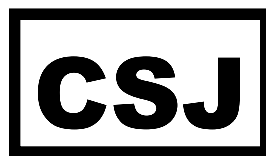
RIGHT TO HEALTH IN NIGERA

(A Review of Key Health Development Policies Against Federal Health Budgets 2009-2013)



Centre for Social Justice

(*Mainstreaming Social Justice In Public Life)*

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LIST OF ABBREVIATIONS

AI:	Amnesty International
AU:	African Union
BOF:	Budget Office of the Federation
CCT:	Conditional Cash Transfers
CHEWS:	Community Health Workers
CSJ:	Centre for Social Justice
CEDAW:	Convention on the Elimination of all forms of Discrimination against Women
CFRN:	Constitution of the Federal Republic of Nigeria
CISLAC:	Civil Society Legislative Advocacy Centre
CRC:	Convention on the Rights of the Child
ECA:	Excess Crude Account
ESCR:	Economic, Social and Cultural Rights
FGN:	Federal Government of Nigeria
FMOH:	Federal Ministry of Health
GAVI:	Global Alliance for Vaccines and Immunization
GDP:	Gross Domestic Product
GH:	General Hospital
HCD:	Human Capital Development
HERFON:	Health Reform Foundation
HRH:	Human Resources for Health
HSRC:	Health Sector Reform Coalition
ICESCR:	International Covenant on Economic, Social and Cultural Rights
ICERD:	International Convention on the Elimination of all forms of Racial Discrimination
IHRL:	International Human Rights Laws
KPPPs:	Key Policies, Programmes and Projects
LBs:	Life Births
LGAs:	Local Government Areas
MCH:	Maternal and Child Health

MNCH:	Maternal, Newborn and Child Health
MTEF:	Medium Term Expenditure Framework
MTSS:	Medium Term Sector Strategies
MDGs:	Millennium Development Goals
MHCP:	Minimal Health Care Package
MDAs:	Ministries, Departments and Agencies
NABRO:	National Assembly Budget and Research Office
NCH:	National Council on Health
NDHS:	National Demographics Health Survey
NDPs:	National Development Plans
NEED:	National Economic Empowerment and Development Strategy
NHP:	National Health Policy
NIP:	National Implementation Plan
NILS:	National Institute for Legislative Studies
NHB:	National Health Bill
NHIS:	National Health Insurance Scheme
NHMIS:	National Health Management Information System
NMRC:	National Medical Research Council
NPC:	National Planning Commission
NPC:	National Population Commission
NPHCDA:	National Primary Health Care Development Agency
NSHDP:	National Strategic Health Development Plan
NSHIP:	National Strategic Health Investment Plan
OOPE:	Out of Pocket Expenditure
PHC:	Primary Health Care
PHCDF:	Primary Health Care Development Fund
SERI:	Socioeconomic Rights Initiative
SWF:	Sovereign Wealth Fund
SURE-P:	Subsidy Reinvestment and Empowerment Programme
THE:	Total Health Expenditure
UDHR:	Universal Declaration of Human Rights

UN:	United Nations
USD:	United States Dollar
VAT:	Value Added Tax
WHO:	World Health Organization
WHR:	World Health Report

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EXECUTIVE SUMMARY

Chapter One is the introduction and affirms the strategic importance of health to national development and its relationship with productivity. It acknowledges that Nigeria's health indicators are poor. They do not measure up to the status of the country as a leading African country with vast human and natural resources. Nigeria is stated to have one of the worst health indicators in the World. The Chapter states the objectives, terns of reference, methodology and limitations of the Study. Specifically, the terms of reference are to:

- Review the alignment of federal health MTEF, budget allocation (appropriated and actual releases) to high level sectoral policy goals in the last five years;
- Review the alignment of recurrent and capital expenditure in the sector;
- Review the alignment of federal health budgets with best practices in budgeting;
- Review whether the FGN is using the maximum of available resources for the progressive realisation of the right to health;
- Make recommendations for the improvement of services and for greater value for money;
- Make recommendations for improved funding (including new sources) for the sector.

Chapter Two is on literature review, from national to international standards. It reviews the provisions of the 1999 Constitution, the African Charter on Human and Peoples' Rights and the International Covenant on Economic, Social and Cultural Rights. It specifically examines the normative framework of Article 2 (1) of the ICESCR which states that:

> *Each State Party to the Present Covenant undertakes to take steps, individually and through international assistance and cooperation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realisation of the rights recognized in the present Covenant by all appropriate means including particularly the adoption of legislative measures.*

The Study reviews the provisions of Vision 20:2020 and its First National Implementation Plan; the baseline positions and the projections for improvement. Also, the Transformation Agenda and the National Strategic Health Development Plan are reviewed. The Chapter concludes with a harmony analysis between the provisions of the components of the National Development Plans.

Chapter Three relates health specific development goals with Federal government's health expenditure 2009 - 2013. The first point is the disharmony in the fiscal projections of components of the NDPs. The second level of disharmony is that existing between annual

appropriations and all the components of the NDPs. It shows that budgeted sums are inadequate to meet the goals of the NDPs; what gets budgeted is not fully released and what gets released is not fully utilised. The percentage allocation to health is low beneath regional and international standards; capital and recurrent expenditure is mis-aligned and recurrent spending is over 90% personnel vote. SURE-P intervention in health focused mainly on PHC has recorded some success but it is still held down in a myriad of challenges.

Chapter Four is the matters arising from fiscal and literature review. It discusses the alignment of federal health spending with best practices in public finance management. The checklist to assess the performance of federal health spending returns a verdict that health expenditure is non-compliant to best practices in the sector. The second part of the Chapter focuses on whether Nigeria is using the maximum of available resources for the progressive realisation of the right to health. It reviews the health indicators including life expectancy at birth, maternal, infant and under-5% mortality rates; hospital bed density, physicians and other health professionals' density. The Chapter further reviews the issue of framework laws, total health expenditure, the absence of MTSS and MTEF prepared through popular participation and stakeholder input; poor oversight over health finances and outcomes, wasteful and frivolous expenditure, etc.

Chapter five is the conclusions and recommendations. The recommendations are stated as follows.

1. Harmonisation of the Fiscal Projections of NDPs

High level policies and plans provide the framework for budgeting and provision of finances for every sector. Even though the high level policy documents in health are virtually in agreement in terms of their objectives and what they intend to achieve, their fiscal projections vary and contradict one another. It is therefore imperative for these fiscal projections to be harmonised for effective resource provision to the sector. The policies whose fiscal projections should be harmonised include Vision 20:2020 and its First NIP, the NSHDP, TA and MTEFs.

2. Increase Resource Allocation to the Sector

(i) Resource allocation for the right to health should be adequate and aligned with the fiscal projections of the NDPs. Urgent investments in the nation's healthcare system especially through increased allocations to the sector is imperative.

(ii) As a minimum, 15% of the federal budget should be dedicated to the health sector and governments should keep faith with the commitments entered into under the Nigerian Partnership for Health.

3. Full Release and Cash-Backing of all Appropriated Funds
All sums budgeted for the right to health should be released and cash-backed by the MoF and BOF and fully utilised by the MoH. The releases for the sector should be prioritised.

4. Improve Absorptive Capacity of MoH
To improve the absorptive capacity of the FMoH requires capacity building in procurement reforms and management for the personnel of the FMoH.

5. Realign the Structure of Health Spending
(i) It is imperative to realign the structure of health spending in order to strike a balance between recurrent and capital expenditure in the health sector. Non alignment of funding to the major components of healthcare delivery (personnel, infrastructure and equipment, logistics, vaccines and other supplies, etc) will lead to policy failure. While continuing with improvements in the service conditions of medical staff, more investments are required in capital expenditure and the non salary components of recurrent spending.

(ii) The skewed allocation in favour of tertiary health care and curative services should be reconsidered in subsequent budgets in favour of PHC and this should respond to the predominant disease burdens of Nigeria.

6. Enhance Value for Money
FGN should take targeted and concrete steps to enhance value for money in the health sector. It will not be enough to increase funding to the sector; a full health budget expenditure review and thorough review of the sectoral challenges should precede increased allocations. Leakages should be plugged and misappropriated resources should be recovered.

7. Revive MTSS, MTEF in the Education Sector
Under the Fiscal Responsibility Act 2007, the MTEF is the basis for the annual budget. However, the MTEF is preceded by the MTSS which brings stakeholders in the MDA together; they review high level policy documents, get out the goals and objectives of the policies; review ongoing and new projects and their contributions to attaining sectoral goals; prioritise and cost them and finally fit them into the available resource envelope. The stakeholders will include MDA personnel, representatives of the oversight committees in the legislature, professional groups, organised private sector and civil society organisations working in the health sector. The MTSS will ensure that budgets are aligned to sectoral goals and plans and improve operational and allocative efficiencies.

8. Cut Down the Cost of Health Governance

It is imperative to implement the recommendations of the Oronsaye Committee on the governance of the health sector. Specifically, pruning the number of boards of teaching hospitals, federal medical centres, orthopaedic and psychiatric hospitals should be the beginning point.

9. Verify the Minimum Core Obligations and the Minimum Core Content of the Right to Health in Nigeria

The FGN in collaboration with state governments should in accordance with our obligations under the ICESCR and other standards define the minimum core obligations of the state and the minimum content of the right to health within the context of available and potential resources. These core obligations should respond to the prevalent disease conditions as demonstrated by epidemiological data and prevalent health indicators.

10. Devise Alternative and Complimentary Means of Funding

FGN and states should explore alternative and complimentary means of funding the realisation of the right to health. This will include:

- Setting aside of 2% of the Consolidated Revenue Fund of the Federation and the States to a special fund for PHC. This will be modelled after the Universal Basic Education Fund.

- The National Health Insurance Scheme should be expanded to become compulsory for al Nigerians as this would raise a huge pool of funds for the sector. There is need to ensure that our health system moves away from the OOPE to draw contributions through a pre-payment system. Put simply, the National Health Insurance Scheme (NHIS) Act requires urgent amendment to make provision for the extension of coverage to ensure that all Nigerians are entitled to a guaranteed minimum package of health services through legally sanctioned pre-payment and risk pooling system.

- Minimal surcharges from the tariffs of GSM telephone companies will also raise hundreds of billions for health services every year.

- A Special Health Fund set aside by the Central Bank of Nigeria attracting minimal interest and service charges for financing health infrastructure and equipment.

11. Enact Framework Law(s)

(i) The National Health Bill and any other framework laws should be considered expeditiously by the National Assembly and assented to by the President.

(ii) Components of the right to health specifically, the right to primary health care including maternal, new born and child health, immunisation, etc should be made justiciable rights and transferred to Chapter 4 of the 1999 Nigerian Constitution (the Fundamental Rights Chapter).

12. Stop Public Funding of Medical Tourism

To guarantee the commitment and political will of government, it is imperative to stop the payment for foreign medical trips by the treasury. All public officers should be treated in Nigerian hospitals and anyone who desires foreign medical treatment should pay from his pockets. This will stem the resources lost to medical tourism and ensure that policy makers who are treated abroad get committed to reforming the sector.

13. Improve Legislative Oversight

Considering the poor health outcomes and indicators and other challenges facing the sector, the oversight role of the legislature is very crucial for the revitalisation of the health sector. The leadership and relevant committees of the legislature should intensify oversight over the sector. Health budgets should be crafted with definite milestones and deliverables which can be monitored and evaluated over the budget year. Simply providing resources for the FMoH without any indicators to establish the achievement of targets is a waste of time. Institutions should be required to provide on a quarterly or half-yearly basis reports that show how utilisation of public resources have contributed to the achievement of sectoral targets and objectives.

14. Improve Civil Society Oversight

Although some work has been done in the health sector, civil society organisations need to invest more time and energy in advocating for improvements, tracking and reporting and seeking compliance with laws and policies on health. The CSOs include the NGOs, media, faith based groups etc. The use of the Freedom of Information procedure to get information concerning health funding, disbursement and prudent utilisation of resources is also imperative. Communities where PHCs are located should take more interest in their management, quality of service delivery and financing.

Chapter One

INTRODUCTION

1.1 INTRODUCTION

The strategic importance of health to overall national development has been well espoused in development literature[1] and recognised in several of Nigeria's development blueprints such as the National Economic Empowerment and Development Strategy (NEEDS), Vision 20:2020, the 7-Point Agenda of Yar' Adua's Administration as well as the Transformation Agenda of the incumbent Jonathan Administration. According to a Federal Ministry of Health (FMOH) document[2], the centrality of health to national development and poverty reduction is self-evident as improving health status and increasing life expectancy contributes to long term economic development. As a means to productive life, health is a functional need and it is essential to guaranteeing the wellbeing of people. It has a direct impact on national development given that public health problems could pose serious socioeconomic, political and even security threats to millions of people if not addressed. In essence, good health is part of the foundation for building a stable economy as poor health undermines national development, reinforces the existing cycle of poverty, exacerbates political instability, and hinders ability to access educational opportunities or hold a job. Therefore, the role of health in development is underpinned by its role as an enabler; hence the aphorism, *health is wealth.*

The development of any nation has a direct relationship with the productivity of its workforce, because a healthy workforce tends to be more productive. The quality of human resources remains a critical success factor in the development process. Human capital development is a process of building a productive, competitive and functional human resource base for economic growth and social development. By definition, human capital refers to the stock of competencies, skills, knowledge and personal attributes embodied in the ability of labour to produce goods and services[3]. From a macroeconomic point of view, the accumulation of human capacity facilitates technological innovations, increases returns to capital and makes growth more sustainable[4]. As such, human capital is regarded as a key factor of production in the economy, more so, as human beings constitute the ultimate reason for production. Thus, improving the productivity of the people, protecting the vulnerable in the society

[1] See *Report of WHO Commission on Macroeconomics and Health* for detailed analysis.
[2] FMOH (2010); the National Strategic Health Development Plan (2010-2015). P. 11
[3] See the Introduction to Human Capital Development in the Transformation Agenda
[4] Ibid.

and enhancing their well being and quality of life are at the heart of human development.

Health has been articulated as a basic human right:[5]

> *Health is a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity. The realisation of the right to health may be pursued through numerous, complementary approaches, such as the formulation of health policies, or the implementation of health programmes developed by the World Health Organization (WHO), or the adoption of specific legal instruments. Moreover, the right to health includes certain components which are legally enforceable*

Nigeria is bound by national and international law to respect, protect and fulfil the right to health of its citizens and residents in Nigeria using the maximum of its available resources[6]. However, Nigeria's health indicators are generally poor. They do not measure up to the status of the country as a leading African nation with vast natural and human resources. Global health indicators reveal improvements in many areas such as eradication of communicable diseases, increased life expectancy, declining maternal and child mortality and broad advancement in the quality of life[7]. However, Nigeria currently has one of the highest under 5 mortality rates with 124 deaths in every 1000 births between 2009 – 2011, the second highest mother mortality rate in the world after India and rising incidence of non-communicable diseases such as cancer, diabetes and hypertension. Nigeria's health system is organised into three-tier levels of care; primary, secondary and tertiary. It is overstretched by a growing population, decaying physical infrastructural facilities, obsolete equipment, and scarcity of skilled healthcare professionals. As such, Nigeria had been performing very badly on the global health rankings.

It is often assumed that the poor state of healthcare delivery in Nigeria can be attributed to inadequate public funding of the sector. Total spending on health in the country is low; it is about 5% of the GDP[8]. The total health expenditure (THE) is dominated by household out of pocket expenditure (OOPE). Since 1999, the average annual

[5] General Comment No.14 on the Right to Health, UN Committee on Economic, Social and Cultural Rights interpreting article 12 of the Covenant on Economic, Social and Cultural Rights.

[6] Article 2 of the ICESCR and section 17 (3) (d) of the Fundamental Objectives and Directive Principles of State Policy of the 1999 Constitution.

[7] Excerpt from the Presentation by Prof. Isaac F. Adewole, Vice Chancellor, University of Ibadan, at the NMA's First National Health Summit held at the Event Centre, Asaba, Delta State, from January 20 – 27, 2013 on the theme of *Repositioning the Medical Profession and Nigeria's Health System for National Development*.

[8] WHO figure cited in *Health Overview*, p. 310. See: Oxford Business Group (OBG), Nigeria 2012 Report.

budgetary allocation to the sector by the Federal Government of Nigeria (FGN) is about 7% which is less than 15%, the benchmark recommended for developing countries by the World Health Organisation; and reinforced by the 2001 Abuja Declaration of the African Union (AU) countries. More so, health expenditure falls short of the 2009 Nigerian Partnership on Health Declaration. The Presidential Summit on Health in Nigeria attended by the President of Nigeria and all the 36 State Governors and Federal Capital Territory (FCT) Minister committed governments at all tiers to significantly improve the health status of Nigeria through increasing budget allocation to health at the Federal, State and local government areas (LGAs) from the present level by at least 25% each year.

Accordingly, Nigeria's performance in adequately funding the sector has not been encouraging. Based on available and potential resources, there is the assumption that the country has the capacity to address its basic health needs if resources are properly channelled. This raises several posers; how much does it cost to achieve the goal of health for all Nigerians? To what extent is the FG demonstrating willingness and commitment to adequately fund the health sector? Are there alternative funding mechanisms not yet explored? There is also the concern on whether the existing structure of federal health spending is contributing to the growing fad of *medical tourism* and *brain-drain* in the sector thereby acerbating the poor health indicators and outcomes in the country. Another concern is whether the Nigerian State sees health as a part of fundamental human rights or a mere basic need?

1.2 OBJECTIVES AND TERMS OF REFERENCE

The Study focuses on public funding of the health sector in the last five years (2009 – 2013) at the federal level. The Study seeks to interrogate the level of consistency between the objectives of National Development Plans (NDPs) in the health sector on the one hand and Medium Term Expenditure Frameworks (MTEF) as well as annual budget allocations to the health sector, on the other hand. The NDPs referred to are Nigeria's Vision (NV) 20:2020, its First National Implementation Plan (First NIP), the National Strategic Health Development Plan and the Transformation Agenda (TA) of President Goodluck Jonathan's administration. By so doing, the Study undertakes to investigate the level of seriousness the FG attaches to transforming the health sector to fulfill the role expected of it under the economic transformation agenda and or development blueprints. This is important in order to evaluate factors hindering the FGN from fulfilling its commitment to health-related goals and the right to health of all Nigerians. The overall goal of the Study is to present evidence to health authorities on how best to improve the quality of federal health spending.

From the terms of reference, the specific objectives of the Study are:

- Review the alignment of federal health MTEF, budgets allocation (appropriated and actual releases) to high level sectoral policy goals in the last five years;
- Review the alignment of recurrent and capital expenditure in the sector;
- Review the alignment of federal health budgets with best practices in budgeting;
- Review whether the FGN is using the maximum of available resources for the progressive realisation of the right to health; and
- Make recommendations for the improvement of services for greater value for money;
- Make recommendations for improved funding (including new sources) for the sector.

1.3 METHODOLOGY

The data used for the Study is mostly through secondary sources. The researcher also benefitted from personal communications with selected stakeholders in the health sector. The main data-set, on federal budgets (Appropriation Acts), MTEFs (2010-2012, 2011-2013, and 2014-2016) and Budget Implementation Reports 2009 – 2013 (BIR) were largely retrieved from the website of Budget Office of the Federation (BOF) and complemented with hard copies of documents obtained from the National Institute for Legislative Studies (NILS), Policy Analysis and Research Project (PARP) and the National Assembly Budget and Research Office (NABRO). Other relevant materials such as NV 20:2020 Economic Blueprint (and its First NIP), the TA Document, revised National Health Policy (2004), the National Health Bill (2012), the National Strategic Health Development Plan (2010 – 2015) and World Health Statistics 2014 as well as relevant publications from the Centre for Social Justice (CSJ) and others were obtained from both virtual and physical libraries.

Thus, the Study employs descriptive analysis using simple charts and tables to draw conclusions. Methodologically, the level of priority government attaches to a sector is measured through indicative spending ceiling outlined for the sector in the MTEFs, approved budgets and actual expenditure outturns. Therefore, the resources earmarked for the health sector indicates the level of seriousness government attaches to transforming the sector. The technique used closely scrutinises approved budgets to establish the degree of alignment with the investment projections set out for the sector in the National Development Plans. More specifically, it compared estimated investment costs outlined under high level sectoral documents (NV 20:2020/First NIP, NSHDP and TA Document) against budgetary allocations to the sector for the period under review.

1.4 LIMITATIONS OF THE STUDY

The main limitation of this Study relates to its scope which focuses only on federal spending even though the country operates a three-tier federal system - local

governments, states and FGN. The three-tier model of healthcare delivery - primary secondary and tertiary healthcare should have been shared among the three tiers of government but that is not the case. Both FGN and states invest across the broad spectrum of the health sector while LGs limit themselves to primary health care. The implication is that federal spending on health, like other issues on the Concurrent List would not adequately capture and reflect the overall national health spending in Nigeria. Another challenge revolves around the disjointed nature of fiscal data coming from different sources in government.

Chapter Two

LITERATURE REVIEW

2.1 NATIONAL LAW

The Constitution of the Federal Republic of Nigeria 1999 is the fundamental law. In section 17 (3) (c) and (d), it provides in Chapter 2 under the Fundamental Objectives and Directive Principles of State Policy that:

> *The State shall direct its policy towards ensuring that-*
>
> > *The health, safety and welfare of all persons in employment are safeguarded and not endangered or abused;*
> >
> > *There are adequate medical and health facilities for all persons*

Chapter 2 of the Constitution is generally stated to have created non-justiceable rights[9]. But this does not divest the provisions of its vitality since it can be the basis for government policies and legislative actions to ensure the protection of the right to health. The Supreme Court in *Attorney General Ondo State v Attorney General of the Federation*[10] held as follows:

> *The Constitution itself has placed the entire Chapter 11 under the Exclusive Legislative List. By this, it simply means that all Directive Principles need not remain mere or pious declarations. It is for the Executive and the National Assembly, working together, to give expression to anyone of them through appropriate enactment as occasion may demand.*

The African Charter on Human and Peoples Rights domesticated as Nigerian law makes provisions for the right to health:

> *Every individual shall have the right to enjoy the best attainable state of physical and mental health.*

Other laws that impact on the right to health include the law establishing the National Health Insurance Scheme, environmental health laws, labour laws protecting maternity rights, Child Rights Act, etc.

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[9] *Archbishop Okogie v Attorney General, Lagos State* (1981) 1 NCLR 337
[10] Per Uwaifo J.S.C (2002) 9 N.W.L.R (Pt 772) 222 at 391.

2.2 INTERNATIONAL STANDARDS

The following international standards applicable to Nigeria contain provisions on the right to health:

- Universal Declaration of Human Rights (article 25);
- International Covenant on Economic, Social and Cultural Rights (article 12);
- Convention on the Rights of the Child (article 24);
- African Charter on the Rights and Welfare of the Child (article 14);
- Convention on the Elimination of all Forms of Discrimination against Women (article 12);

In delineating the nature of Nigeria's obligations on the right to health, resort has to be made to the International Covenant on Economic, Social and Cultural Rights (ICESCR) which apparently is the most comprehensive standard on the right to health ratified by Nigeria. This is necessary for a proper understanding of the specific obligations that should attract adequate funding from the budget. The ICESCR states in article 2 (1):

> *Each State Party to the Present Covenant undertakes to take steps, individually and through international assistance and cooperation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realisation of the rights recognized in the present Covenant by all appropriate means including particularly the adoption of legislative measures.*

In article 12, the ICESCR states:

1. *The States Parties to the present Covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.*
2. *The steps to be taken by the State Parties to the present Covenant to achieve the full realisation of this right shall include those necessary for:*
    a. *The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;*
    b. *The improvement of all aspects of environmental and industrial hygiene;*
    c. *The prevention, treatment and control of epidemic, endemic, occupational and other diseases.*
    d. *The creation of conditions which would assure to all medical service and medical attention in the event of sickness.*

An examination of the operative phrases in article 2 (1) of the ICESCR which are relevant to fiscal analysis will follow.

2.2.1. To the Maximum of Available Resources

The phrase "maximum of available resources" recognises the difference in wealth and resources available to the different countries in the world who are State Parties to the ICESCR. In accordance with the Limburg Principles,[11] Nigeria is obligated regardless of its economic development status, to ensure respect for minimum subsistence rights for all. Resources include what can be sourced locally and from aid and general international cooperation. It includes already available resources and potentials which could be tapped to improve healthcare. Resources could be classified into different categories - human, technological, information, natural and financial resources[12]. So, it is not only the finances available in the budget that constitute resources. For Nigeria to rely on lack of resources as an excuse for failing to meet its obligations, it must show that every effort has been made to use all the resources at its disposal to satisfy the minimum core obligation[13]. In times of grave economic crisis, vulnerable groups are still entitled to subsistence rights by the adoption of low cost measures. The question of prioritising the expenditure of the state becomes relevant here. It has been noted that corruption absorbs a lot of resources that could have been invested in housing, education, health, etc. In the circumstances, it would be problematic for Nigeria to plead the unavailability of resources as a reason for the non implementation of the right to health while refusing to plug the leaking pipes of corruption.

2.2.2 To Achieve Progressively the Full Realisation of ESC Rights

The progressive realisation phrase is not to be interpreted to mean an indefinite postponement of action to realize the right to health. Rather, it obliges Nigeria to move immediately and as expeditiously as possible towards the realization of the right to health. The obligation exists independently of increase in resources; requiring effective use of available resources and developing societal resources for the realisation of the right to health[14]. The concept of progressive realisation is a recognition of the fact that full realisation of the right to health will generally not be achieved in a short time[15]. However, the components of the right to health on non discrimination and special measures for the protection of the health of the child do not require progressive realisation but are capable of immediate implementation[16].

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[11] The Limburg Principles on the Implementation of ICECR, UN Document E/CN 4/1987/17

[12] Resources have been classified into human, technological, information, natural and financial resources; see Roberts E. Robertson *"Measuring State Compliance with the Obligation to Devote the Maximum of Available Resources to Realising Economic, Social and Cultural Rights* (1994) 16 HUM RTS.Q 693, 695-697.

[13] See General Comment No. 3 of the UN Committee on ESCR, adopted at the Fifth Session of the ESCR Committee in 1990, UN Doc E/199/123, Annex 111, para 10.

[14] See Principles 21-24 of the Limburg Principles.

[15] See para 9 of General Comment No. 3 of the UN Committee on ESCR.

[16] Para 10 of General Comment No.9 of the ESCR Committee on the Domestic Application of the ICESCR adopted December 3 1998; UN document E/C.12/1998/24.

2.2.3 To Take Steps… by all Appropriate Means Including Particularly the Adoption of Legislative Measures

The phrase recognises the need for Nigeria to take deliberate, concrete and targeted steps which are as clear as possible towards meeting the obligation to protect the right to health.[17] It acknowledges legislation as an important step while not limiting the steps to be taken by states parties to legislation alone. It is expected that Nigeria before ratification or immediately after ratification of the ICESCR should bring its domestic law in conformity with the requirement of the Covenant. Other means to be adopted by the state may include administrative, judicial, economic, social and educational measures consistent with the nature of the right to health[18]. Nigeria is also under obligation to provide an effective remedy to persons whose right to health have been violated and this may include judicial remedies. States enjoy a margin of discretion in the selection of the means and methods for implementing obligations on the right to health under the ICESCR. This is also the case for many civil and political rights[19]. The ICESCR clearly requires Nigeria to take whatever steps that is necessary for the purpose of realising the right to health.

It is imperative to point out that violations of the right to health whether directly perpetuated by the state (action) or by private entities which could have been prevented by the state (omission) engages the state's responsibility. Nigeria is obligated to prevent, investigate and punish any human rights violation carried out in its territory not only by the acts of public officers but also directly resulting from acts not directly imputable to officers of the state. This has been aptly captured in the following words[20]:

> *..to take reasonable steps to prevent human rights violations and to use the means at its disposal to carry out investigations of violations committed within its jurisdiction, to identify those responsible, to impose the appropriate punishment and to ensure the victims adequate compensation.*

In accordance with Maastricht Guidelines, there are three layers of obligations in matters of ESC rights including the right to health: obligations to respect, protect and fulfil. Like civil and political rights, the right to health imposes three different types of obligations on states: the obligations to respect, protect and fulfil. Failure to perform any one of the three obligations constitutes a violation of the right. The obligation to respect

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[17] General Comment No. 3 of the UN ESC Rights Committee (Supra).
[18] Principle 17 of the Limburg Principles.
[19] Guideline 8 of the Maastricht Guidelines on Violations of ESCR developed by the Experts Meeting held from January 22-26 1997 at the instance of the International Commission of Jurists (Geneva, Switzerland), the Urban Morgan Institute of Human Rights (Cincinnati Ohio, USA) and the Centre for Human Rights of the Faculty of Law of the Maastricht University (The Netherlands).
[20] *Velasques Rodrigues* case- Inter American Court of Human Rights of July 29 1988, 1 ACHR series C, Decisions and Judgements No.4, paras 174-175 or (OAS/ser.I/V111 19, doc 13 1998, para 174. The position in this case can be rightly asserted to have become *jus cogens.*

requires states to refrain from interfering with the enjoyment of the right to health. Thus, the right to health is violated if a state engages in demolition or vandalisation of existing health institutions or pollution of air, water and soil which will deleteriously impact on health. The obligation to protect requires Nigeria to prevent violations of such rights by third parties. Thus, the failure to ensure that oil extracting companies do not flare associated gas which constitutes a threat to the health of residents in the vicinity of the gas flare amounts to a violation of the right to health. The obligation to fulfil requires States to take appropriate legislative, administrative, budgetary, judicial and other measures towards the full realisation of the right to health. Thus, considering that primary health care is one of the core contents of the right to health, the failure of FGN to provide essential primary health care to those in need may amount to a violation of the right to health[21].

2.2.4 The Minimum Core Content and State Obligation on the Right to Health

There is a duty to satisfy what the ESCR Committee has identified as the minimum core obligation(s) of the Covenant's articles to wit; a minimum core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights[22]. The Committee went ahead to state that if the ICESCR were to be read in such a way as not to establish such a minimum core obligation, it would be largely deprived of its raison d'être. Thus, the minimum core obligation on the right to health is the threshold below which Nigeria will not be allowed to descend. It is an obligation which must be met regardless of resources available to the state. The concept of the minimum core obligation, which is in essence, the basic nature and essence of the right to health - the essential elements without which the right to health loses its r*ight hood* and substantive significance. It is the floor below which conditions should not be permitted to fall. Below this floor, Nigeria will be deemed to be in violation of its right to health obligations. In determining the core content of the right to health, the prevalent disease conditions as demonstrated by epidemiological data and health indicators in the Nigerian society will be taken into consideration. Within this context, primary health care, maternal new born and child health will be automatic candidates for recognition as minimum core obligations of Nigeria. Millennium Development Goals 4, 5 and 6 (reduce child mortality; to improve maternal health; and to combat HIV/AIDS, malaria, and other diseases) also come in handy as candidates for recognition as part of the core obligations. They are part of a worldwide consensus on targets to be met on or before 2015.

Lack of access to resources has been touted as one of the main reasons for the poor health indicators of Nigeria; it is pertinent to point out that the duties to respect and protect the right to health can be implemented without expending too much resources.

[21] See Guideline 6 of the Maastricht Guidelines.
[22] See General Comment No. 3 (supra).

The obligation to respect is a negative duty while the obligation to protect imposes no greater burden than that incurred through the normal law enforcement mechanism. It is only fulfilment bound obligations that directly require resources to implement. In a state like Nigeria, proper management of resources and mobilisation of manpower can go a long way in addressing the problems raised by lack of resources.

2.3 THE VISION 20:2020 ECONOMIC BLUEPRINT

The NV 20: 2020[23] Economic Blueprint recognises that the people are the most essential assets of any nation thereby envisioning a peaceful, equitable, harmonious and just society, where every citizen has a strong sense of national identity and citizens are supported by an educational and healthcare system that caters for all, and sustains a life expectancy of not less than 70 years. It is envisaged that by the year 2020, Nigeria will have a large, strong, diversified, sustainable and competitive economy that effectively harnesses the talents and energies of its people and responsibly exploits its natural endowments to guarantee a high standard of living and quality of life to its citizens. That is, a country with a healthy and economically productive population that is growing at a sustainable pace, supported by a healthcare system that caters for all, sustains a life expectancy of not less than 70 years and reduces to the minimum, the burden of infectious and other debilitating diseases. Accordingly, the blueprint recommends investment in HCD to enhance national competitiveness as part of immediate policy focus. The First Pillar of Vision 20:2020 is *Guaranteeing the Productivity and Wellbeing of the People* and two of its strategic objectives are focussed on health - *enhance access to quality and affordable healthcare and provide sustainable access to portable water and basic sanitation.*

Unfortunately, the NV 20: 2020 noted that education and health, the foundations for lifelong learning and capacity building are currently constrained by underfunding, inadequate and poor infrastructural facilities, very high patient to doctor ratio as well as inefficient service delivery. It thus pointed out that vast majority of Nigerians do not have access to good quality education and affordable healthcare and therefore cannot unleash their full productive potentials. This underscored the strategy of guaranteeing the productivity and wellbeing of the people which was anchored on investing in HCD to enhance national competitiveness. Specifically, the Blueprint contends that a holistic government led effort to revive the health sector would be required to support the aspirations of Vision 20: 2020.

[23] See, amongst others: *Nigeria Vision 20:2020 (2009). Economic Transformation Blueprint*; *The First National Implementation Plan of NV20:2020 (2010 – 2013): The Vision and Development Priorities, Vol. I.* Abuja: National Planning Commission (NPC).

The desired goal of NV20:2020 is to place Nigeria in the human development index (HDI) ranking of not less than 80 by 2020, and support a life expectancy of not less than 70 years. It targets improvements in the health indicators to achieve remarkable drop in maternal, newborn and under-5 mortality rates as indicated in Table 1. It also targets reduction by half of the HIV prevalence rate of 4.4% by 2015 and increasing immunisation coverage from 27% at the base year to 95% in 2015. These goals are well aligned to the MDGs for health: reduction in the maternal mortality, reduction in under-5 mortality, and reduction in HIV/AIDs amongst others.

Table 1: **Selected Health Indicators and Targets under the Vision 20:2020 Document**

Indicator	Baseline	Targets	
		2015	2020
Life Expectancy	46.5years	60 years	70years
Under-5 Mortality rate (per 1,000 live births)	110	63	22
Infant Mortality ratio (per 1,000 live births)	138	30	15
Maternal Mortality Ratio (per 100,000 live births)	800	100	70
%of population with access to improved sanitation	35%	67%	80%
HDI Ranking	Low Human Development (158)	Medium Human Development (100-155)	Medium Human Development (71-100)

Source: NV20:2020, p.43.

More specifically, the Vision 20:2020 Blueprint[24] identifies the following important strategic initiatives for implementation, namely:

- *To site at least one PHC facility in each ward with appropriate complement of staff;*
- *Development and implementation of a health infrastructure policy that will guarantee minimum standards and ensure that referral systems to secondary and tertiary healthcare facilities are strengthened and able to support PHC;*
- *Provision of adequate infrastructure and well maintained equipment through partnership with the private sector;*
- *Expansion of secondary and tertiary healthcare coverage will require the sitting of at least one general hospital (GH) in each LGA. Each GH will have specialists: Surgery, Paediatrics, Medicine, Obstetrics and Gynaecology. Also required will be the re-equipping of all Teaching Hospitals, Federal Medical Centres, Specialist Centres and General Hospitals;*
- *Inclusion of family life education should be part of the junior secondary school curriculum, with a view to encouraging the citizenry to seek healthcare knowledge from appropriate health sources;*

[24]See pp. 31 – 32 of the NV 20:20202. op. cit.

- *The development of adequate and appropriate manpower for the health sector will require a thorough assessment of the training needs, and the update of in-service training programmes so as to ensure that healthcare service providers have the appropriate competences and attitudes for integrated maternal, newborn and child health services;*
- *Embarking on training and re-training of all health personnel such as biomedical engineers, medical specialists, nurses, midwives, laboratory scientists and other care providers to update their skills and competences. In this regard, the Postgraduate Medical Colleges, Colleges/Faculties of Medicine and the Teaching Hospitals will be better funded to help perform their training mandates more effectively. A Special fund for training of house officers and other interns is also necessary. To meet the new, growing demand for health workers, the relevant institutions, such as Schools of Health Technology and Midwifery, would be strengthened and empowered to accommodate more intakes;*
- *Strengthening existing national health information systems and integrating them into a comprehensive national database to improve health data and promote research. This will be supported by ensuring effective vital registration (births, deaths, marriages, divorce) at all levels and the establishment of the mechanisms for collation, coordination and management of health research by a well funded body such as the National Medical Research Council (NMRC);*
- *Enhancing the availability and management of health resources (financial, human and infrastructural) by consolidating and expanding the national midwifery scheme;*
- *Implementing a competitive Health Workers compensation and motivation packages across all levels;*
- *Strengthening the various health regulatory agencies and acceleration of the implementation of the three components of the National Health Insurance Scheme for the attainment of 100% coverage of Nigerians by 2015.*

The estimated investment plan to achieve all the foregoing is about N487, 448.59 bn under the first NIP of Vision 20:2020[25]. When disaggregated annually, the investment plan is put at N67, 277bn (2010), N120, 502bn (2011), N148, 408bn (2012) and N151, 262bn (2013) respectively for the period of First NIP (2010 – 2013). Table 2 below shows the breakdown of priority programmes and projects that the health sector investment projections will be channelled to within the period of the First National Implementation Plan of Vision 20: 2020.

[25] See (Appendix 49: Health), p.113-114, op. cit, the First National Implementation Plan (2010 – 2013), of NV 20:2020.

Table 2: Prioritised Health Programmes and Projects identified under the First NIP

Thematic Area: HCD – Health						
		Costs in N Million				
SN	Priority Projects	2010	2011	2012	2013	Total
1	Disease control and health emergency response programme		21,884.47	36,135.75	28,261.36	86,281.55
2	Expanded immunization programme		3,166.37	3,588.55	3,799.64	10,554.56
3	Federal Health Institutions revitalization, modernization and development programme		20,879.95	16,330.61	39,055.94	76,266.51
4	Health research and development programme		801.46	908.32	961.75	2,671.52
5	Human Resources for health development programme		4,699.75	5,326.39	5,639.70	15.665.84
6	Integrated management of maternal, newborn and child health programme		16,907.74	28,828.77	22,289.29	68,025.80
7	National Emergency Ambulances Services		1,492.98	1,692.05	1,791.58	4,976.61
8	National Health Insurance Programme		2,590.41	2,935.79	3,108.49	8,634.69
9	National Health Promotion Programme		1,130.31	1,281.02	1,356.37	3,767.69
10	National Health System strengthening and development programme		10,345.13	7,391.15	8,414.16	26,150.44
11	NHMIS/M&E Programme		995.01	1,127.68	1,194.01	3,316.70
12	National Food and Drugs Control Programme		2,664.63	3,091.92	3,197.56	8,882.11
13	National Professional Health Regulatory Institutions Strengthening Programme		2,261.56	2,563.10	2,713.87	7,538.52
14	Health Projects	67,277.03				
15	Non Priority Projects		30,681.94	37,279.02	29,478.04	97,439.00
		67,277.03	**120,501.71**	**148,408.09**	**151,261.76**	**487,448.59**

Source: NV20:2020, the first NIP (2010-2013).

2.4 THE TRANSFORMATION AGENDA AND THE NATIONAL STRATEGIC HEALTH DEVELOPMENT PLAN

The Jonathan Administration outlined its own development agenda called the Transformation Agenda (TA) which is targeted at prioritising the projects of NV20:2020 and its First NIP based on available resources[26]. The TA is to run for the period 2011-2015. Under the TA, health is seen as wealth, implying that the nation's wealth comprises not only the physical capital but also human capital which was rightly pointed out as one of the factors of production required to achieve high and sustainable economic growth. Since human capital is strategic to the socio-economic development of a nation, investing in HCD is therefore critical as it is targeted at ensuring that the nation's human resource endowment is knowledgeable, skilful, productive and healthy to enable the optimal utilisation of other resources in the effort to engender growth and development. Thus, the TA reiterates the strategic importance of health on national development and stresses improvements in human capital through focused spending on health and related social sector services. According to the TA[27], improving the productivity of the people, protecting the vulnerable in the society and enhancing their well-being and quality of life are at the heart of human development.

Table 3 shows selected health indicators and targets under the Transformation Agenda.

Table 3: Key Indicators and Targets under the Transformation Agenda/NSHDP

Indicator	Baseline	Targets		
		2011	2013	2015
Under-5 Mortality Rate	157/1000 LBs[28]	130/1000 LBs	103/1000 LBs	75/1000 LBs
Infant Mortality Rate	75/1000LBs	60/1000 LBs	45/1000 LBs	30/1000 LBs
Maternal Mortality Ratio	545/100,000LBs	409/100,000LBs	273/100,000LBs	136/100,000LBs
Proportion of 1 year old immunised against measles	41.4%	60%	80%	95%
Percentage of children Under-5 sleeping under insecticide-treated bed nets	5.5%	24%	42%	60%
Percentage of children Under-5 who are underweight	27.1%	24%	20%	17.90%

Source: TA Document, page 76 and NSHDP (2010), p.19.

[26] See Transformation Agenda 2011 – 2015: Priority Policies, Programme and Projects of the FGN.
[27] Ibid, p. 67.
[28] LBs – Life Births

In terms of priority, the TA prioritises only 38 out of 71 key policies, programmes and projects (KPPPs) from the federal component of the National Strategic Health Development Plan (NSHDP 2010-2015) [29]. The projected federal investment plan for capital projects of about N229bn for the health sector under the TA document is disaggregated annually as presented in Table 4.

Table 4: Investment Projections under the TA Document for the Health Sector

Year	2012 (N' Billion)	2013 (N' Billion)	2014 (N' Billion)	2015 (N' Billion)	Total (N' Billion)
Allocation	45,310	54,000	60,000	70,000	229,310

Source: TA Document, page 139.

The TA adopts the NSHDP as its health component implementation framework. The NSHDP seeks to achieve the following:

- *Implement good governance at all levels of health system through the application of a National Heath Law, thereby creating a system where regulatory responsibilities are shared between the three tiers of government;*
- *Foster integrated service delivery by clarifying technical responsibilities of federal institutions; improve the efficiency of the federal health workforce by implementing a comprehensive human resources for health agenda;*
- *Ensure increase in availability of and access to financial resources for health including appropriate risk pooling and exemption mechanisms;*
- *Strengthen the National Health Management Information System (NHMIS) to improve the use of routine health information for programmes/service performance monitoring and evaluation;*
- *Improve community ownership and participation during implementation of the National Health Agenda through a purposeful engagement of Community Service Organizations; and*
- *Embed appropriate solutions to health equity issue, including service provision, access to finance, financial risk protection for vulnerable, low and middle income groups.*

The eight strategic priorities of NSHDP are Leadership and Governance for Health, Health Service Delivery, Human Resources for Health (HRH), Financing for Health, National Health Information System, Community Participation and Ownership, Partnerships for Health, and Research for Health. Thus, the NSHDP is conceived as the vehicle for actions at all levels of healthcare delivery system. Its goal is to provide a roadmap for reaching the MDGs as well as other local and international targets and commitments. As depicted in Table 3 above, the NSHDP is aimed at reducing the mortality rates due to communicable diseases to the barest minimum, reverse the

[29] See National Strategic Health Development Plan, 2010-2015; FMOH, Abuja.

increasing prevalence of non-communicable diseases, meet global targets on the elimination and eradication of diseases[30], and significantly increase the life expectancy and quality of life of Nigerians[31]. It is seen as a vehicle to implement Nigeria's commitments in the health sector especially in Vision 20:2020.

The estimated total cost of investments for implementing the NSHDP for the six years period (2010-2015) amounts to N3.997trillion which will come from the federal, state and local governments. Contributions are also expected from development partners, CSOs and the private sector. The federal component[32] is expected to cost N1.135trillion. Table 5 shows the breakdown of the estimated investment cost for the eight strategic priorities.

Table 5: Cost of Implementing the NSHDP (2010 – 2015)

S/n	Priority Area	NSHDP Total Cost (NGN)	Federal Component of the NSHDP Cost (NGN)
1	Leadership and Governance For Health	27,587,202,750	1,847,592,000
2	Health Service Delivery	1,946,257,153,350	437,855,075,653
3	Human Resources for Health	1,664,676,299,550	689,031,103,464
4	Financing for Health	218,976,510,300	1,483,864,000
5	National Health Information System	41,605,199,400	1,554,920,000
6	Community Participation and Ownership	23,913,081,450	950,318,500
7	Partnerships for Health	25,502,477,700	655,316,000
8	Research For Health	49,448,161,050	2,086,399,500
Sum		**3,997,966,085,850**	**N1,135,464,589,117**

Sources: NSHDP (2010), Pages 16 and 107

The overall amount gives an annual cost per capita of NGN 4,745 (USD 31.6), which is fairly close to USD34 being the estimate of the WHO's Commission for Macroeconomics on Health for delivering an essential healthcare package. According to the NSHDP, the financial projections take into consideration a focus on the allocation of such funds for the implementation of the strategic priorities.

[30] Nigeria shoulders 10 percent of global disease burden due to high incidence of diseases [see, NSHDP (2010), p.23].
[31] CISLAC (2011); p.55.
[32] The National Strategic Health Development Plan (NSHDP) aims inter alia at strengthening the FMOH to perform its statutory duties and provide necessary leadership and technical assistance to the other levels of government to implement their plans. The federal SHDP is intended to form the basis for resource allocations to be deployed by the FMOH. See, page 28, FMOH (2010) - The Federal Strategic Health Development Plan (2010-2015).

2.5 HARMONY ANALYSIS OF HEALTH PROVISIONS IN NATIONAL DEVELOPMENT PLANS

In terms of goals and objectives, the different components of the NDPs all set out to improve service delivery in the sector. However, Vision 20:2020 being the foundation document seems to have larger and more ambitious goals. The NSHDP fleshes out the implementation mechanisms and costing of reforms in the health sector. There is convergence in the components of the NDP in terms of improving access to health services, increasing life expectancy, reducing the disease burden and guaranteeing improvements in health indicators. There is further convergence in identifying the linchpins for the sector which include human resources for health, health financing, national health information system, community participation and ownership, partnerships for health, research for health, health service delivery and leadership and governance for health. Also, the components of the NDP understand the interconnectedness and linkage between the right to health and other human rights including education, housing, sanitation, access to water, etc. Health is not a stand-alone issue and is heavily influenced by other economic and social circumstances. The NDP are also in harmony with the provisions of the 1999 Constitution and Nigeria's obligations under international and regional standards. However, the analysis of the financial provisions in the different components of the NDP may reveal discrepancies as will be shown in the next and subsequent chapters of this Study.

Chapter Three

RELATING HEALTH-SPECIFIC DEVELOPMENT GOALS TO FEDERAL GOVERNMENT HEALTH EXPENDITURE (2009 – 2013)

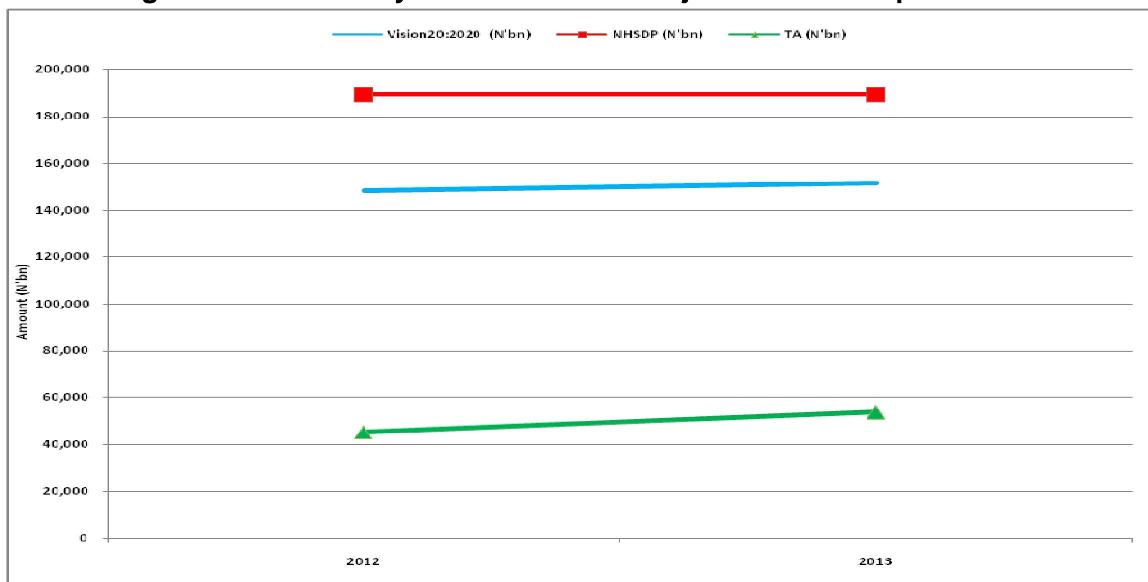
3.1 THE FIGURES OF THE COMPONENTS OF THE NDPs DO NOT AGREE

Vision 20:2020 and its First NIP are like mother and foundation documents which should provide a guide for other financial documentation on improving the right to health. There is as such an expectation of harmony between the provisions of the Vision and other documents such as the NSHDP and the TA. But Table 6 and Figure 1 give a different picture.

Table 6: Financial Provisions of Components of the NDP on Health

Year	Vision 20:2020 (First NIP) (N'bn)	NSHDP (N'bn)	TA (N'bn)
2010	67,277.03	189,244.09	-
2011	120,502.71	189,244.09	-
2012	148,408.09	189,244.09	45,310.00
2013	151,262.76	189,244.09	54,000.00
2014	-	189,244.09	60,000.00
2015	-	189,244.09	70,000.00

Figure 1: Disharmony in the Financial Projections of Components of NDP



Source: Vision 20:2020, TA and NHSDP

The disparity in the provisions of the various components seems to suggest lack of coordination and this delivers a wrong message to policy implementing agencies. Even

though the costing in the TA could be termed the costing of priority projects and the difference in costs justifiable, there is no justification for the substantial difference in the costing of the First NIP and the NSHDP. The First NIP and the NSHDP all bear the date of 2010; what was the reason for the different costing? What was the basis for the difference?

3.2 THE DEGREE OF ALIGNMENT OF FEDERAL HEALTH SPENDING WITH HIGH LEVEL SECTORAL DOCUMENTS

The level of harmony between NDPs and fiscal strategies has been noted to have a positive impact on the level of socioeconomic development a country attains[33]. It explains why fiscal planning tools such as the Medium Term Sector Strategies (MTSS), Medium Term Expenditure Framework (MTEF)[34], and Fiscal Strategy Papers (FSP) as well as budgets are supposed to be prepared in tandem with NDPs as they provide rational options for putting down resources to reach stated goals. As such, the degree of consistency between NDPs and Appropriation laws indicate the extent of commitment by the government to genuinely pursue its stated development agenda as the budget remains the single most important policy instrument converting development plans and priorities into a programme of action – an indication of public expenditure priorities for the fiscal year.

Therefore, in reviewing the alignment of Federal Government's Health Expenditure (FGHE) with high level sectoral policy documents, investment projections contained under the first NIP (2009-2013) of NV 20:2020 and Transformation Agenda (2011-2015) will be compared with resources allocated to the sector through budgets (2009-2013) as indicative of the extent of FGN commitment to the sector. It is instructive to note that in fixing MDAs expenditure ceilings[35], FGN usually takes into account the priority accorded to the particular sector in its development programme trajectories.

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[33] The most critical areas for consistency seem to be in resource allocations through budgets and implementation of budgets in line with the plans of NDPs. Given the fact that investment in capital projects is what translates to greater availability of infrastructure, promotes quicker socioeconomic development; the quantum of resources dedicated to infrastructural development and actual expenditure of dedicated resources to implement the projects is indicative of genuine commitment to development by the government. See: amongst others: Ngene, E. and Amakom, U. (2012). *Review of the 2013 Capital Budget Proposal of Key Ministries against Nigeria's Development Agenda*; and Amakom, U. and Agu, C. (2012). *A Review of Nigeria's Key Economic Development Policies and Financial Commitments on Infrastructural Projects (2010 – 2013)*. Abuja: CSJ Publications.

[34] For one thing, the MTSS is used to achieve effective resource allocation by tying spending to the priority areas and the MTEF is aimed at striking a balance between the need to spend money to achieve stated development objectives and the need to live within available resources. The annual budget is drawn up to serve as a legal and policy framework for achieving the goals encapsulated in these medium term instruments. See: *A Citizens' Guide to Federal Budget*: A Publication of BOF, Abuja.

[35] The Envelope System indicates the resources available to fund expenditures - MDAs are obliged to limit their spending to commitments within allotted ceilings. However, the ceilings that are imposed on

3.2.1 Vision 20:2020

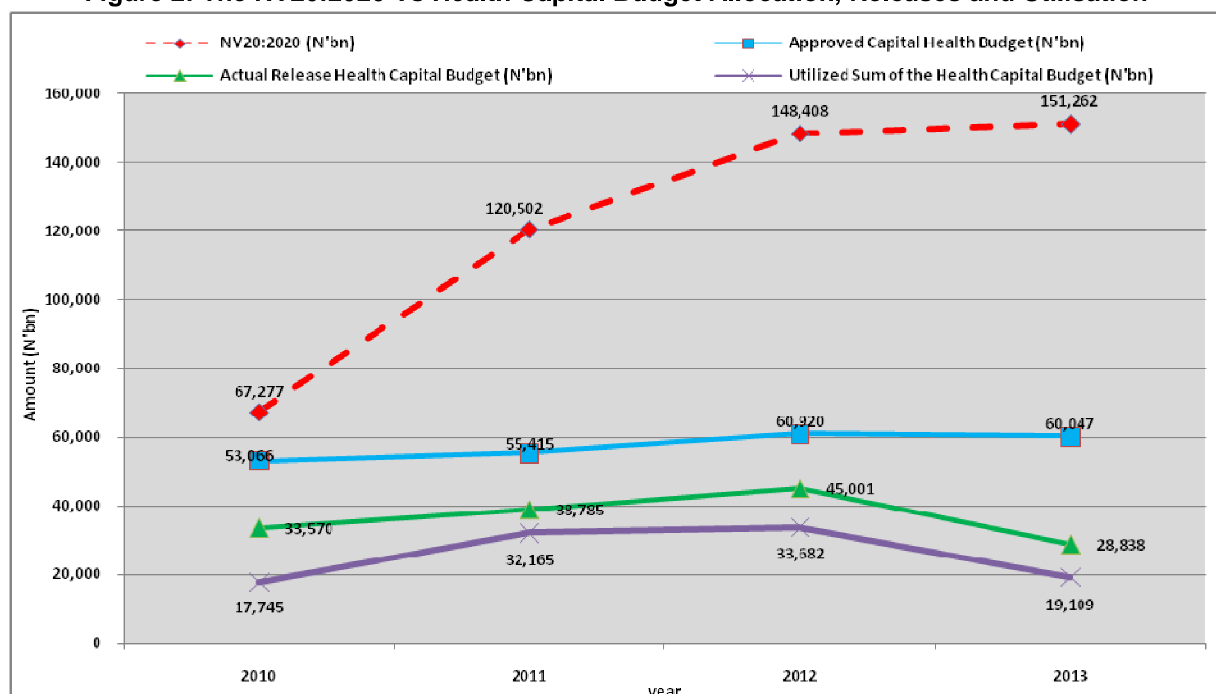
Table 7 captures the comparison of investment proposals in Vision 20:2020 vis-a-vis the health capital budget proposals and utilisation. Figure 2 captures the disharmony between the Vision and the annual budgets in graph.

Table 7: NV20:2020 Vs Health Capital Budget Allocation, Releases and Utilisation

Year	NV20:2020 (N'bn)	Approved Capital Health Budget (N'bn)	*(Short fall) Approved Health Capital Budget from NV20:2020 (N'bn)*	Actual Release Health Capital Budget (N'bn)	*(Short fall) Released Health Capital Budget from NV20:2020 (N'bn)*	Cash Backed Health Capital Budget (N'bn)	Utilised Sum of the Health Capital Budget (N'bn)	*(Short fall) Utilised Health Budget from NV20:2020 (N'bn)*
2009	**-**	50,803	-	48,643	-	48,659	24,509	-
2010	**67,277.03**	53,066	*14,211*	33,570	*33,707*	33,562	17,745	*49,532*
2011	**120,501.71**	55,415	*65,087*	38,785	*81,717*	38,716	32,165	*88,337*
2012	**148,408.09**	60,920	*87,488*	45,001	*103,407*	37,171	33,682	*114,726*
2013	**151,261.76**	60,047	*91,215*	28,838	*122,424*	28,838	19,109	*132,153*
Total	**487,448.59**	**280,251**	**258,001**	**194,837**	**341,255**	**186,946**	**127,210**	**384,748**

Source: The NV20:2020 (1st NIP) and Budget Implementation Reports of the BOF 2010-2013

Figure 2: The NV20:2020 Vs Health Capital Budget Allocation, Releases and Utilisation



Source: The NV20:2020 (1st NIP) and Budget Implementation Reports of the BOF 2010-13

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the health sector by the treasury are implicit forms of rationing the quality of care as the allocated ceiling constrain spending from which services must be delivered.

When placed against the Investment Plan of NV 20:2020, capital allocations to health through federal budgets (2010-2013) demonstrate a clear picture of lack of alignment between investment projections and resource allocated to the sector. When the Vision's projections are compared to the approved capital health budget, a shortfall of N258b emerges; when compared to releases, a shortfall of N341.255 is shown. And when compared to actual utilisation, there is a shortfall of N384.748b. Essentially, the Health Vision has been ignored as it provides no clue or guide for health sector budgeting. The figure actually utilised for health is 26% of the Vision's overall projections.

3.2.2 Transformation Agenda

A comparison of the provisions of annual budgets and the TA is shown in Table 8.

Table 8: Transformation Agenda Vs Health Capital Budget Allocation, Releases and Utilisation

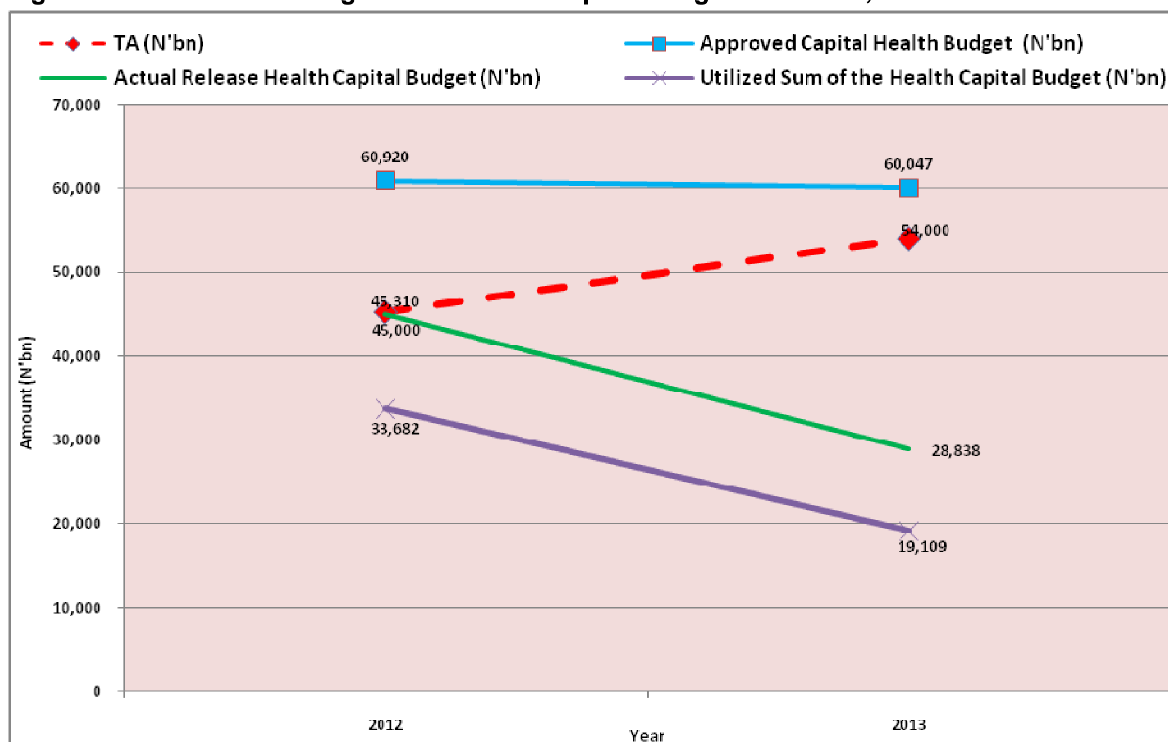
Year	TA (N'bn)	Approved Capital Health Budget (N'bn)	*Short fall: Approved Health Budget from TA (N'bn)*	Actual Release Health Capital Budget (N'bn)	*Short fall: Released Health Capital Budget from TA (N'bn)*	Cash Backed Health Capital (N'bn)	Utilized Sum of the Health Capital Budget (N'bn)	*Short fall: Utilised Health Budget from TA (N'bn)*
2012	**45,310**	60,920	*+15,610*	45,000	*-310*	37,171	33,682	*-11,628*
2013	**54,000**	60,047	*+6,047*	28,838	*-25,162*	28,838	19,109	*-34,891*
2014	**60,000**							
2015	**70,000**							
Total 2012-13	**99,310**	**120,967**	**+21,657**	**73,838**	**-25,472**	**66,009**	**52,791**	**-46,519**

Source: Transformation Agenda and Budget Implementation Reports of the BOF 2010-13

Again, there is remarkable disharmony between the provisions of the TA, the approved budget and actual utilisation for the two years 2012 and 2013. Whole the TA projected N99.3b, the approved budgets were in the sum of N120.9b. However, actual utilisation was N46.5b less the TA financial projections. It is baffling that the budgets would provide more than the projections of the TA. The implication is that the costing of the TA was haphazardly done and not based on empirical foundations. The disparity between budgeted and utilised sums is also so wide. So, the TA and the budget itself provide no clue as to the actual expenditures.

The situation and relationship between the financial provisions of the TA and annual budgets is graphically described in Figure 3.

Figure 3: Transformation Agenda Vs Health Capital Budget Allocation, Releases and Utilisation



Source: Transformation Agenda and Budget Implementation Reports of the BOF 2010-13

3.2.3 The NSHDP

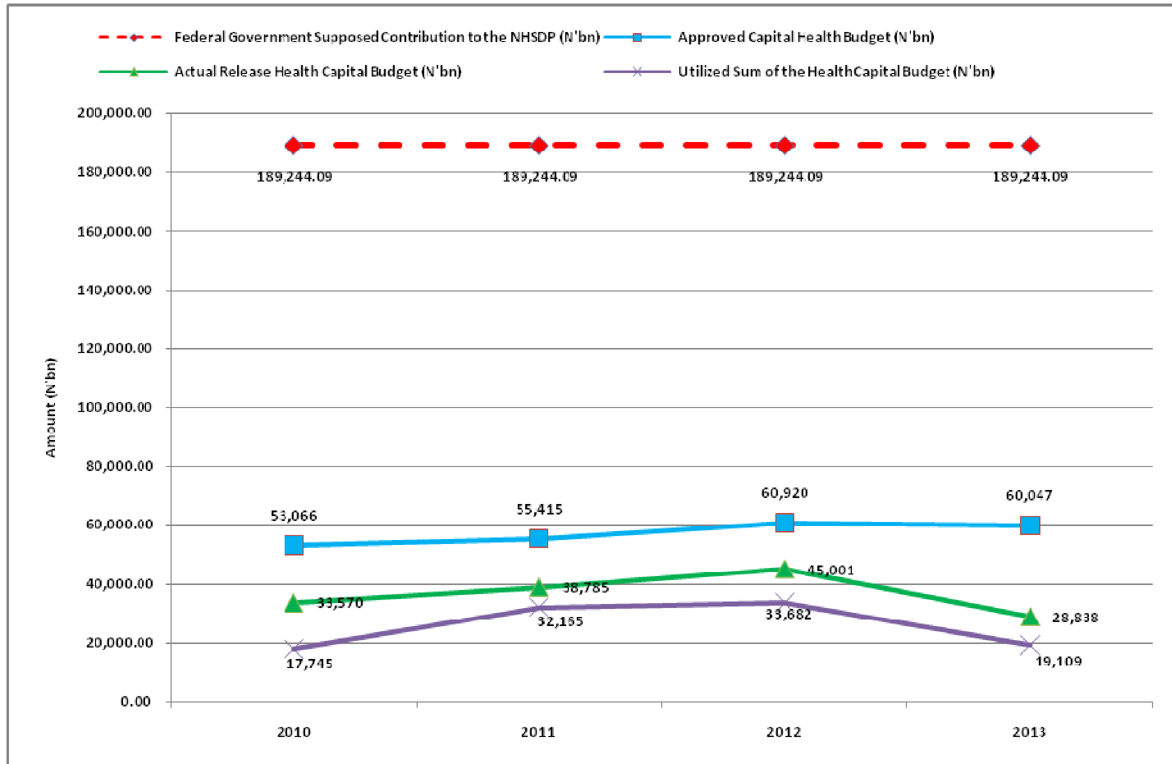
Table 9 shows the allocations to the health capital budget compared to the projects of the NSHDP and the graphic presentation is as shown in Figure 4.

Table 9: NSHDP Vs Health Capital Budget Allocation, Releases and Utilisation

Year	Federal Government Projected Contribution to the NHSDP[36] (N'bn)	Approved Capital Health Budget (N'bn)	*Difference: Approved Health Capital Budget from NHSDP (N'bn)*	Released Health Capital Budget (N'bn)	Cash Backed Health Capital Budget (N'bn)	Utilised Sum of the Health Capital Budget (N'bn)	*(Short fall) Utilised Health Capital Budget from NHSDP (N'bn)*
2010	189,244.09	53,066	136,178	33,570	33,562	17,745	171,499.09
2011	189,244.09	55,415	133,829	38,785	38,716	32,165	157,079.09
2012	189,244.09	60,920	128,324	45,001	37,171	33,682	155,562.09
2013	189,244.09	60,047	129,197	28,838	28,838	19,109	170,135.09
Total	**756,976.36**	**229,448.00**	**527,528.36**	**146,194.00**	**138,287.00**	**102,701.00**	**654,275.36**

[36] Total FG cost in the **NHSDP** for 2010-2015 is N1,135,464,589,117 (an average of N189,244,098,186.17) a year.

Figure 4: NSHDP Vs Health Capital Budget Allocation, Releases and Utilisation



From Table 9 and Figure 4, it is clear that the financial figures of the NSHDP have nothing in common with the annual budget figures. The utilised sum for capital expenditure amounts to a paltry 13.57% of the NSHDP projection. When government fails to commit enough resources for the implementation of a plan, it is unlikely to have the desired impact. What can be deduced from the foregoing is that while the NDPs acknowledged the strategic importance of the health sector, government has not matched the NDPs with sufficient resources that would enable the country to advance its healthcare delivery system. This is evident from the federal budgets. Indeed, the pattern of budgetary allocations to the health sector questions the government commitment to the sector.

3.3 PERCENTAGE ALLOCATION AND GROWTH OF ALLOCATIONS

Table 10 below shows the allocations to the health sector compared to the overall national budget.

Table 10: Percentage of Health Allocation to Total Federal Budget (2009 – 2013)

Year	Total Federal Budget (N)	Health Allocation (N)	Health Allocation As % of Total Budget	Expected 15% Allocation to Health Sector {International Standard} (N)	*Variance of Health Allocation from the International 15% Benchmark (N)*
2009	3,205,156,150,000	154,567,493,157	4.82	480,773,422,500.00	*326,205,929,343.00*

2010	5,159,660,000,000	164,914,939,155	3.20	773,949,000,000.00	*609,034,060,845.00*
2011	4,484,750,000,000	257,870,810,310	5.75	672,712,500,000.00	*414,841,689,690.00*
2012	4,877,209,156,933	284,967,358,038	5.84	731,581,373,539.95	*446,614,015,501.95*
2013	4,987,220,425,601	279,819,553,930	5.61	748,083,063,840.15	*468,263,509,910.15*
Average	**4,542,799,146,507**	**228,428,030,918**	**5.0**	**681,419,871,976.00**	***452,991,841,058.00***

Source: Appropriation Acts 2009 - 2013

Table 10 above shows the percentage allocation to the health sector in relation to the total size of the federal budget, and the estimated shortfall from the 15% benchmark for the sector. Average percentage allocation to the health sector in relation to overall federal budget is not more than 5% between 2009 and 2013. This pattern of annual appropriation to the sector presents evidence of lip service paid to the health and well being of Nigerians. The annual allocation to the health sector was well below international standards as depicted in the last column. This manner of appropriation against the expectations contained in the sectoral documents shows that the linkage between the NDPs and the budget is very weak. Budgetary allocations to the sector reinforce the challenges in the sector when considered against the background of underdevelopment of alternative sources of health funding. The health insurance scheme, for instance, does not cover up to 10% of the population.

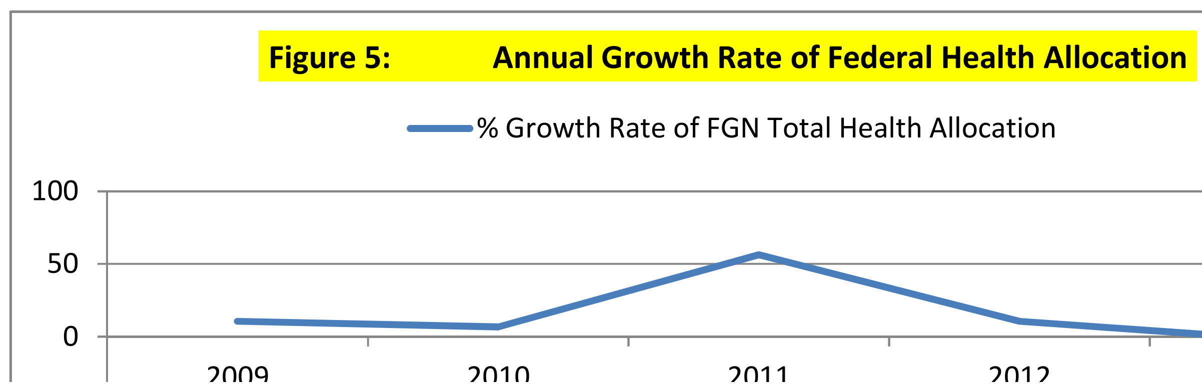
Similarly, the nominal growth in budgetary allocations to the health sector between 2009 and 2013, as demonstrated in Table 11 and Figure 5 below, reveals that only in 2011 was FGN able to fulfill its pledged 25 present annual increase in allocation to the sector. Based on the nominal value, the percentage increase in FGHE ranges between 10.6% (in 2009 and 2012) to 6.7% (in 2010), and -2.1% (in 2013). The impressive growth of 56.4% recorded for 2011 could be attributed to the implementation of approved wage increase for federal workers following agitations by labour unions leading to a net increase in federal wages by 53.37% from 2010[37].

Table 11: Annual Growth Rate of Federal Health Allocation (2009-2013)

Year	Total Health Allocation (N)	Nominal Growth Rate
2009	154,567,493,157	10.6
2010	164,914,939,155	6.7
2011	257,870,810,310	56.4
2012	284,967,358,038	10.5
2013	279,819,553,930	-2.1

Source: Computed from Appropriation Acts (2009 -2013)

[37] The Health Sector secured a large wage increase following the conclusion of negotiations in 2010 on salaries. See: Budget Implementation Report, 2010 (BIR), p.25.



Source: Computed from Appropriation Acts (2009 -2013).

Policy priorities of government are reflected in the goals it is most committed to achieve through prioritisation in the budgeting process. The poor state of healthcare delivery system in Nigeria is largely hinged on a combination of factors including low public investment in the sector. Thus, aligning the sector to the overall structural transformation strategies of NV 20:2020 and the TA will require the FG to redouble its efforts especially through increasing budget allocations to the heath sector. As pointed out in the NV 20:2020, the reforms of the social sector have not been as aggressively pursued as economic reforms, and the result has been economic growth without commensurate development. Similarly, the National Institute for Legislative Studies (NILS) noted inter-alias, that:

> *It appears the budgets in the last decade have not impacted positively on the social sector particularly on health, education and unemployment. Federal Government Policy documents such as the Vision 20:2020 and Transformation Agenda clearly states that in order for public spending on health and education to significantly improve the welfare of the masses, it must be 15 and 26 percents respectively of the entire national budget. Nonetheless, the effectiveness of the spending which is equally important in achieving the results is key to the achievement of the objectives.*[38]

3.4 NON-ALIGNMENT OF HEALTH SECTOR RECURRENT AND CAPITAL SPENDING

Apparently, social sector financing is biased towards recurrent expenditure. For example, the expenditure outlays for the health sector are more on recurrent than capital expenditure as can be seen from Table 12 and Figure 6. There is an element of justification in this because as a key component of the social sector, the health sector requires sufficient recurrent resources, both human and material, to enable it function effectively. The cost of staffing health institutions and its overhead is as important as the

[38]NILS (2013); *Review of 2013 Budget Proposal of the FGN*, Abuja: NILS Publication.

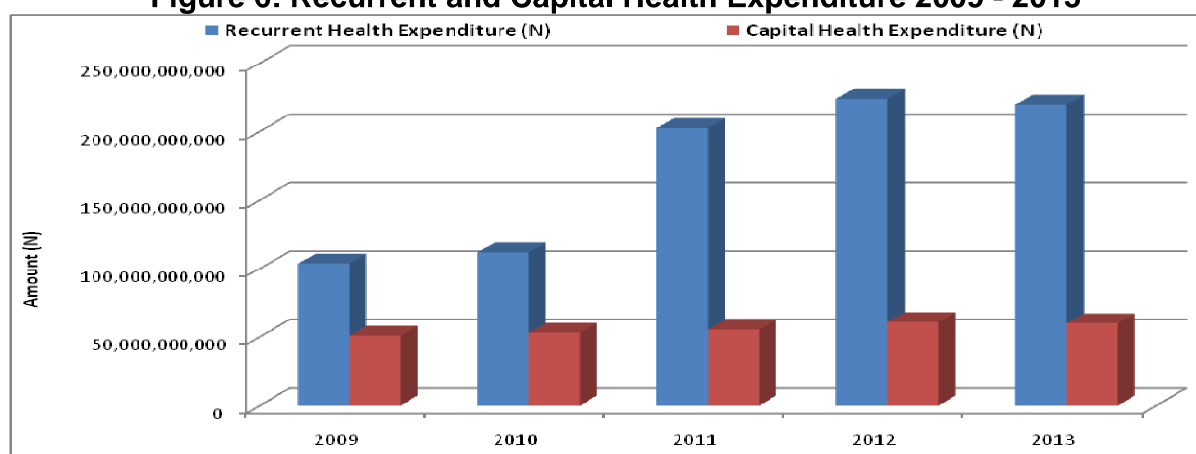
cost of constructing the centres and equipping them. Therefore, there is a tendency to privilege recurrent expenditure above capital spending in the sector particularly given the importance of securing and retaining appropriate manpower, training and retraining as well as procuring other essential consumables for efficient functioning of health service delivery.

Table 12: Recurrent and Capital Health Expenditure Ratio: 2009-2013

Year	Total Health Allocation	Recurrent Health Expenditure	% of Recurrent to Total Health Allocation	Capital Expenditure	% of Capital to Total Health Allocation
2009	154,567,493,157	103,764,216,256	67.1	50,803,276,901	32.9
2010	164,914,939,155	111,908,323,964	67.9	53,006,615,191	32.1
2011	257,870,810,310	202,458,852,933	78.5	55,411,957,377	21.5
2012	284,967,358,038	224,047,138,336	78.6	60,920,219,702	21.4
2013	279,819,553,930	219,737,084,655	78.5	60,047,469,275	21.5

Source: Compiled from Appropriations Acts, 2009 – 2013

Figure 6: Recurrent and Capital Health Expenditure 2009 - 2013



Source: Compiled from Appropriations Acts, 2009 – 2013

The delivery of healthcare involves three components: inputs, health production, and outputs[39]. System inputs include facilities, personnel, equipment and supplies that are required for health production by health providers who offer health services as system outputs to patients. That is, apart from the investments in the healthcare facilities, there are needs for procurement of logistics, essential drugs, commodities and medical equipments or upgrading of the existing ones. As such, the building blocks of health systems revolves around the people; service delivery, information, vaccines and technologies, including financing, leadership and governance. Therefore, there is the need to realign the structure of the health spending in order to strike a balance between the recurrent and capital expenditure. Creating centres of excellence would require

[39]See, *Health Budget News,* Volume 1 (1), September, 2006, Health Budget News is a Newsletter of Socioeconomic Rights Initiative (SERI).

investments in human resources as well as equipment and facilities to sustain it. Even though health is programmatic driven, non-alignment of funding to all the three components would hamper the overall performance of the health delivery system[40], which reflects already in abysmal quality of services, dearth of health facilities including essential drugs.

3.5 DISAGGREGATING RECURRENT EXPENDITURE

Financing human resources for health (HRH) consumes the bulk of the recurrent spending as revealed in Table 13 below.

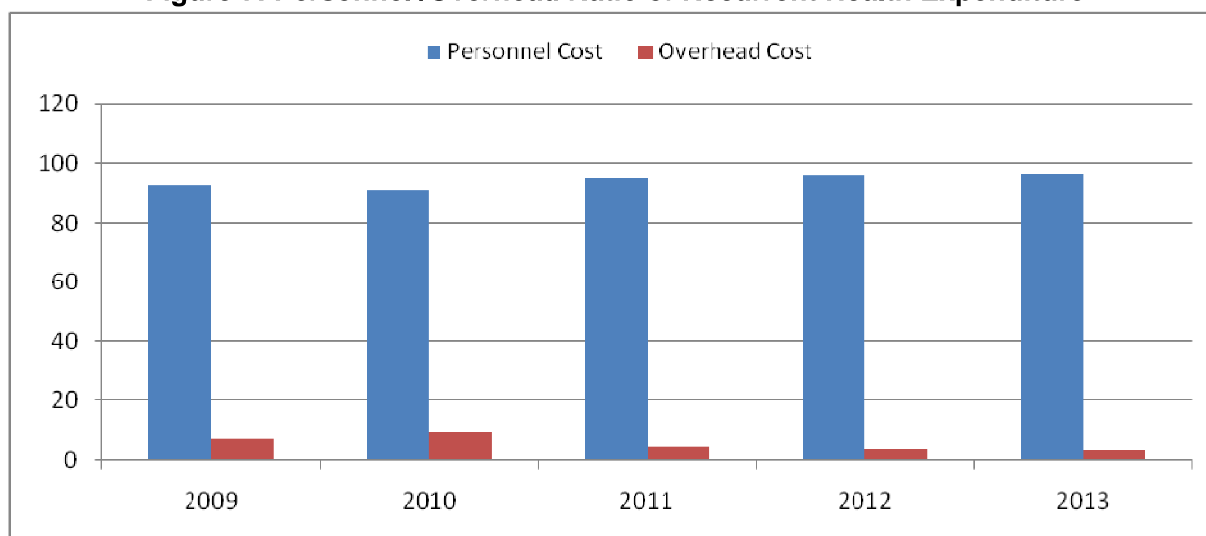
Table 13: Composition of Recurrent Health Expenditure: 2009-2013

Year	Total Recurrent	Personnel Cost	%	Overhead Cost	%
2009	103,764,216,256	96, 251, 615, 051	92.8	7, 512, 601,205	7.2
2010	111,908,323,964	101,488,915,684	90.7	10,366,595,406	9.3
2011	202,458,852,933	192,885,136,669	95.3	9,573,716,264	4.7
2012	224,047,138,336	215,660,019,553	96.3	8,387,118,784	3.7
2013	219,737,084,655	212,517,989,099	96.7	7,219,095,556	3.3

Source: Compiled and computed from Appropriations Acts, 2009 – 2013

Figure 7 below captures Table 13 in graphic form.

Figure 7: Personnel /Overhead Ratio of Recurrent Health Expenditure



Source: Compiled and computed from Appropriations Acts, 2009 – 2013

The recurrent spending in the last 5 years for the sector surpasses the 15% suggested in the revised National Health Policy (NHP) for financing HRH. According to the NHP[41],

[40] WHO describes a health system as the sum of all organisations, institutions and resources whose primary purpose is to improve health.

[41] See, *Revised National Health Policy*, 2004.

a minimum of 15% of the health allocation shall be devoted to human resources for health development in order to achieve the aims and objectives of human resources development[42]. A disaggregation of recurrent spending indicates under financing of non-personnel operating costs. The ratio of personnel to overhead costs far outstrips the threshold suggested in the 2004 revised NHP for financing human resources for health. There is a mismatch between personnel and other recurrent spending. In fact, a maximum threshold ceiling of not more than 60 percent of total health recurrent resources should be channel for HRM while the remaining 40 percent should be earmarked for the overhead related spending.

Without doubt, HRH is the cornerstone of the health system. Thus, the appropriate and targeted application of the human and material resources as envisaged in relevant key sector policies, guidelines and frameworks is central for achieving the goals and objectives of the NHP. This should be factored into the composition of health spending by the government.

3.6 FURTHER DISAGGREGATION OF HEALTH EXPENDITURE

The National Health Account [NHA] (2003 – 2005) revealed a skewed allocation to curative services (74.2%) rather than public health prevention (12.8%), and capital investments rather than to service delivery related spending. As such, resources seem to be concentrated at the tertiary health care than primary health care. Funds should be spent on the right items in order to meet the overall sectoral goals and objectives. The sectoral blueprint reaffirms this when it asserted that:

> *Increased funding of Primary Health Care (PHC) is arguably the most important financing goal for the current Government. The NSHDP asserted that commitment to the PHC approach and support of the ward health system must be backed up with sufficient financial resources.*[43]

Without sufficiently prioritising the level of care that is most crucial and the magnitude of disease burden facing the population, resource distribution in the sector would continue to be skewed in favour of non-prioritised areas of spending. Most public health facilities in the country are primarily at the PHC level and poorly equipped.

In 2005, FMOH estimated a total of 23,640 health facilities in Nigeria of which 88.5% are primary, 14% secondary and 0.2% tertiary while 38% of the facilities are privately owned[44]. Nonetheless, the extant funding regime has not adequately factored this

[42] For the detailed goals and strategy of achieving adequate manpower for health, see the National Policy of HRH.
[43] See, National Strategic Health Development Plan 2010-2015
[44] See page 33 of the NSHDP, 2010.

consideration into annual budgetary appropriations. The reason was attributed to the absence of a legal framework. The National Health Bill (NHB) intends to address this lapse through the proposed PHC Development Fund. The NHB proposes that 2% of the Consolidated Revenue Fund of the Federal Government should be contributed towards a PHC Development Fund, which will finance maternal, newborn and child health and other PHC activities through the National Primary Health Care Development Agency (NPHCDA).The Fund will thus guarantee provision of free medical care for the most vulnerable.

Given that the main policy thrust of NV 20: 2020 on health is to enhance PHC, there is more compelling reason to increase funding to PHC. It appears that PHC is receiving greater financial attention through off budget financing or special intervention funds and grants. For example, through the intervention of SURE-P[45], N32.85bn was budgeted for maternal and child health (MCH) programme; for 2012 it was N15.94bn[46] and in 2013, it got N16.9bn. Also, PHC interventions have been driven by grants from donor agencies[47].

3.7 SURE-P HEALTH INTERVENTIONS

The SURE-P Maternal and Child Health Care programme (MCH) aims to reduce child and maternal morbidity and mortality in Nigeria through the utilisation of cost effective demand and supply interventions to increase access to and provide quality delivery of health services to ensure that Nigeria is on track of achieving MDG goals 4 and 5[48]. It also seeks to tackle inequalities in the provision of primary health care[49]. Some of the expenditure so far is as indicated in Table 14.

[45] The SURE-P programme on health focused on MCH and it is aimed at reducing maternal, new-born morbidity and mortality through the utilisation of cost effective demand and supply interventions. It is also aimed at increasing access to, and providing quality health delivery services to Nigerians and ensuring the successful achievement of the targeted MDGs 4 and 5. See, Amakon, U., 2013; *A Review of Subsidy Reinvestment and Empowerment Programme (SURE-P) Intervention in Nigeria* p.30.

[46] Of the N15.94bn budgeted in 2012 for SURE-P Maternal and Child Health, only N3.8bn (23.9%) was utilised. Source: SURE-P 2012 Report.

[47] The US Consul in Nigeria, Jeffrey Hawkins, disclosed recently that since 2004, the American People have invested over $3 billion of their tax dollar into combating HIV/AIDs in Nigeria. According to him, this year's US Foreign Assistance to Nigeria is $697 million, of which about $400 million is dedicated to fighting HIV/AIDs or other health programming. Similarly, the Global Alliance for Vaccines and Immunization (GAVI) claims that since 2000, it has committed more than $670 million in vaccine support. It was reported that as part of efforts to boost vaccine access and partnering with the FGN in tackling preventable diseases through scaling up routine immunization, the GAVI has approved $21 million to help improve vaccine supply chains in Nigeria. See, *The Nation,* August 8, 2013, pp 4-5, and *The Guardian*, Thursday, August 1, 2013, p.32.

[48] SURE-P Annual Report 2012 at page 11.

[49] SURE-P Final Draft: Federal Government 41% Share at Work

Table 14: Extracts of Expenses in the MCH Intervention Scheme

Amount	Purpose
N209,257,229.76	Recruitment of 4,604 health workers (1,168 midwives, 2,188 community health workers and 1,248 village health workers)
N2,304,686.48	Training of health workers in Kuje and Karu and cash support for beneficiaries
N12,708,130	Two weeks state of readiness assessment in 9 pilot states – including advocacy and sensitization
N9,079,100	Selection and assessment of 500 primary health centres and 125 general hospitals
N810,500,000	Purchase and supply of branded medical supplies and drugs to 500 PHCs
N93,579,775.99	Setting up state implementation units – rents, running costs, allowances and consultants
N4,302,190	Production of programme manual and advocacy materials
N600,000,000	Purchase of buffer drug stock

Source: 2012 Annual Report and Ministerial Platform Progress Report July 2013

Some of its achievements and challenges include the following.

3.7.1 Human Resources for Health and Service Delivery

In terms of achievements, the Progress Report as at July 2013[50] states that SURE-P has increased the supply of human resources for health and created jobs by recruiting 6,630 health care workers. These health care workers comprise: 1,304 midwives; 2,254 community health extension workers (CHEWs); and 3,072 female village health workers (VHWs). These new workers cut across the six geo-political zones of the country. They have been deployed to provide quality ante-natal, skilled birth delivery and post-natal services for previously under-served rural poor women. Maternal, neonatal and child health services are now accessible in 500 SURE-P supported Primary Health Centres (PHC) spread across the 36 states and FCT. A total of N209.257million was used to recruit the heath workers. This amounts to N45,451 per health worker recruited. This is a little bit on the high side. The programme in 2013 plans to add additional 1500 midwives to bring the number to 2804; new 2,800 CHEWS to bring the number to 5,054 and additional 4,200 VHWs to bring the total to 7,272.

The SURE-P MCH Programme has generated significant increase in the uptake of services at PHCs in communities hosting them. 223,786 pregnant women have received antenatal care services in SURE-P MCH supported facilities; 28,435 deliveries have been taken by skilled birth attendants in these same facilities and 19,514 new acceptors of family planning have been recorded in these same facilities.

[50] SURE-P Progress Report, Ministerial Platform, July 2013 by Nze Akachukwu Nwankpo (Secretary SURE-P)

The challenges encountered in the recruitment of health workers include[51]:

- Shortage of midwives accommodation in the states;
- Low literacy level of the participants;
- Discrepancies in the list of midwives and CHEWs submitted;
- Shortage of information technology equipment for bio data capturing;
- Low response of midwives in the Northern zones when compared to the South.

3.7.2 Conditional Cash Transfer (CCT)

SURE-P MCH has successfully launched the Conditional Cash Transfer (CCT) Pilot Programme. It is a demand side cash incentive of N5000 offered to pregnant women to encourage the uptake and use of PHCs after completing and fulfilling certain conditions. The inauguration of State Steering Committees has taken place in eight pilot states and the FCT namely Anambra, Bauchi, Bayelsa, Ebonyi, Kaduna, Niger, Ogun and Zamfara States. 45 PHCs in the six geo-political zones were chosen to administer the programme. The CCT was designed against the background that user fees charged by PHCs and transport costs were major barriers impeding access of poor and rural women to health services.

The CCT services available in the FCT are in 5 PHCs and a total of 2,150 beneficiaries have been enrolled into the programme as at 30th June, 2013 as follows:

- Dei-Dei Comprehensive Health Centre: 670 beneficiaries
- Old Dei-Dei Health Post: 200 beneficiaries
- Byazhin Health Centre: 272 beneficiaries
- Dutse Alhaji Health Centre: 449 beneficiaries
- Kuje Health Centre: 559 beneficiaries

Ward Development Committee (WDC) members have been enrolled in 32 pilot PHC facilities in the 8 pilot states. Beneficiaries are now being enrolled.

3.7.3 Health Facility Upgrade

In 2012, SURE-P MCH selected 625 health facilities made up of 500 PHCs and 125 General Hospitals across the 36 states of the Federation and FCT in collaboration with states and local governments. These health facilities will be transformed into model health facilities with funding support from the SURE-P MCH Programme through extensive renovation and infrastructural upgrade which will include provision of boreholes and toilet facilities. According to the SURE-P 2012 Annual Report:

> *"In each state and the FCT, 3-4LGAs/wards were selected and in each of these wards, 4 PHCs and GH were selected for the SURE-P MCH programme. The 4 PHCs and 1 GH formed what is called a "Cluster, so in each state, 3 or 4 clusters were formed. The health facilities selected were all from health facilities that had no form of donor partner".*

[51] SURE-P 2012 Annual Report at page 16.

SURE- P MCH has completed the Bill of Quantities Assessment of all 625 health facilities to determine the state of physical infrastructure upgrade required for their visible transformation. So far, 74 facility renovations have been approved and awarded. In addition, 313 boreholes have been approved and awarded. In 2013, the projection is to support additional 700 PHCs by the SURE-P MCH Programme to bring the number of upgraded PHCs to 1200. 175 new GH will be supported to bring the number of GHs supported to 300. Based on lessons learnt and hardship experienced by deployed healthcare workers, provision of accommodation for health workers is a paramount consideration for 2013.

3.7.4 Drug and Equipment Supplies

The MCH committee has initiated the supply of essential drugs, health commodities and medical equipments to all 625 SURE-P supported primary and secondary health facilities. The SURE-P MCH Programme is committed to ensuring that no programme beneficiary will be required to pay any user fees when accessing services at any SURE-P supported PHC by ensuring all-year round availability and supply of basic maternal, newborn and child health drugs and health commodities. In addition, the right set of medical equipments will be available to provide quality antenatal, delivery and post-natal services to all programme beneficiaries accessing any SURE-P supported PHC across the country. The standard list of items include medical equipment, MAMA Kits, Midwifery Kits, outreach Kits, VHW kits, maternal neonatal and child health drugs and medical consumables[52].

In 2012, a total of N810.5million was spent on drugs and equipment and by July 2013, the expenditure had gone up to N1.8billion. This is an increased expenditure of about N1billion. Also, N600million worth of buffer stock was procured and stored in zonal medical stores to stamp out “out of stock syndrome”. In all, 425 facilities across the country have been supplied a full complement of drugs, consumables and medical equipments

3.7.5 Communications and Advocacy

SURE-P has commenced communication and advocacy activities towards ensuring sustainability and to preserve the gains of the SURE-P MCH. The National Primary Health Development Agency (NPHDA) is constructively engaging state and local government authorities through advocacy visits and sensitisation meetings with a wide variety of stakeholders including state and local government officials, traditional leaders, community based organizations, and professional associations. It has also developed a draft Memorandum of Understanding (MOU) that will be signed by State Governments to facilitate their ownership and partnership contribution to the SURE-P MCH Programme. Advocacy visits have been successfully conducted in the 13 states of the North East and North West geo-political zones and 11 states in the South East and South West geo-political zones; production and airing of radio and television jingles have commenced in 3 stations in the FCT and a quarterly MAMA magazines has been published and launched.

[52] Page 25 of the 2012 SURE-P Annual Report.

3.7.6 Observations

Visits to the SURE-P headquarters to get a detailed breakdown of the expenditure for the provisions of MCH services did not yield any results. There are more questions than answers. How much was actually used to procure the drugs and kits? What are their descriptions, quantity and quality of the drugs and kits and for what category of patients? What type of drugs, health equipment and kits were purchased at N2.4billion? How were the drugs and equipment distributed to the various PHCs, and GHs? And did the supplies get to the designated locations especially in rural communities? SURE-P headquarters refused to provide details of expenditure on MCH and directed the researchers to the Budget Office of the Federation, which in turn declined giving the information.

The claims on the selected PHCs and GHs cannot be independently verified since their locations are unknown to anyone but the SURE-P team. The claim that thousands of health workers have been employed cannot also be independently verified since the names, addresses and locations of the employees are not available to the public.

Some of the stated challenges on the recruitment of health workers need further interrogation. The low literacy level of participants raises the concern of whether the programme needs health workers who have very low literacy; how will they be able to render services to the intended beneficiaries? A major challenge that will face this component of the MCH is about sustainability. The 2012 Annual Report states that a memorandum of understanding with clearly spelt out roles and responsibilities for federal, state and local government will be signed as binding agreements including a responsibility for state governments to absorb the SURE-P health workers into the state workforce. This looks problematic because states will not easily give in to including new staff on their payroll when they were not been part of the initial planning, consultations and project design. MCH interventions done at the local level would have been more appropriately left to states and local governments. The sustainability of the MCH human resources for health programme after the SURE-P intervention is in doubt.

Another challenge is that the entire MCH intervention looks like a duplication of previous activities under the Millennium Development Goals Projects. Again, the criteria for the selection of the beneficiaries of the CCT are not clear. The long term sustainability of this activity is also doubtful. For the PHC and GH facilities being upgraded and renovated, the authority to continue their maintenance after the end of SURE-P is not clear.

For the projections to increase the number of PHCs and GHs to be upgraded in 2013, there is no confirmation yet whether the increase did take place. The list of the particular PHCs and GHs to be upgraded is not publicly available. Also, whether the planned recruitment of more health staff in 2013 was done cannot be confirmed.

3.8 HEALTH BUDGET UTILISATION RATES

The BOF's Budget Implementation Reports (BIR) indicates that the utilisation of the health sector's capital budget stands at 45.5% from 2009 to 2013. This is below average. Table 15 tells the story.

Table 15: Health Capital Expenditure Utilisation Rate (2009 – 2013)

Year	Approved Capital Health Budget (N)	Actual Release (N)	Cash Backed (N)	Utilised sum (N)	% of Approved Capital Budget Utilised	% of Released Sum Utilised	% of Cash Back Sum Utilised
2009	50,803,276,901	48,643,289,834	48,658,789,834	24,509,417,925	48.2	50.4	50.4
2010	53,066,015,191	33,570,452,816	33,562,153,452	17,745,264,501	33.4	52.9	52.9
2011	55,414,957,377	38,785,000,000	38,716,000,000	32,165,000,000	58.0	82.9	83.1
2012	60,920,219,702	45,000,074,681	37,171,222,265	33,682,405,609	55.3	74.8	90.6
2013	60,047,469,274	28,838,429,775	28,838,439,775	19,108,867,782	31.8	66.3	66.3
Average					**45.4**	**65.6**	**68.6**

Source: BOF (BIRs 2009 – Q3 2013)

Based on the sums released, the amounts utilised seem to have a fair performance, as the percentage of the released sum utilised stands at an average of 65.6% from 2009 to 2013; peaking at 82.9% in 2011. The World Bank's Public Expenditure and Financial Accountability standard (PEFA, 2005) recommends at least 97% rate of utilisation as acceptable. With a utilisation rate under 50% for the health budget against the 97% mark, the sector's capital budget implementation is way below average.

As indicated in Table 15 above, the cash backed sum for the 2009 Appropriation Act was about N48.6bn while only N24.5091bn (50.4%) was utilised as at 31st December, 2009. For the 2010 fiscal year, the sum of N33.562bn was cash-backed and only N17.7 bn (52.9%) was utilised. In 2011, N38.7 was cash-backed and only N32.165bn (82.9%) was used for the implementation of the capital projects/programmes. Similarly, in the 2012 fiscal year, N37.17b was cash-backed while only N33.6bn was utilised for approved programmes. For the year 2013, the sum of N60.05billion was earmarked for capital expenditure, but as at 30th of September, 2013, only N19.11bn (66.5%) was utilised.

Implicit in the foregoing analysis is the low absorptive capacity of the Federal Ministry of Health. With the relatively low releases and cash-backing of releases, in no year did the Ministry expend all its cash-backed allocation. This evidences that the Health Ministry lacks the capacity to fully utilise cash-backed resources as the percentages of the cash-backed funds utilised were fairly low. Comparing the cash-backed sums to the

appropriation further buttresses this low capacity in the MoH. Also, a disproportionate percentage of appropriated funds go into the tertiary level of healthcare implying that tertiary institutions such as Teaching Hospitals, Federal Medical Centres (FMCs), and highly specialised health centres are usually privileged in resource distribution for the sector.

Chapter Four

MATTERS ARISING FROM LITERATURE AND FISCAL REVIEW

4.1 ALIGNMENT OF FEDERAL HEALTH SPENDING WITH BEST PRACTICES IN BUDGETING

Budgeting involves a process of translating government policies, plans and visions into action through the process of appropriation, implementation, monitoring and evaluation (M&E) and drawing lessons from the results achieved to enhance the system in the next cycle.[53] The principles of good budgeting require that budgets must be open in both language and content; while various sources of revenue and expenditure outlays are clearly spelt out in a manner that all stakeholders can understand. A good budgeting system takes cognisance of the goals of fiscal transparency and discipline, effective allocation of resources to priority areas and efficient service delivery. It should adhere to the principles of transparency and accountability, comprehensiveness, predictability of resources and policies, flexibility to respond to changing needs and priorities, contestability i.e. being open to evaluation for improvements[54].

Considering the paucity of resources, there is the need to optimise the outputs and outcomes from every government spending to ensure value for money - enhance economy, efficiency and effectiveness of the outputs and outcomes realisable from a given set of financial and other resources in the annual federal budget. To this end, efficiency of spending in the sector will be increased if healthcare resources are being utilised to achieve more - with the same set of available resources. It would therefore be concerned with the relationship between resources (inputs) such as costs, in the form of labour, finance, or equipment; and outputs, such as numbers treated, waiting time reduced, etc, and outcomes such as lives saved, life years gained, etc[55]. Put simply, budget input refers to the allocation of funds for a specific use in the budget; output refers to how inputs are used, for example, to train health workers, to build hospitals, or to buy medicines and supplies; and outcome refers to the impact or result of budget inputs and outputs, for example, improved child health, and fewer maternal and child deaths.

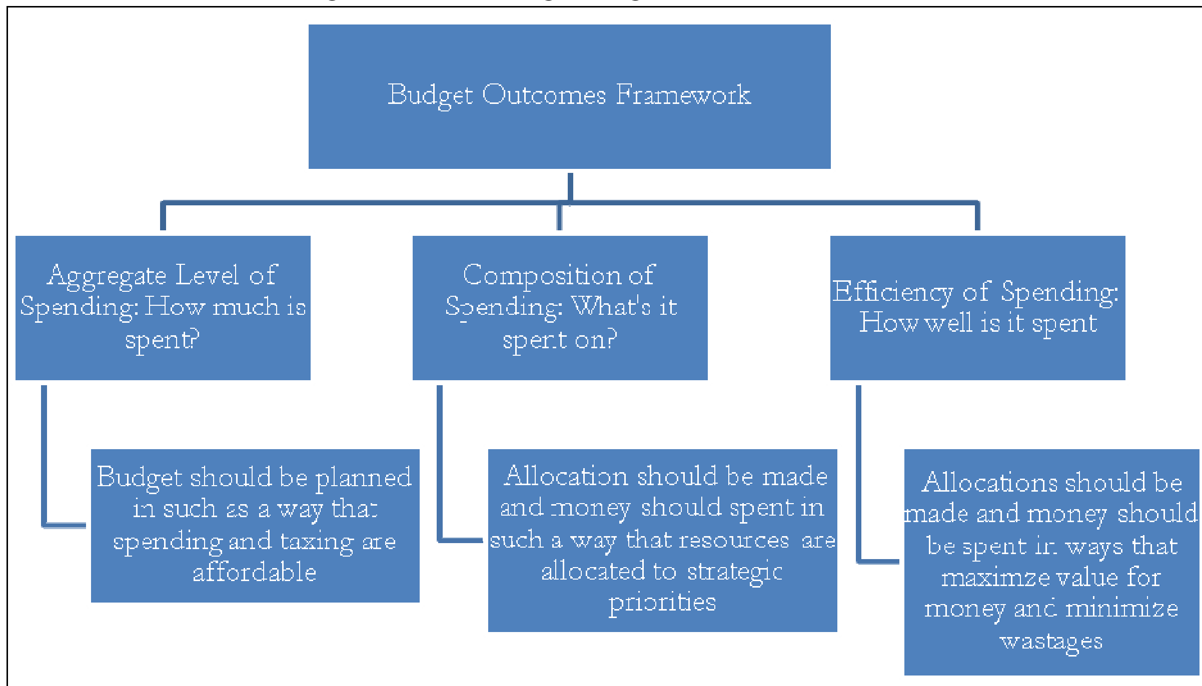
According to the NSHDP, the criterion of economic efficiency implies that the Nigerian society will make choices that will maximise the health outcomes gained from the resources allocated to the sector. Inefficiency in the system will continue to exist when resources are not allocated in a way that would increase the health outcomes produced. Accordingly, efforts must be made to achieve allocative, operational, productive and

[53] See Onyekpere, E. p.91, in CISLAC 2012.
[54] Save the Children, 2012, p.10
[55] NSHDP [2010 – 2015] (2010), pp. 70 – 71.

technical efficiencies by ensuring that available resources are deployed to maximum advantage; ensure productive efficiency with different combination of resources in the system in a manner that achieves maximum health benefit at the given minimal costs; and also ensuring allocative efficiency by funding a right mixture of healthcare programmes in order to maximise the health of Nigerian society.

Thus, budget outcomes are a product of how much is spent, what it's spent on, and how well it is spent. Figure 8 illustrates this framework succinctly.

Figure 8: Budget Alignment Framework[56]



Like other MDAs, the resource envelope available to the Federal Ministry of Health (FMOH) is limited and it is imperative to get the best out of this limited envelope. Through the FMOH, the FG aims to achieve tangible improvements in PHC, disease control, sexual and reproductive health (including STDs and HIV/AIDs), secondary and tertiary health care, drug production and organization and management of healthcare delivery. The priority programmes include Disease Control and Health Emergency Response Programme; Expanded Immunization Programme; Federal Health Institutions Revitalization, Modernisation and Development Programme; Health Research and Development Programme; Human Resources for Health Development Programme; Integrated Management of Maternal, Newborn and Child Health Programme; National Emergency Ambulances Services; National Health Insurance Programme; National Health System Strengthening and Development Programme; NHMIS/M&E Programme;

[56] Adopted from Save the Children, 2012, P.12, op. cit.

National Food and Drugs Control Programme; and National Professional Health Regulatory Institutions Strengthening Programme.

Using the Framework in Figure 8 above, a useful Checklist to assess the level of harmony and alignment of federal health spending within the period under review is presented in Table 16. The Checklist thus serves as an indicator that measures adequacy, priority level, progress, equity, efficiency and effectiveness of health spending.

Table 16: Checklist to Assess the Performance of Federal Health Budgets

Checklist	Indicator	Remarks
Is the current health budget adequate to meet the government's stated development and policy objectives?	How much priority is given to health when compared with other sectors?	Health is accorded secondary priority with about 5% of total budget allocated to the sector since 2009 (See Tables 10 and 11).
Is progress being made in real terms?	Has government expenditure on health increased in real terms (above the rate of inflation) over time (when compared with previous years)?	Marginal growth[57] is recorded short of pledged 25% increase in annual budgetary allocations to the sector committed to by the Presidential Summit on Health (the Nigerian National Partnership on Health) in 2009. Inflation rate has surpassed growth of allocations to the sector.
Are budget allocations equitable?[58]	Are cost-effective interventions being prioritised? Or is a disproportionate share of resources going to tertiary care in urban areas (specialised, consultant care, usually in a hospital), to the neglect of primary and secondary services in rural and urban areas? Put simply, which services and	A disproportionate share of resource allocations goes to tertiary level of care, for example, over N107 billion out of about N154bn to Health Sector under the 2009 Budget went to tertiary healthcare (THC) institutions, compared with about N16bn for the primary level of care represented by NPHCDA and NPI.

[57] The dramatic upsurge in nominal growth rate recorded in 2011 could be attributed to a large wage increase secured by the health sector following the conclusion of negotiations in 2010 on salaries with government.

[58] Budget analysis can reveal any inequities in resource allocations.

	commodities are being funded; and are they proportional to the most common diseases among different population groups, or targeted where needs are greatest?	
Are resources being spent efficiently?	Exploring discrepancies between budget allocations (what is planned to be spent) and expenditure (what is actually spent) can reveal inefficiencies, blockages or weak capacities in the system.[59]	The BOF's BIRs indicate that health sector utilisation rate is low. The full budget is not released to the FMoH; what is released is not fully cash-backed; and what is cash-backed is not fully utilised (See Table 15).[60]
Are resources being spent effectively?	Is the money being spent on the right outputs in order to achieve the desired outcomes? Are the interventions being funded the most appropriate (i.e. do they lead to the desired outcome) and cost effective? Thus, funds should be spent on the right items to meet the overall objective.	As hinted, funds are concentrated at the THC than PHC. This does not sufficiently prioritise the magnitude of disease burden on the population such as malaria which seems to be driven more by grants and off-budgets or special intervention funds.

Source: Checklist is adapted from Save the Children 2012, pp. 13 -14

The above Table clearly indicates that the Nigerian health budget performance is poor.

4.2 USING THE MAXIMUM OF AVAILABLE RESOURCES FOR THE PROGRESSIVE REALISATION OF THE RIGHT TO HEALTH

As a State Party to international treaties containing the right to health, Nigeria has committed itself to guarantee the right to its citizens to good health. The poser is whether Nigeria is using the maximum of available resources for the progressive

[59] A lack of capacity within a ministry or health facility may mean the full budget allocation cannot be spent. Unspent funds may have to be returned to the national treasury at the end of the financial year, which can result in less funding allocated for that service in the next budget cycle.

[60] The 1st Presidential Summit on Health commits to at least 90% budget release and 100% utilisation by the end of each fiscal year in the health sector. However, it is important to point out that this has never happened in the health sector. Improved utilisation only happens when the implementation period for capital expenditure is extended to March 31st of the following Financial Year; spanning 15 months duration instead of the normal 12 months provided by the Financial Year Act.

realisation of the right to health or whether it has taken all necessary, concrete and targeted steps for the realisation of the right to health. The comparative data from a few health indicators below seeks to resolve these posers. We will also review other indicators such as framework laws, total health expenditure, etc, and use the analysis to come to a conclusion on whether the maximum of available resources have been used for the realisation of the right to health in Nigeria.

4.2.1 Life Expectancy at Birth (Year)

According to the World Health Statistical Report 2014[61], in 2012, global life expectancy at birth was 68 years for men and 73 years for women. Among men, life expectancy ranged from a high of 75.8 years in high-income countries to a low of 60.2 years in low-income countries – a difference of 15.6 years. The report shows Nigeria's life expectancy from birth to be 54 years as at 2012; a slight improvement from 1990's 46years. This is the 7th lowest in the world, and less than the African continent's 58 years average and the global average life expectancy from birth. Despite Nigeria's abundant resource profile, neighbouring African countries seem to be doing better in terms of life expectancy. From the report, Niger Republic has a life expectancy (at birth) of 59 years, Togo 58 years, Benin 59 years, South Africa 59 years, Gambia 61 years, Liberia 75 years, Kenya 61 years, Rwanda 65 years, Senegal 64years, Ghana 62 years, Libya 75 years and Algeria 72 years. Other comparative countries like Afghanistan has a life expectancy at birth of 60 years, Malaysia and Brazil have a life expectancy age of 74 years from birth while India is 66 years.

The Report also shows that in Nigeria, men have the likelihood of dying earlier than their female counterparts. It put the male life expectancy at 52 years of age and the female at 54 years of age. These are far below the global averages of 68years for male and 73 years for female.

4.2.2 Infant Mortality Rate[62]

Further analysis of the World Health Statistics 2014 shows that Nigeria's infant mortality rate dropped from 126 per 1000 live births in 1990 to 112 per 1000 live births in 2000, and impressively lowered to 78 per 1000 live births in 2012. Within the periods, Africa's figures of infant mortality per 1000 births was comparatively lower from 105/1000 live births in 1990 to 63/1000 live births by 2012. Our infant mortality rate does not meet the Transformation Agenda's target of 60 per 1000 live births for 2011. It also failed to meet the 2013 mark of 45/1000 live births. Nigeria had the 7th highest infant mortality rate in the world as of 2012. The countries that had higher infant mortality rates as of 2012 were Sierra Leone with 117 per 1000 live births, Angola 100/1000, Democratic Republic

[61] World Health Statistics Report 2014 (World Health Organization)
[62] Infant mortality rate (probability of dying by age 1 per 1000 live births)

of Congo 100/1000, Chad 89/1000, Guinea Bissau 81/1000, and Mali 80/1000. Evidently, these countries are not Nigeria's peers in terms of resource profile.

4.2.3 Under-Five Mortality Rate[63]

According to the World Health Statistics 2014, under-5 mortality in Nigeria dropped from 213 per 1000 live births in 1990 to 124 per 1000 live births in 2012. Though this exceeds the Transformation Agenda's projection of 130 deaths per 1000 live births, these is still the possibility that the 2013 mark of 103 deaths per 1000 live births would have been achieved with the increased PHC interventions in the SURE-P MCH intervention. Comparatively, this position is however poor considering the position of the country as the biggest economy in Africa. Countries like Togo (96/1000), Benin Republic (90/1000), Congo (96/1000), Kenya (73/1000), Ghana (72/1000) and South Africa with the lowest of 45 per 1000 live births. Once again, Nigeria is under performing.

4.2.4 Maternal Mortality Ratio

The World Health Statistics 2014 reports that Nigerian maternal mortality rate was 1200 per 100,000 live births in 1990, 950/100,000 in 2000 and improved to 560/100,000 in 2013. Nigeria in 2013 is virtually in the same league with Mali at 550/100,000; Niger at 630/100,0000, Malawi 510/100,0000. Generally, African countries are performing badly on this score with the exception of a few like South Africa at 140/100,0000. But when Nigeria is compared with India (190/100,000), Brazil (69/100,000) and Mexico (49/1000,000), it will be clear that Nigeria is very backward. As the largest economy in Africa, our resource profile and potential can provide a more improved ratio.

4.2.5 Hospital Bed Density[64]

According to the CIA Fact Book[65], Nigeria has precisely 0.53 beds per 1,000 population. That is 53 hospital beds for 1000 Nigerians as at 2012. Comparatively, other African countries with less resource endowments seem to have more hospital beds for thier citizens. From the Fact Book, Mali (0.57beds/1000 population), Liberia (0.7beds/1000 population), Togo (0.85 beds/1000 population), Ghana (has 0.93 hospital beds/1000 population), Gabon (1.25beds/1000 population) Kenya (1.4 beds/1000 population), Guinea (1.9 beds/1000 population), Algeria (1.7beds/1000 population), Egypt

[63] The under-5 mortality rate is defined as the probability of dying by age 5 expressed as the total number of such deaths per 1000 live births.

[64] The number of hospital beds per 1,000 people. Hospital beds include inpatient beds available in public, private, general, and specialised hospitals and rehabilitation centres. In most cases, beds for both acute and chronic care are included. Because the level of inpatient services required for individual countries depends on several factors - such as the burden of disease - there is no global target of number of hospital beds per country

[65] CIA World Factbook - Unless otherwise noted, information from this source page is stated to be accurate as of January 1, 2012.

(1.7beds/1000 population), South Africa (2.84beds/1000 population), Zimbabwe (3beds/1000 population), Libya (3.7 beds/1000 population). Japan has the highest number of hospital beds per 1000 of her population with 13.75beds. Other similar countries to Nigeria in terms of structure like Malaysia has 1.82 hospital beds, Singapore 3.14 hospital beds, India 0.9 hospital beds, Brazil 2.4 hospital beds per 1000 of their populations; far more impressive than Nigeria.

4.2.6 Physicians Density[66]

According to the CIA compilation, Nigeria has an estimate of 0.395 physicians per 1000 population[67]. The World Health Statistical Report for 2014 puts the ratio of Physicians per 10,000 populations to be 4.1 physicians per 10,000 population from 2006 to 2013. The same report indicates that the ratio of nurses and midwifery personnel to 10,000 populations is 16.1 (16.1 nurses to 10,000 Nigerians). This scenario is common in most African countries. However, some African nations like South Africa have more impressive medical staff - population ratio; (7.8 physicians to 10,000 population, and 49 nurses to 10,000 population); Egypt has 28.3 physicians per 10,000 of her population and 35.2 nurses per 10,000 of her population. Libya has 19 physicians and 68 nurses per 10,000 of her population. Other comparative countries such as Brazil have18.9 physicians and 76 nurses per 10,000 of Brazilian population; India has 7 physician and 17.1 nurses per 10,000 of her population; Malaysia has a ratio of 12 physicians per 10,000 of her population and 32.8 nurses per 10,000 Malaysian population. Qatar has the highest number of physicians; with 77.4 per 10,000 of her population, while Monaco was reported to have the highest number of nurses and midwifery personal at 172.2 per 10,000 of her population. On the average, Africa has a ratio of 2.6 physicians and 12 nurses per 10,000 population, while globally; the ratio stands at 14.1 physicians and 29.2 nurses per 10,000 population between 2006 to 2013. Again Nigeria’s performance is below average.

According to the President of NMA[68], Nigeria currently has about 65,000 medical and dental practitioners listed on the official register of the Medical and Dental Council of Nigeria (MDCN), with less than half of them (about 25,000) currently practicing in

[66] The number of medical doctors (physicians), including general and specialist medical practitioners, per 1,000 of the population. Medical doctors are defined as doctors that study, diagnose, treat, and prevent illness, disease, injury, and other physical and mental impairments in humans through the application of modern medicine. They also plan, supervise, and evaluate care and treatment plans by other health care providers. WHO estimates that fewer than 23 health workers (physicians, nurses, and midwives only) per 10,000 would be insufficient to achieve coverage of primary healthcare needs.

[67] By estimation if 0.395 doctors to 1000 population; then 65,965 doctors should be operating for 167 million Nigerians. This is a ratio of 1doctor to 2500 patients which still exceeds the WHO standard of 1 doctor: 600 patients.

[68] Nigerian Medical Association (NMA) official: One doctor to 6400 patients in Nigeria (Source: Business Day, May 3. 2013)

Nigeria. This indicates a doctor-patient ratio of 1: 6,400 patients[69], which is against the World Health Organization (WHO) standard of 1:600. With the increase in the number of medical manpower lost to brain drain, unavailable and poor quality health infrastructure, the country is faced with poor health indicators. According to the NMA report, over 5,000 Nigerians travel to India and other countries monthly for medical treatment. The Association reported that Nigeria loses over $500m annually to health tourism and about $260m of this sum is spent in India. Nigeria's Sovereign Wealth Fund Authority puts the sum lost annually to medical tourism at over USD $1b.

4.2.7 Absence of Framework Laws(s) and New Sources of Funding

Opportunities for additional resource mobilisation for the progressive realisation of the right to health abound in Nigeria. These resources can be mobilised if government develops the political will to do so. The National Health Bill seeks inter alia to establish the Primary Health Care Development Fund (PHCDF) to be financed from the Consolidated Revenue Fund of the Federation as an amount not less than 2% of its value. The Health Sector Reform Coalition has estimated that the 2% value of the Consolidated Revenue Fund (calculated on current available revenue) will be about N60bn annually[70]. This will be in addition to the regular health budget and grants by development partners and funds from other sources. However, the Bill is held down by controversy and professional rivalry between medical doctors and other professionals in the health sector and disputations about organ and tissue transfers. The Bill was passed by the National Assembly but it did not get the assent of the President. Again, it is still pending in the current legislature which is the 7th National Assembly while it was first presented at the 5th Assembly. To this end, the passage of NHB is vital for the realisation of the right to health in Nigeria[71].

Another avenue for mobilising resources for health is through health insurance. The National Health Insurance Scheme (NHIS) is aimed at providing easy access to healthcare for all Nigerians at an affordable cost through various pre-payment systems. While universal coverage was intended by NHIS, only about 5.3million Nigerians are insured under the scheme with beneficiaries limited to employees of federal government and large corporations. However, it is the contention of this Study that if all Nigerians

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[69] Assuming the population of Nigeria to be 167 million

[70] Executive Director, Health Reform Foundation was reportedly said to have estimated N60 billion in Thisday Online, August 2013.

[71] The NHB which is expected to provide the legal framework for the regulation, administration and development of the healthcare sector in Nigeria, suffered a setback following the denial of presidential assent by President Jonathan after the its passage by the 6th National Assembly (NASS). A revised version of the NHB is still undergoing legislative review on the floor of the NASS without optimism of sailing through given the intense inter-professional rivalry among various healthcare professionals in the country. Yet NHB is expected to be the basic law which guides the development, regulation and administration of the health sector in Nigeria.

are compelled by law to sign on to take health insurance, the resources required to adequately revitalise the sector would be raised in a number of years.

To achieve universal health insurance coverage for all persons living in Nigeria[72] would require the repeal of the NHIS Act and its amendment to make it compulsory for all employers of labour to buy health insurance for their employees; scale up community-based health insurance and intensifying marketing of voluntary contributory social health insurance scheme. Another proposal for a new source of funding is the collection of one kobo per second for calls made by Nigerians using their mobile phones and the remittance of the money by GSM companies to a special health fund. This is projected to yield not less than N300b annually.

4.2.8 Total Health Expenditure[73]

According to the 2014 World Health Statistics Report, Nigeria's total expenditure on health as a percent of the GDP increased from 4.6% in 2000 to 5.7% in 2011. Decomposing the aggregate health spending to GDP, the general government expenditure on health as a fraction of the total health spending in 2011 was 34% (33.5% in 2000), while the private expenditure on health as a percent of total health expenditure was 66% in 2011 (down from 66.5% in 2000). The external resource for health as a percentage of total health expenditure was only 5.1% in 2011 (dropping from 16.2% in 2000). FGN did not spend any resources on health as a component of social security. This suggests that most Nigerian tend to finance their health needs from their personal pockets as at 2011. In Ghana 2011, the government provided 55.9% of the total health expenditure (21.65 of which are sourced from the social security expenditure; i.e. health insurance), private expenditure contributes only 44.1% of total health expenditure while the external resource provides for 13.2% of the total health expenditure. In South Africa, while the government contributes only 47.7% of the total health expenditure, private expenditure provided 52.3% of the total health expenditure and external resources accounted for 2.1% of the total health expenditure in 2011. Health expenditure as a percentage of GDP was 8.7% in South Africa in the year 2011. The Brazilian government's general expenditure on health in 2011 was 45.7% of THE. The Nigerian figures clearly show that access to health care in Nigeria is to large extent dependent on

[72] The NHIS Re-enactment Bill before the 7th National Assembly, which provides for a National Health Insurance Commission with various schemes such as Public Sector Health Insurance Scheme; Organized Private Sector Health Insurance Scheme; Private Health Insurance Scheme; Mutual Health Insurance Scheme; and Vulnerable Group Health Insurance, is well intended. In fact, the Minister of Health, Prof. Onyebuchi Chukwu, once claims that his performance contract with President Jonathan stipulates that by 2015, at least 30% of Nigeria's population will be covered by health insurance.

[73] World Health Statistics 2014: These data are generated from information that has been collected by WHO since 1999. The most comprehensive and consistent data on health financing are generated from National Health Accounts (NHAs) that collect expenditure information within an internationally recognised framework. NHAs trace financing as it flows from funding sources to decision-makers (who decide upon the use of the funds) and then to the providers and beneficiaries of health services.

the finances of the individual and his family and the government can afford to improve on its contribution to health care.

4.2.9 Distinguishing Inability from Unwillingness

Evidently, the amount of resources available to FGN has increased with the succession of crude oil windfalls since 1999 leading to the establishment of many national fiscal saving schemes such as Excess Crude Account (ECA), Sovereign Wealth Fund (SWF), and upsurge in foreign reserves. For example, the value of ECA in 2009 was about USD $20.44bn, while foreign reserves stood at $42.41bn. Therefore, allocating sufficient resources to the sector to meet the minimum requirement should not be a difficult task if there is the political will.

It is therefore imperative to distinguish inability to fulfil the right to health from the unwillingness of government to use the maximum of available resources to progressively realise and implement the right to health for its citizenry. The FGHE is grossly inadequate, insufficient, and inequitable. The poor state of healthcare delivery system in the country is largely hinged on this lack of strong commitment by the Government of Nigeria evidenced in the low public investment in health sector over the years. Indeed, the poor performance of Nigeria's health system can therefore be primarily attributed to low financial resourcing for health services.

Table 17 below shows the picture of the huge shortfall in meeting the 15% internationally set benchmark of public funding of the health sector for developing countries over the period spanning 1999 - 2013. This shows a pattern and a trend for fourteen years.

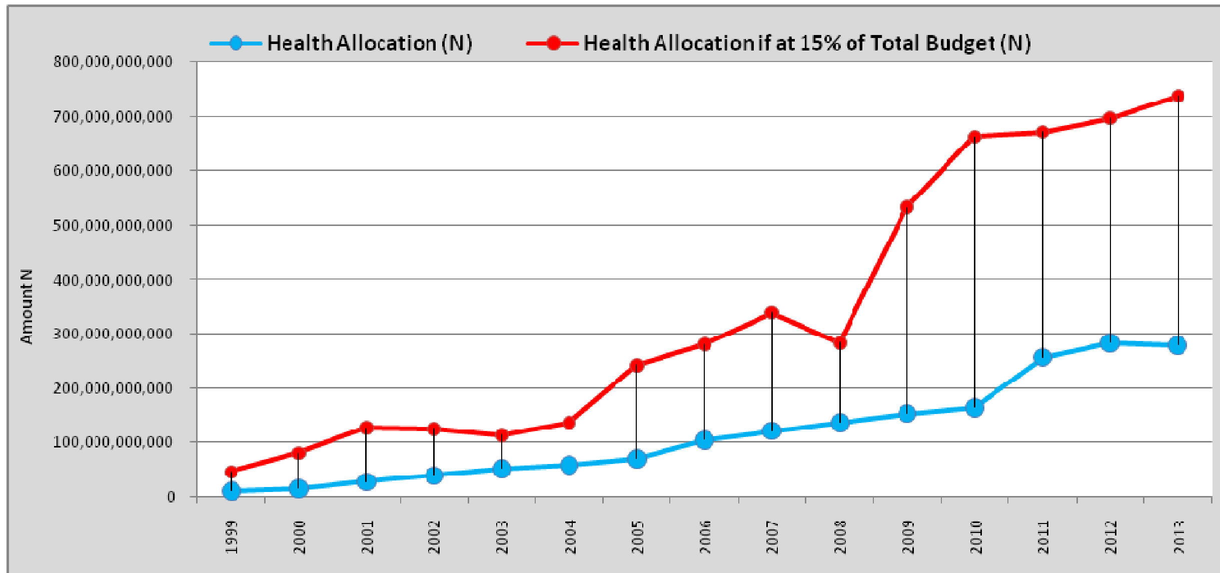
Table 17: Shortfall in the 15% Benchmark to Health Sector

Year	Total Budget (N' Trillion)	Health Allocation (N' Brillion)	As % of Total	As 15% of Total (N' Brillion)	Variance of 15% Benchmark (N' Brillion)
1999	315,219,252,837	10,929,579,649	3.5	47,282,887,926	36,353,308,277
2000	537,569,135,062	15,613,509,364	3.0	80,635,370,259	65,021,860,896
2001	851,754,887,883	28,405,884,484	3.3	127,763,233,182	99,357,348,698
2002	840.853,787,128	39,741,137,140	4.7	126,128,068,069	86,386,930,929
2003	765,132,027,979	52,249,106,213	6.8	114,769,804,197	62,520,697,984
2004	918,295,494,202	59,787,376,511	6.5	137,744,324,130	77,956,947,619
2005	1,617,629,111,162	71,685,426,092	4.4	242,644,366,374	170,958,940,582
2006	1,876,302,363,351	105,590,000,000	5.6	281,445,354,503	175,855,354,503
2007	2,266,394,423,477	122,399,999,999	5.4	339,959,163,522	217,559,163,523
2008	1,893,838,933,017	138,179,657,132	5.6	284,075,839,953	145,896,182,821
2009	3,557,683,000,000	154,567,493,157	4.3	533,652,450,000	379,084,956,843
2010	4,427,184,596,534	164,914,939,155	3.7	664,077,689,480	499,162,750,325
2011	4,484,736,648,992	257,870,810,310	5.7	672,710,497,349	414,839,687,039
2012	4,648,849,156,932	284,967,358,038	6.0	697,327,373,540	412,360,015,502
2013	4,924,604,000,000	279,819,553,930	5.7	738,690,600,000	458,871,046,070

Source: Adapted [and expanded] from CISLAC (2011), p.57.

Figure 9 below also demonstrates the trend.

Figure 9 Funding Gap: 15% International Standard for Health Allocation Vs Appropriated Health Allocation. 1999 - 2013



When this poor funding is juxtaposed against the fact that Nigerian loses not less than 350,000 barrels of crude oil a day to oil theft, then the excuse of unavailability of resources for implementing the right to health becomes very weak. Some estimates put the losses at 500,000 barrels per day. Taking the lower figure of 350,000 barrels per day, at an average price of $100 per barrel, the loss in a year is the sum of $12.78bn. When translated at the exchange rate of N160=$1USD, it comes out to N2.04trillion which is more than the sum needed to tackle the health challenge. Indeed, this is about 50%of actual annual federal budget expenditure over the last four years.

4.2.10 Poor Oversight over Health Expenditure and Outcomes

From the amounts budgeted for health, to the releases, the cash-backed sums and the actual utilised sums, it is evident that there is poor oversight over the allocation and management of resources for health care. The first non functional oversight is that done by the legislature through the relevant committees on health in the Senate and the House of Representatives. It is not enough to claim that oversight activities are ongoing; the evidence of oversight should be in the outcomes and results. Oversight is not a mere routine visitation exercise but one anchored on deliverables. The second level of oversight that has failed is the civil society and citizens' oversight over the management of resources in the sector. Functional democracies require engagement by citizens of the processes of service delivery. As such, it is not enough to leave the health sector to the health professionals and their interminable industrial actions, turf war and bickering.

Rather, civil society should engage for agenda setting and holding public officers to account. This has hardly been witnessed in the sector.

4.2.11 MTSS and MTEF

It is apparent that the practice of preparing MTSS with the input of stakeholders has been consigned to the dustbin of fiscal management history in Nigeria. If the MTSS process is still in use, it is done secretly by MADA personnel alone. The result is a health system that does not respond to the needs of stakeholders and those who need it most. Rather, it responds to the whims and caprices of a few men and women of power.

4.2.12 Wasteful and Frivolous Expenditure

The nineteen federal teaching hospitals have separate governing boards of not less than seven and not more than ten members. At ten members each, this will amount to one hundred and ninety board members while at seven members each, it will amount to one hundred and thirty three. Board members draw requisite perks of office. This is a waste and opportunity "of a job for the boys" that adds no value to the improvement of the health system. If one board to run all the teaching hospitals is conservative, about four boards (grouping the teaching hospitals into clusters) would make eminent sense and save costs. Further, all the Federal Medical Centres are administered by governing boards without an enabling law. These Centres do not need a board with members that draw unnecessary perks of office. This is another area of waste. In line with the Oronsaye Committee report, a management team should run the Centres rather than a board. This will save costs. The eight psychiatric hospitals, three orthopaedic hospitals all have single boards. But this should not necessarily be so. One board to run the psychiatric hospitals and another to run the orthopaedic hospitals is enough. If the recommendations of the Oronsaye Committee on reducing the cost of health governance and the reform of health institutions are ratified and implemented by government, tens of billions of naira will be saved on a yearly basis.

4.2.13 Conclusion before the Main Conclusions

The conclusions is that the FGN is not using the maximum of its available and potential resources for the realisation of the right to health as it is failing to meet the basic minimum international standards. The extant public funding of the health sector is contributing to the poor health outcomes in the country. There are potential sources of new financing waiting to be tapped. Corruption is also eating deep into available resources.

Chapter Five

CONCLUSIONS AND RECOMMENDATIONS

5.1 CONCLUSIONS

National and international standards guarantee the right to health in Nigeria and this imposes an obligation on the country to use the maximum of available resources for the progressive realisation of the right to health. Nigeria is also bound to take steps including the adoption of policies, legislative measures and financial commitments in the direction of fulfilling the right to health of its citizens, especially the minimum core obligation to guarantee minimum essential levels of healthcare that respond to the prevalent disease conditions as demonstrated by epidemiological data and prevalent health indicators. This obligation is in tandem with Millennium Development Goals 4, 5 and 6; to reduce child mortality, improve maternal health, combat HIV/AIDS, malaria and other diseases.

All components of the NDPs acknowledge the strategic importance of health to economic growth and national development. They are all in agreement on the need for increased resource mobilisation and allocation to the sector. But their fiscal projections differ. There is a weak alignment between the fiscal projections of NDPs, budgetary allocations and investments for meeting the goals of NDPs and the dream of the highest attainable state of physical and mental health for all Nigerians. The Study points to the evidence which disconnects budgets from the NDPs. In budgetary terms, the percentage of federal health budget as a component of the overall budget is about 5%, which is less than the 15% benchmark set for a developing country like Nigeria. The overall health budget even falls short of the Nigerian Partnership for Health 2009 Declaration which pledged 25% annual increase in budgetary allocation to the sector until the benchmark is met. The percentage growth has not kept pace with inflation. The implication of this is that health is not regarded as a priority by the government. In other words, the priority set for health is not matched by resource allocation to the sector.

The average per capita federal health budget between 2009 and 2013 is about $10.2. This is short of the $34 recommended by WHO for delivering essential health care. Nigeria's total expenditure on health increased from 4.6% of the GDP in 2000 to 5.7% of the GDP in 2011. Thus, the greater part of health expenditure is from the pockets of patients and their families. Even within the relatively low figures budgeted for health, the sums made available by the Ministry of Finance are usually low and this is compounded by the poor absorptive capacity of the FMoH. Essentially, the full health budget is not released to the FMoH; what is released is not fully cash-backed; and what is cash-backed is not fully utilised. The percentage of approved capital budget utilised in the last

five years has been 45.4%. This is very poor and below average. The recurrent component of the budget which is mainly about salaries are fully released and utilised. MTSS and MTEF preparation in the health sector is now a mere routine that ignores stakeholders. It has become another bureaucratic process for members of the bureaucracy alone without external inputs.

FGN has also failed to explore alternative and complimentary means of funding the realisation of the right to health. Such complimentary funding ideas like the expansion of the National Health Insurance Scheme, the allocation of 2% of the Consolidated Revenue Fund to primary healthcare, surcharges from telephone tariffs set aside for health financing, etc have been on the drawing board without concrete steps to implement them.

Federal health budgets have given priority to recurrent expenditure which averaged 74% of the annual appropriation. As a key component of the social sector, the health sector requires sufficient recurrent resources, both human and material, to enable it function effectively. However, personnel costs consume the large chunk of the recurrent expenditure gulping about 93% of the recurrent vote. Without doubt, human resources for health (HRH) is the cornerstone of the health system, but the extant position is a mismatch between personnel and other recurrent spending. There is also mismatch between recurrent and capital expenditure. The delivery of healthcare involves three components: inputs, health production, and outputs. System inputs include facilities, personnel, equipment and supplies that are required for health production by health providers who offer health services as system outputs to patients. That is, apart from the investments in the healthcare facilities, there are needs for procurement of logistics, essential drugs, commodities and medical equipments or upgrading of the existing ones. As such, the building blocks of health systems revolves around the people; service delivery, information, vaccines and technologies, including financing, leadership and governance. Therefore, there is the need to realign the structure of the health spending in order to strike a balance between the recurrent and capital expenditure. The cost of governance in the health sector is very high and contributes to the skewed and huge personnel costs. This can be reduced and properly aligned to the health needs of Nigerians.

The National Health Account revealed a skewed allocation to curative services rather than public health prevention. A disproportionate share of the budget resources go to tertiary health care instead of primary health care. This pattern of allocation is not responsive to the disease burden of Nigerians and current epidemiological analysis. The NDPs had stated that PHC should be prioritised but this has not been done. The conclusion here is that PHC is not sufficiently prioritised through resource distribution.

Nigeria's health indicators on life expectancy, infant and under-5 mortality, maternal mortality, hospital bed density, physicians and health professionals density are all poor. Nigeria lacks a framework law for the health sector. Legislative and civil society oversight over the allocation and management of health expenditure is low and ineffective. As such, duty bearers have not been properly held to account by rights holders. Apparently, Nigeria is unwilling to fulfil the right to health of her citizens as distinguished from being unable to do so. Monumental waste and corruption bedevils the fiscal governance apparatus.

On the basis of the foregoing, the following recommendations have emerged.

5.2 RECOMMENDATIONS

5.2.1 Harmonisation of the Fiscal Projections of NDPs

High level policies and plans provide the framework for budgeting and provision of finances for every sector. Even though the high level policy documents in health are virtually in agreement in terms of their objectives and what they intend to achieve, their fiscal projections vary and contradict one another. It is therefore imperative for these fiscal projections to be harmonised for effective resource provision to the sector. The policies whose fiscal projections should be harmonised include Vision 20:2020 and its First NIP, the NSHDP, TA and MTEFs.

5.2.2 Increase Resource Allocation to the Sector

(i) Resource allocation for the right to health should be adequate and aligned with the fiscal projections of the NDPs. Urgent investments in the nation's healthcare system especially through increased allocations to the sector is imperative.

(ii) As a minimum, 15% of the federal budget should be dedicated to the health sector and governments should keep faith with the commitments entered into under the Nigerian Partnership for Health.

5.2.3 Full Release and Cash-Backing of all Appropriated Funds

All sums budgeted for the right to health should be released and cash-backed by the MoF and BOF and fully utilised by the MoH. The releases for the sector should be prioritised.

5.2.4 Improve Absorptive Capacity of MoH

To improve the absorptive capacity of the FMoH requires capacity building in procurement reforms and management for the personnel of the FMoH.

4.2.5 Realign the Structure of Health Spending

(i) It is imperative to realign the structure of health spending in order to strike a balance between recurrent and capital expenditure in the health sector. Non alignment of funding to the major components of healthcare delivery (personnel, infrastructure and equipment, logistics, vaccines and other supplies, etc) will lead to policy failure. While continuing with improvements in the service conditions of medical staff, more investments are required in capital expenditure and the non salary components of recurrent spending.

(ii) The skewed allocation in favour of tertiary health care and curative services should be reconsidered in subsequent budgets in favour of PHC and this should respond to the predominant disease burdens of Nigeria.

4.2.6 Enhance Value for Money

FGN should take targeted and concrete steps to enhance value for money in the health sector. It will not be enough to increase funding to the sector; a full health budget expenditure review and thorough review of the sectoral challenges should precede increased allocations. Leakages should be plugged and misappropriated resources should be recovered.

4.2.7 Revive MTSS, MTEF in the Education Sector

Under the Fiscal Responsibility Act 2007, the MTEF is the basis for the annual budget. However, the MTEF is preceded by the MTSS which brings stakeholders in the MDA together; they review high level policy documents, get out the goals and objectives of the policies; review ongoing and new projects and their contributions to attaining sectoral goals; prioritise and cost them and finally fit them into the available resource envelope. The stakeholders will include MDA personnel, representatives of the oversight committees in the legislature, professional groups, organised private sector and civil society organisations working in the health sector. The MTSS will ensure that budgets are aligned to sectoral goals and plans and improve operational and allocative efficiencies.

4.2.8 Cut Down the Cost of Health Governance

It is imperative to implement the recommendations of the Oronsaye Committee on the governance of the health sector. Specifically, pruning the number of boards of teaching hospitals, federal medical centres, orthopaedic and psychiatric hospitals should be the beginning point.

4.2.9 Verify the Minimum Core Obligations and the Minimum Core Content of the Right to Health in Nigeria

The FGN in collaboration with state governments should in accordance with our obligations under the ICESCR and other standards define the minimum core obligations of the state and the minimum content of the right to health within the context of available and potential resources. These core obligations should respond to the prevalent disease conditions as demonstrated by epidemiological data and prevalent health indicators.

4.2.10 Devise Alternative and Complimentary Means of Funding

FGN and states should explore alternative and complimentary means of funding the realisation of the right to health. This will include:

- Setting aside of 2% of the Consolidated Revenue Fund of the Federation and the States to a special fund for PHC. This will be modelled after the Universal Basic Education Fund.

- The National Health Insurance Scheme should be expanded to become compulsory for al Nigerians as this would raise a huge pool of funds for the sector. There is need to ensure that our health system moves away from the OOPE to draw contributions through a pre-payment system. Put simply, the National Health Insurance Scheme (NHIS) Act requires urgent amendment to make provision for the extension of coverage to ensure that all Nigerians are entitled to a guaranteed minimum package of health services through legally sanctioned pre-payment and risk pooling system.

- Minimal surcharges from the tariffs of GSM telephone companies will also raise hundreds of billions for health services every year.

- A Special Health Fund set aside by the Central Bank of Nigeria attracting minimal interest and service charges for financing health infrastructure and equipment.

4.2.11 Enact Framework Law(s)

(i) The National Health Bill and any other framework laws should be considered expeditiously by the National Assembly and assented to by the President.

(ii) Components of the right to health specifically, the right to primary health care including maternal, new born and child health, immunisation, etc should be made justiciable rights and transferred to Chapter 4 of the 1999 Nigerian Constitution (the Fundamental Rights Chapter).

4.2.12 Stop Public Funding of Medical Tourism

To guarantee the commitment and political will of government, it is imperative to stop the payment for foreign medical trips by the treasury. All public officers should be treated in Nigerian hospitals and anyone who desires foreign medical treatment should pay from his pockets. This will stem the resources lost to medical tourism and ensure that policy makers who are treated abroad get committed to reforming the sector.

4.2.13 Improve Legislative Oversight

Considering the poor health outcomes and indicators and other challenges facing the sector, the oversight role of the legislature is very crucial for the revitalisation of the health sector. The leadership and relevant committees of the legislature should intensify oversight over the sector. Health budgets should be crafted with definite milestones and deliverables which can be monitored and evaluated over the budget year. Simply providing resources for the FMoH without any indicators to establish the achievement of targets is a waste of time. Institutions should be required to provide on a quarterly or half-yearly basis reports that show how utilisation of public resources have contributed to the achievement of sectoral targets and objectives.

4.2.14 Improve Civil Society Oversight

Although some work has been done in the health sector, civil society organisations need to invest more time and energy in advocating for improvements, tracking and reporting and seeking compliance with laws and policies on health. The CSOs include the NGOs, media, faith based groups etc. The use of the Freedom of Information procedure to get information concerning health funding, disbursement and prudent utilisation of resources is also imperative. Communities where PHCs are located should take more interest in their management, quality of service delivery and financing.

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