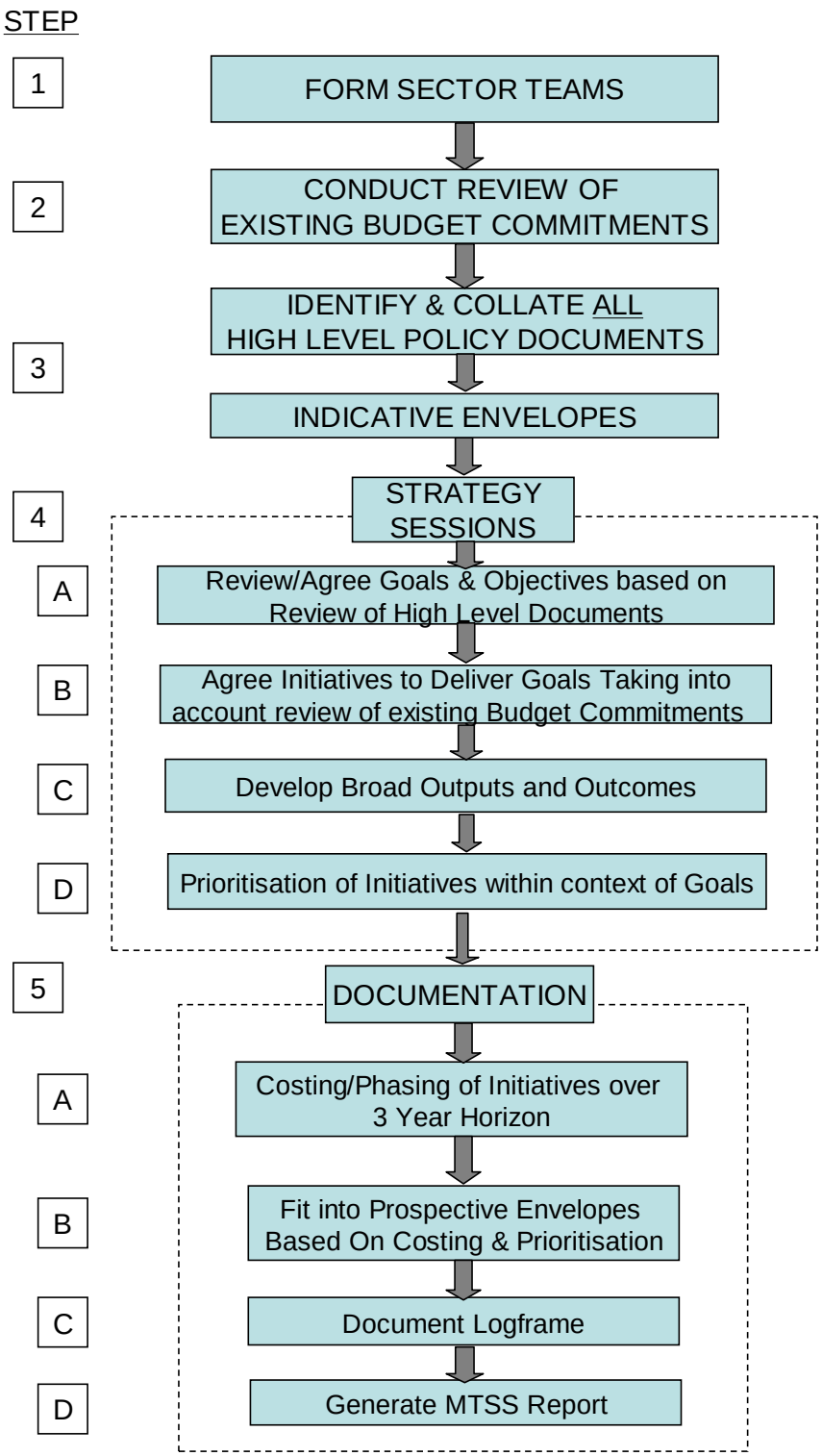
(i) prescribe circumstances under which health care personnel may be recruited from other countries to provide health services in the Federation.

It is further provided in S.44 of the NHA that:

> *The National Council on Health shall ensure that there is adequate plan for manpower development throughout the Federation or any part thereof to keep pace with evolving trends of expansion and improvement in health care delivery.*

Recommendations: The FMoH should commence the yearly preparation of MTSS including a human resource plan. The Human Resource Plan will identify available human resources and their alignment to the needs of the sector; make projections for future human resource needs while aligning the forces of demand and supply in support of high-level strategic goals of the health sector. This will involve analysis of sectoral plans and objectives; preparing a human resource inventory; assessing future supply and demand; matching supply and demand and preparing an action plan. Essentially, it ensures proactivity and the continued supply of the right skills and competencies to meet UHC and other goals of the health sector. The Human Resources Plan facilitates the operationalization of Human Resources for Health Policy and the provisions of the NHA at various levels of governance. It should deal with identified gaps, critical challenges like brain drain/emigration in the sector, availability of health workers in rural and underserved areas and funding for training of unavailable critical competencies.

This is the roadmap for the MTSS


STEP
1
FORM SECTOR TEAMS
2
CONDUCT REVIEW OF EXISTING BUDGET COMMITMENTS
3
IDENTIFY & COLLATE ALL HIGH LEVEL POLICY DOCUMENTS
INDICATIVE ENVELOPES
4
STRATEGY SESSIONS
A
Review/Agree Goals & Objectives based on Review of High Level Documents
B
Agree Initiatives to Deliver Goals Taking into account review of existing Budget Commitments
C
Develop Broad Outputs and Outcomes
D
Prioritisation of Initiatives within context of Goals
5
DOCUMENTATION
A
Costing/Phasing of Initiatives over 3 Year Horizon
B
Fit into Prospective Envelopes Based On Costing & Prioritisation
C
Document Logframe
D
Generate MTSS Report

The MTSS should be prepared by a sector team including representatives of the FMoH headquarters and agencies under the ministry, professional associations, organized labour and private sector, civil society, etc. The MTSS should identify high level policies and plans, their milestones, deliverables and results and thereafter prioritise old and new projects within the context of available resources and phase their implementation over the medium term.

The MTSS is the MDA/sectoral expenditure plan that has the following objectives:

- Articulates medium-term (three years) goals and objectives against the background of the overall goals of overarching high-level policies, the attainment of the SDGs, etc.
- Identifies and documents the key initiatives (that is, projects and programs) that will be embarked upon to achieve the goals and objectives.
- Costs the identified key initiatives in a clear and transparent manner.
- Phases implementation of the identified initiatives over the medium-term.
- Defines the expected outcomes of the identified initiatives in clear measurable terms; and
- Links expected outcomes to their objectives and goals.

2.2 ANNUAL REPORT ON THE STATE OF HEALTH OF NIGERIANS AND THE NATIONAL HEALTH SYSTEM

Section 2 (2) (d) of the NHA states that:

Without prejudice to the foregoing functions, the Federal Ministry of Health shall -

(d) ensure the preparation and presentation of an annual report of the state of health of Nigerians and the National Health System to the President and the National Assembly

Also, section 35 of the NHA states that:

(1) The Federal Ministry of Health shall facilitate and co-ordinate the establishment, implementation and maintenance by State Ministries, Local Government Health Authorities and the private health sector of the health information systems at national, state and local government levels in order to create a comprehensive National Health Management Information System.

(2) The Minister may, for the purpose of creating, maintaining or adapting databases within the national health information system desired in subsection (1)

of this section, prescribe categories or kinds of data for submission and collection and the manner and format in which and by whom the data is to be compiled or collated and shall be submitted to the Federal Ministry of Health.

(3) The Minister and Commissioners shall publish annual reports on the state of health of the citizenry and the health system of Nigeria including the States thereof.

A similar duty is created for the Federal Capital Territory (FCT) and its Area Councils in sections. 36 and 37 of the NHA. Furthermore, S.38 of the NHA provides duties for private healthcare providers under the national health information system.

(*1) All private healthcare providers shall:-*

(a) establish and maintain a health information system as part of the national health information system as specified under section 35 (1) of this Act; and

(b) ensure compliance with the provision of sub-section (1)(a) of this section as a condition necessary for the grant or renewal of the Certificate of Standards.

(2) Any private healthcare provider that neglects or fails to comply with the provision of subsection (1) of this section commits an offence and is liable on conviction to imprisonment for a term of six months or a fine of N100,000 or both.

(3) Nothing in this section precludes a State Assembly from making laws with regards to health information system for that State and the Local Government Areas and the private health sector within that State.

It appears that compliance with S.2 (2) (d) of the NHA is contingent on the full implementation of sections 35, 36, 37 and 38 of the same law. Implementing sections 35, 36,37 and 38 will provide the information required to prepare and present the annual report. From the commencement date of the NHA in 2014 till date, no report has been prepared and presented as an annual report of the state of health of Nigerians and the national health system to the President and the National Assembly.

A report on the state of health of Nigerians and the strength of the national health system provides a means of holding government officials and health authorities accountable for their actions and decisions. Regular reports on the state of health of Nigerians and the strength of the national health system will facilitate the identification of emerging health challenges, trends, and disparities within the population. Reports on the state of health and the strength of the national health system serve as essential references for planning and policy development. They provide insights into areas requiring improvement, areas of success, and overall health priorities. The process of preparing the report also facilitates the collation of health system information and data.

Recommendation: The Minister should ensure the full implementation of the health information system required by SS.35, 36, 37 and 38 of the NHA. Prepare the report envisaged in S.2 (2) (d) in clear and concise language that can be easily understood by

a wide range of readers; present the data and outcome indicators in tables, charts, and graphs to enhance visual understanding; provide explanations and interpretations for the data, highlighting both positive and negative trends. Based on the findings of the report, include recommendations for improving the state of the health system and healthcare. These recommendations should be practical, evidence-based, and actionable. The report should address key areas of concern and propose strategies for intervention and improvement. State commissioners for health should prepare similar reports at the state level for submission to the governor and State House of Assembly.

2.3 ELIGIBILITY FOR EXEMPTION FROM PAYMENT FOR HEALTH SERVICES IN PUBLIC HOSPITALS FOR CERTAIN CATEGORIES OF PERSONS

S. 3 (1) and (2) and S.15 (2) of the NHA are relevant to this specific discourse.

> ***3.****-(1) The Minister, in consultation with the National Council on Health, may prescribe conditions subject to which categories of persons may be eligible for exemption from payment for health care services at public health establishments.*
>
> *(2) In prescribing any conditions under subsection (1), the Minister for health shall have regard to-*
>
> *(a) the range of exempt health services currently available;*
>
> *(b) the categories of persons already receiving exemption from payment for health services;*
>
> *(c) the impact of any such condition on access to health services; and*
>
> *(d) the needs of vulnerable groups such as women, children, older persons and persons with disabilities.*

This is further reinforced by S.15 (2) of the NHA as follows:

> *15. (2) The Minister, in consultation with the National Council on Health, may prescribe conditions subject to which categories of persons may be eligible for exemption from payment for health care services rendered by public health establishments.*

These provisions on eligibility for exemption from payment for health services in public hospitals for certain categories of persons have not been implemented. The conditions and criteria for exemption have not been stipulated. Indeed, subsection (3) indirectly drew up a suggestive list of vulnerable persons such as women, children, older persons and persons with disabilities. Vulnerable group is defined in the interpretative S.59 of the National Health Insurance Authority Act (NHIAA) as including children under five, pregnant women, the aged, physically and mentally challenged, and the indigent as may be defined from time to time. This also provides a guide to the Minister.

When this section is read in conjunction with S.26 of the NHIAA, more clarity is provided and the task of the Minister becomes easier. S.26 on the objectives of the Vulnerable

Group Fund created by S.25 of the NHIAA states that it is to provide finances to subsidize the cost of healthcare for vulnerable persons in Nigeria. It is for subsidy on health insurance coverage and the payment of premiums for vulnerable persons.

Recommendation: The Minister in consultation with the NCH should follow the lead already set in the NHIAA on eligibility for exemption from payment for health services in public hospitals. This should be tied to the free services obtainable under the health insurance window of the BHCPF and the Vulnerable Group Fund as well as the social health insurance interventions of states.

2.4 STATE AND LOCAL GOVERNMENT COUNTERPART FUNDING UNDER THE BASIC HEALTH CARE PROVISION ACT

S.11 (1) of the NHA establishes the Basic Health Care Provision Fund (BHCPF) and by subsection (5):

(*5) For any State or Local Government to qualify for a block grant pursuant to sub-section (1) of this section, such State or Local Government shall contribute:*

(a) in the case of a State, not less than 25 per cent of the total cost of projects; and

(b) In the case of a Local government, not less than 25 per cent of the total cost of projects as their commitment in the execution of such projects.

Available information indicates that only 12 of the 36 state governments and the FCT are paying their counterpart funding of the BHCPF. This brings to the fore the need for full implementation of the NHA in this regard or devising other strategies to get states to commit resources to the BHCPF.

Recommendations: States should be persuaded and nudged to come up with their counterpart funds. The medium to long-term strategy should be to use this opportunity to raise more funds for the BHCPF and the VGF of the NHIAA through engagement with the Nigeria Governors Forum leading to an amendment of the NHA (or any other relevant law) to route funding of the BHCPF through the Federation Account. 2% of the Federation Account Allocations will yield more revenue and will not require any counterpart funding from the states.

2.5 CLASSIFICATION OF HEALTH ESTABLISHMENTS AND TECHNOLOGIES

This is provided in S.12 of the NHA.

12. (1) The Minister shall, by regulation-

(a) classify all health establishments and technologies into such categories as may be appropriate, based on-

(i) their role and function within the national health system,

(ii) the size and location of the communities they serve,

(iii) the nature and level of health services they are able to provide,

(iv) their geographical location and demographic reach,

(v) the need to structure the delivery of health services in accordance with national norms and standards within an integrated and coordinated national framework, and

(vi) in the case of private health establishments, whether the establishment is for profit or not, and

(b) in the case of federally owned tertiary hospitals, determine the establishment of the hospital board and the management system of such tertiary hospital.

(2) Nothing in this section shall preclude the House of Assembly of any State from making laws for that State for the regulation and inspection of public, private and non-governmental health facilities in that State.

The information contained in this classification, especially when published and made available to Nigerians will improve access and usage of existing health facilities and competencies. It will also provide information for planning and budgeting since gaps, challenges and limitations of existing establishments and technologies will be known. This may also help to cut down on overseas medical tourism.

Recommendations: The Minister can start this classification through a review of existing databases and unofficial classifications. Information available from the national health information system established under SS. 35, 36, 37 and 38 of the NHA will be helpful in the classification exercise. The data of hospitals and institutions available to state Ministries of Health will be relevant. However, fresh collection of information will be imperative to ensure that changes in role, function, size, location and nature of services will be reflected. Classification of available technologies may require collaboration with other relevant government agencies. It will also require collection of data and relevant information.

2.6 PROPORTION OF REVENUE GENERATED BY PUBLIC HEALTH ESTABLISHMENTS TO BE RETAINED BY THE ESTABLISHMENT

S.15 (1) (b) of the NHA provides:

(1) The Minister, in respect of a tertiary hospital, and the Commissioner, in respect of all other public health establishments within the State in question, may:

(b) in consultation with the relevant treasury, determine the proportion of revenue generated by a particular public health establishment classified as a hospital that may be retained by that hospital, and how those funds may be used.

The criteria for the determination of the proportion of revenue generated by health establishments (hospitals), to be retained by the hospitals and how the funds may be spent should be a product of empirical evidence and applicable across board to all hospitals. Consultation with the treasury is a pre-condition to setting the applicable rules.

However, the extant practice seems not based on evidence. For instance, in the 2023 federal health budget, University College Ibadan has a projection in excess of N4billion while the Lagos University Teaching Hospital has a projection of a paltry N48million and Ahmadu Bello University Teaching hospital only N8.1million. The gap is very wide and unaccounted for. Many health agencies that should contribute to the revenue had zero contributions. There should be a transparent, accountable empirical standard, on the basis of which these Teaching Hospitals generate and retain revenue. As such, the variance between their respective retained revenue should be within respectable margins. Beyond Teaching Hospitals, this empirical approach should be applicable to the retained revenue of other agencies under the Ministry.

Recommendations: The Minister in consultation with the Ministry of Budget and Finance should prepare an empirical template, applicable across board to all tertiary determining the proportion of revenue generated by tertiary hospitals which may be retained by that hospital, and how those funds may be used. In consideration of their statutory role, it is important to consult the National Tertiary Health Institutions Standards Committee in the determination of the contents of the proposed template. Also, the commissioners at the state level should prepare a similar template applicable to state hospitals.

2.7 ENTITLEMENT OF ALL CITIZENS TO A BASIC MINIMUM PACKAGE OF HEALTH SERVICE

S. 15 (3) of the NHA states that:

Without prejudice to any prescription made by the Minister under subsection (2) of this section, all citizens shall be entitled to a basic minimum package of health services.

Basic minimum package of health services is interpreted in S.64 to mean the set of health services as may be prescribed from time to time by the Minister after consultation with the NCH. This basic minimum package has been elaborately defined in the BHCPF Guidelines. It is linked to the minimum core obligations of the state within the context of the minimum core content of the right to health under the African Charter on Human and Peoples Rights, the International Covenant on Economic, Social and Cultural Rights, the Convention on the Elimination of All forms of Discrimination against Women, etc. This is an obligation to satisfy, at the very least, minimum essential levels of healthcare for all citizens.

While the NHA guarantees every Nigerian the basic minimum package of health service, the reality is that the average Nigerian is not receiving the healthcare service. According to the BHCPF Guidelines, basic minimum package of health service includes so many aspects of primary and secondary care.

Recommendations: The Minister and the NCH should take steps to ensure there are adequate public resources for the implementation of this minimum core obligation of the state provided by national law. More resources will be required for this to be available to all Nigerians. The implementation of the compulsory health insurance regime provided in the NHIAA will facilitate the realization of the basic minimum package of health service for all Nigerians. The fragmentation of the premium resource pool (which will be available to State Health Insurance Authorities) needs to be addressed to create an overall larger and national pool to take care of insured health risks.

2.8 S.19: EVALUATING SERVICES OF HEALTH ESTABLISHMENTS

The NHA provides in S.19 that:

> *(1) All health establishments shall comply with the quality requirements and standards prescribed by the National Council on Health.*
>
> *(2) The quality requirements and standards stated in subsection (1) of this section may relate to human resources, health technology, equipment, hygiene, premises, the delivery of health services, business practices, safety and the manner in which users are accommodated and treated.*
>
> *(3) The National Tertiary Health Institutions Standards Committee shall monitor and enforce compliance with the quality requirements and standards stated in subsection (l) as it relates to Tertiary Hospitals.*

This provision requires compliance with quality requirements and standards to be prescribed by the NCH. It appears that some of these standards are not yet in place. Compliance can only be demanded in relation to existing standards or where standards have been set and compliance is not optimal. The challenges inherent in extant practices may have informed the Presidential Health Reform Committee's recommendations vis:

> *A National Healthcare Quality and Standards Commission (NHQSC) will be established. The NQHSC will primarily be responsible for setting standards for FTHIs. Also, the NHQSC will be the regulator and accreditor setting standards on structural quality, clinical processes, and patient outcomes in Nigeria. To align the incentives and strengthen the accountability framework of this commission, the ability of healthcare providers to enter contracts with the NHIA and other insurance systems shall be dependent on receiving its accreditation.*

Recommendations: The NCH has a mandate of issuing and promoting adherence to norms and standards, and provide guidelines on health matters, and any other matter that affects the health status of people. It should through its Technical Committee activate comprehensive standards setting and enforcement of compliance mechanisms**.** This should take cognizance of a part of the statutory mandate of the National Tertiary Health Institutions Standards Committee which is to establish minimum standards to be attained by the various tertiary health facilities in the nation and also to inspect and accredit such facilities.

2.9 RIGHT OF PERSONS TO EMERGENCY MEDICAL TREATMENT

Section 20 (1) and (2) of the NHA states that:

A health care provider, health worker or health establishment shall not refuse a person emergency medical treatment for any reason.

2) A person who contravenes this section commits an offence and is liable on conviction to a fine of N100, 000.00 or to imprisonment for a period not exceeding six months or to both.

The couching of subsection (1) is so wide and no reason suffices to exculpate a healthcare provider who fails to provide emergency medical treatment. There is even a specific law on the Compulsory Treatment and Care for Victims of Gunshot Act, 2017. This provision of the NHA is partially obeyed as some institutions still insist on police report before treatment of gunshot victims. But the provisions of the NHA have a critical challenge. It raises a fundamental question: is there a funding mechanism to support or reimburse a diligent private or even public healthcare provider institution that incurs costs on emergency medical treatment of a patient who is not covered by pre-paid health insurance? The nearest provision is the BHCPF which provides that:

5 per cent of the fund shall be used for emergency medical treatment to be administered by a Committee appointed by the National Council on Health.

The BHCPF Guidelines provide for the Emergency Medical Treatment Gateway and a National Emergency Medical Treatment Committee and State level equivalent. The Gateway requires accreditation of service providers, etc. Essentially, this Gateway is not functional and has hardly been operationalised to rescue anyone or reimburse healthcare providers.

The denial of a person's right to emergency medical treatment can have severe consequences, both for the individual involved and for society as a whole. Some of the potential consequences of such denial include:

a. ***Health Risks:*** Denial of emergency medical treatment can result in serious health risks for the person in need. Depending on the nature of their condition, delaying or denying treatment could lead to permanent disabilities, complications, or even death. Emergency medical interventions are often time-sensitive, and any delay can have detrimental effects on a person's health and well-being.

b. ***Ethical Concerns:*** Denying emergency medical treatment raises significant ethical concerns. The principle of medical ethics emphasizes the importance of providing care to those in need, especially in life-threatening situations. Healthcare professionals are bound by ethical codes that prioritize patient well-being and require them to provide care without discrimination. Denying treatment violates these ethical principles and can damage the trust between patients and healthcare providers.

c. ***Public Health Impact:*** If a person is denied emergency medical treatment due to their social or economic status, it can have broader implications for public health. Access to timely emergency care is crucial for containing the spread of contagious diseases, managing public health emergencies, and preventing the deterioration of health conditions that could affect others. Denying treatment to individuals in need could lead to increased transmission of diseases and worsen overall public health outcomes.

d. ***Societal Trust and Inequality:*** Denying emergency medical treatment can contribute to societal distrust and perpetuate existing inequalities. It may further marginalize vulnerable populations, such as those with limited financial resources, minority groups, or individuals without access to healthcare insurance. Such denial reinforces social disparities and undermines the fundamental principle of equal access to healthcare services.

Recommendations: The NCH should take expeditious steps to ensure that the Emergency Medical Treatment Gateway of the BHCPF is made operational and functional and its bureaucracy kept to a minimum to save lives. The Federal and State Ministries of Health should conduct public awareness campaigns to educate citizens about their right to emergency medical treatment. This can include disseminating information through various channels, such as media, healthcare facilities, community centers, and schools. Foster collaboration between healthcare providers, emergency responders, and government agencies to streamline the delivery of emergency medical treatment. Establish protocols for information sharing, ambulance services, referral systems, and coordinated care to ensure that citizens receive appropriate and timely treatment. Establish feedback channels for citizens to report any issues or concerns regarding their access to emergency medical treatment. This can include hotlines, online platforms, or dedicated offices where individuals can provide feedback, file complaints, or seek assistance. Finally, when the system is fully working, prosecute offenders of the law.

2.10 SLOW GROWTH OF THE HEALTH INSURANCE SCHEME UNDER THE WATCH OF THE NATIONAL COUNCIL ON HEALTH

Section 40 of the National Health Act states that:

It shall be the responsibility of the National Council on Health to ensure the widest possible catchments for the health insurance scheme throughout the Federation or any part thereof.

This provision should be read in conjunction with the provisions of the NHIAA which has made health insurance mandatory for all residents in Nigeria.

As at June 2023, less than 18million Nigerians or 8.5% of the population have been enrolled into public and private health insurance schemes including the BHCPF in Nigeria. From 2014 when the NHA commenced till date, the NCH collaborating with the former National Health Insurance Scheme should have been able to oversee the successful

implementation of interventions aimed at increasing health insurance enrollment to not less than 50% of Nigerians. Some of the consequences of the slow growth of health insurance schemes in Nigeria include:

a. ***Limited Access to Healthcare:*** A slow-growing health insurance enrolment results in limited coverage and access to healthcare services for a significant portion of the population. People without insurance or with inadequate coverage may face financial barriers when seeking medical care, leading to delayed or foregone treatments. This can negatively impact public health outcomes and exacerbate health inequalities.

b. ***Financial Burden on Individuals:*** Without robust health insurance coverage, individuals will bear a significant financial burden when faced with healthcare expenses. Out-of-pocket payments for medical services can lead to high costs, potentially pushing individuals and families into financial hardship, debt and poverty. This can deter people from seeking necessary healthcare or force them to choose less effective or lower-quality treatment options.

c. ***Strain on Healthcare Providers:*** In the absence of adequate insurance coverage, healthcare providers may experience financial strain. Providers may face challenges in receiving timely payments for services rendered, leading to reduced revenue streams. This can impact their ability to invest in infrastructure, technology, and quality improvement initiatives.

d. ***Limited Preventive Care and Early Intervention:*** Health insurance schemes often play crucial roles in supporting preventive care and early intervention services, such as screenings, vaccinations, and health education programs. Slow growth of the national health insurance scheme may result in insufficient resources to promote these services, leading to missed opportunities for disease prevention and early detection. As a result, the burden of illness may increase, and healthcare costs may rise in the long run.

e. ***Inequality in Healthcare Access:*** A slow-growing health insurance scheme can exacerbate existing inequalities in healthcare access. Those who can afford private health insurance or have access to employer-sponsored plans may receive better healthcare services compared to those who rely solely on the national health insurance scheme. This disparity can lead to a two-tier healthcare system, where individuals with better coverage receive more timely and comprehensive care, while others face barriers to accessing essential service.

f. ***Public Dissatisfaction and Loss of Trust:*** The slow growth (including quality improvements) of the national health insurance scheme leads to public dissatisfaction and loss of trust in the healthcare system and government institutions. Citizens may perceive the scheme as ineffective or incapable of meeting their healthcare needs. This can erode public confidence in the system's

ability to provide equitable and affordable healthcare, resulting in a broader loss of faith in the overall governance and social contract

Recommendations: In order to ensure progress in the figures of health insurance enrollment, the NCH in collaboration with the NHIA and State Health Insurance Authorities should ensure that the following is done:

a. ***Increased Resources to the BHCPF:*** Increase allocation to the social health insurance schemes through increased funding of the BHCPF. Instead of the current 1% of the consolidated revenue fund of the Federal Government, it could be changed to 2% of Federation Account belonging to the three tiers of government.

b. ***Public Awareness Campaigns:*** Launch a comprehensive public awareness campaign to educate individuals and communities about the benefits of health insurance and the specific features of the available schemes. Utilize various channels such as television, radio, print media, social media, and community outreach programs to reach a wide audience.

c. ***Enforce Mandatory Health Insurance:*** Introduce measures to ensure that health insurance which is compulsory in law is made compulsory in fact. Such measures include linking up with other government agencies such as lands registry, vehicle licensing, federal and state inland revenue services, etc., to make health insurance a prerequisite for accessing their services. NHIAA can consider direct enforcement activities.

d. ***Full Implementation of State Health Insurance Laws:*** Commence the enrolment of civil servants into the formal health insurance schemes at the state level. This will involve states contributing the required percentages as employers of the workers. Furthermore, states should start the full implementation of their respective health insurance/contributory health laws requiring the setting aside of one percent of their consolidated revenue funds to finance the health needs of the poorest of the poor.

e. ***Simplify Enrollment Process:*** Simplify the process of enrolling in health insurance schemes. Minimize paperwork, streamline the application process, and provide user-friendly online platforms for enrollment. Offer assistance through helplines or customer service centers to guide individuals through the enrollment process.

f. ***Community Outreach Programs:*** Organize community outreach programs in collaboration with local healthcare providers, NGOs, and community leaders. Conduct informational sessions, workshops, and enrollment drives in community centers, schools, and other public spaces to engage with the target population directly. Churches and mosques should also be engaged.

g. ***Continuous Evaluation and Improvement:*** Regularly evaluate the effectiveness of the health insurance schemes and make necessary improvements based on feedback and data analysis. Monitor the uptake of the schemes, identify any barriers or challenges, and adapt strategies accordingly.

2.11 INDUSTRIAL DISPUTES

S.45 of the NHA deals with industrial disputes.

> *(1) Without prejudice to the right of all cadres and all groups of health professionals to demand for better conditions of service, health services shall be classified as Essential Service, and subject to the provisions of the relevant law.*
>
> *(2) Pursuant to subsection (1) of this section, industrial disputes in the public sector of health shall be treated seriously and shall, on no account, cause the total disruption of health services delivery in public institutions of health in the Federation or in any part thereof.*
>
> *(3) Where the disruption of health services has occurred in any sector of the national health system, the Minister shall apply all reasonable measures to ensure a return to normalcy of any such disruption within 14 days of the occurrence thereof.*

This section has been more obeyed in the breach as countless strikes grounding service delivery in public health institutions have been the norm. Most of the strikes have been called on the refusal of the government to implement agreements reached with relevant unions through the process of negotiation and collective bargaining

Recommendations: FGN and the states should ensure that they fulfill agreements reached with industrial unions through the process of collective bargaining agreements. FGN and states should strive towards meeting the Abuja Declaration mandating not less than 15% of the budget for the health sector.

2.12 PUBLIC OFFICIALS SEEKING MEDICAL ATTENTION ABROAD AT PUBLIC EXPENSE

S.46 of the NHA states that:

> *Without prejudice to the right of any Nigerian to seek medical check-up, investigation or treatment anywhere within and outside Nigeria, no public officer of the Government of the Federation or any part thereof shall be sponsored for medical check-up, investigation or treatment abroad at public expense except in exceptional cases on the recommendation and referral by the medical board and which recommendation or referral shall be dully approved by the Minister or the Commissioner as the case may be.*

It has become the norm for public officials to seek medical attention abroad at public expense without following the provisions of the NHA. This development, contrary to the provisions of the NHA, has the following consequences.

a. ***Cost and Resource Allocation:*** Seeking medical treatment abroad can be significantly more expensive than receiving treatment in Nigeria, especially as it involves travel expenses and foreign medical fees. This can strain public funds and divert resources that could have been used to improve the local healthcare system or address other pressing needs. It is estimated that Nigeria spends more than $1billion every year on health tourism and a good part of this is funded from the public treasury.

b. ***Perception of Privilege and Inequality:*** Public officials using public funds for medical treatment abroad creates a perception of privilege and inequality. It can be seen as a demonstration of their access to resources and options that are not available to the general public. This can erode public trust in the fairness and equity of the healthcare system.

c. ***Lack of Confidence in Local Healthcare:*** When public officials choose to seek medical attention abroad, it suggests a lack of confidence in the quality or capabilities of the local healthcare system. This can undermine public confidence in the healthcare system, leading to a loss of faith in the abilities of local healthcare professionals and institutions.

d. ***Brain Drain and Talent Flight:*** If public officials consistently seek medical treatment abroad, it can contribute to brain drain and talent flight in the healthcare sector. This is because skilled healthcare professionals may feel undervalued or unsupported in their own country, leading them to pursue opportunities elsewhere. The loss of talented professionals can negatively impact the quality and capacity of the local healthcare system.

e. ***Political Backlash and Public Scrutiny:*** Public officials seeking medical treatment abroad may face political backlash and public scrutiny. This can arise from concerns about the misuse of public funds, questions about the necessity of seeking treatment abroad, and criticism regarding the official's commitment to the well-being of their constituents. It can also lead to negative media coverage and public opinion.

f. ***Missed Opportunities for Healthcare Improvement:*** If public officials opt for treatment abroad, it may divert attention and resources away from addressing systemic issues in the local healthcare system. Instead of investing in improving local healthcare infrastructure, training healthcare professionals, or expanding healthcare services, public funds may be spent on individual medical treatment abroad.

Recommendations: Enforce the section of the NHA and other laws and regulations that restrict the use of public funds for medical treatment abroad, except in exceptional cases. Enforce penalties for violations, ensuring accountability for public officials who misuse public resources. Encourage top-ranking public officials, including the president, ministers, and senior government officials, to utilize local healthcare services and demonstrate confidence in the domestic healthcare system. Their actions can influence the behavior of other officials and set a precedent. Foster partnerships with renowned international medical institutions and experts to provide consultation and expertise when needed. This can enable local healthcare providers to offer specialized care within the country, reducing the need for officials to seek medical attention abroad. Invest in and improve the quality of healthcare services within the country. Enhancing infrastructure, increasing medical facilities, and ensuring availability of skilled healthcare professionals will encourage public officials to seek medical treatment locally.

3. CONCLUSIONS

The full implementation of the NHA is crucial for improving health outcomes, strengthening the health system and ensuring access to quality healthcare for all Nigerians. By implementing the provisions outlined in the NHA, duty bearers can address the existing gaps in our healthcare system, strengthen primary healthcare services, and enhance the overall well-being of the population.

To achieve the full implementation of the NHA, it is imperative that governments demonstrate strong political will and allocate sufficient financial resources to support the necessary reforms. Additionally, effective coordination and collaboration between relevant stakeholders, including government agencies, healthcare providers, civil society organizations, and the private sector, is essential for successful implementation of the NHA. Moreover, it is essential to prioritize public awareness campaigns and community engagement initiatives to ensure that citizens are informed about their rights and entitlements under the NHA. This will empower individuals to actively participate in their healthcare decisions and hold the healthcare system accountable for delivering the promised services.

The full implementation of the NHA has the potential to transform our healthcare landscape, making it more equitable, accessible, and responsive to the needs of all citizens. By investing in preventive care, improving healthcare infrastructure, and strengthening health governance, we can build a healthier nation, reduce health inequalities, and lay the foundation for sustainable development.

Finally, the successful implementation of the NHA will require sustained commitment, collaboration, and resource allocation. However, the potential benefits are immense, including improved health outcomes, increased healthcare access, and enhanced overall well-being for all citizens. It is crucial for policymakers, healthcare providers, and the public to work together in ensuring the full implementation of the NHA, ultimately leading to a healthier and more prosperous nation.