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Full length Research Paper

Health related policy reform in Nigeria: Empirical analysis of health policies developed and implemented between 2001 to 2010 for improved sustainable health and development

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This study was an empirical analysis of health sector reform on policy developed and implemented between 2001 to 2010. Multiple data collection was used to generate the findings. Not more than 21 States in Nigeria had either started or are implementing various types of health reforms. National, State and Local Government Areas (LGAs) levels elite had dominated policy through the control of resources. The national policy network on health sector reform had being narrowly based in a small number of institutions. We concluded that without continue and sustained institutional or structural policy reform in health; it is unlikely that existing organizational structures and management systems in health sector will be able to deal adequately with the weak and fragile National health care delivery system. It is recommended that health sector reform should therefore be concerned with defining priorities, refining policies and reforming the institutions through which those policies are implemented.

Key words: Health policy, health sector, sustainable health development, Nigeria.

INTRODUCTION

Health is wealth and to create wealth at the individual, family, community or national level, people must be healthy; to enjoy wealth that is created, an individual, family, community or nation must be healthy. Health is good entry point for breaking the vicious circle of ill-health, poverty and under-development and for converting it to the vicious circle of improved health status, prosperity and sustainable development.

Health sector reform (HSR) a sustained process of fundamental change in policy, regulation, financing, provision of health services, re-organization, management and institutional arrangements that is led by government, and designed to improve the performance of the health system for better health status of the population (Federal Ministry of Health, 2004).

HSR is not only a health-related issue but also a development issue as health care systems account for 9% of Global production and a significant portion of global empowerment. Health sector reform implementation varies across different countries and regions of the world, indeed states within a country. This is because of differences in values, goals and priorities.

In Nigeria, the Federal Ministry of Health has the responsibility to develop policies, strategies, guidelines, plans and programmes that provide direction for the

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national health care delivery system. In addition, the Federal Ministry of Health is currently a major provider of tertiary health care services and various other health intervention programmes aimed at promoting, protecting and preventing ill health of Nigerians.

The Health Sector Reform Programme (HSRP) and National Strategic Development Plan (NSHDP) establishes a framework, including goals, targets and priorities that should guide the action and work of the Federal Ministry of Health and, to some extent, State Ministries of Health and development partners over the next four years, 2015 (World Bank, 1997). The document sets the tempo and direction for strategic reforms and investment in key areas of the national health system, within the context of the overall government macroeconomic framework, the New Economic Empowerment and Development Strategy (NEEDS). This was aimed at re-orienting the values of Nigerians, reforming government and institutions; growing the role of the private sector, and enshrining a social charter on human development with the people of Nigeria.

There is no consistently applied, universal package of measures that constitutes health sector policy reform. Rather, the precise agenda for reform will be defined by reviewing how well existing policies, institutions, structures, and systems deal with issues of efficiency, access, cost containment, and responsiveness to popular demand (Federal Ministry of Health Abuja, 2007). The relative importance of these issues will vary between less developed countries, industrialized countries, and countries in transition from a command economy.

In less developed countries, reform strategies need to address the issues of extending the coverage of basic services to under-served populations, improving poor service quality, and addressing the inequitable distribution of resources, in the context of very limited institutional capacity. In many of the world's richer countries, cost containment has been the driving force behind reform. However, the need for systems to ration health care provision in line with national policy objectives is common to all countries. Each country has its own agenda for health sector development, but three broad policy objectives usually feature.

Justification and objectives

While it was apparent that a plethora of non-state actors were increasingly involved in the provision and implementation of health sector reform package, it was less clear whether or not this huge diversity was similarly reflected in debating and formulation of health sector reform. There was skeptical of the claims that Nationalization had increased the range and heterogeneity of voices in the policy process in Nigeria.

The study was carry out to demonstrate the impact of National weight on the process of health sector development reform from 2001 to 2010 and to specifically determine health policies and plans initiated at federal level and adopted or adapted at State level including capacity for implementation.

MATERIALS AND METHODS

We undertook an empirical analysis of health sector reform during 2001 to 2010. Multiple data collection was used to collate data. A tool was developed and sent to trained interviewers each for each state including Federal Capital Territory (FCT) Abuja to administer on the States within their span of work.

The study began by tracing the significant changes in the content of health sector reform policy during the period, marked by transition from strong reluctance to a broader acceptance of private health sectors gurus for a range of health care services.

The key individuals and institutions involved in the discourse on health sector reform were identified through a systematic search of the literature, reports, contacts and follow up meetings etc. this resulted in a list of individuals, institutions, groups, departments and agencies who had contribute to seminal policy documents in different aspect of health. The institution base, source of funding, and nationality of these key actors were noted. The policy makers were interviewed using structured self administered tool to elicit their views on the most influential documents, individuals, institutions and meetings in the policy area and their profile were procured.

Finally, the researcher studied records of attendance and presentations at meetings, workshop study tours and exchange visits reported by informants as very important in the evolution of the policies.

RESULTS

A total of 26 out of Nigeria's 36 States provided varying degrees of information on the status of HSR in their State. The FCT and 10 States did not provide any information. The 10 States include Benue, Kogi, Plateau and the FCT in North Central zone; Borno, Adamawa, Taraba and Bauchi in the North East zone; Sokoto and Kebbi in the North West zone; and Lagos in the South West zone.

The baseline information in the log frame suggest that by the end of 2009, six States, Jigawa, Enugu, Kaduna, Yobe, Bauchi and Lagos had either started or were implementing reforms to improve efficiency and sustainability of the health system. Form the findings, at least 15 additional States have now either started or are implementing various types of reforms as presented in the Table 1. However, it is not very clear how much of these efforts may be attributed to interest groups, pressure groups, Talkawa groups, eminent personality group (EPG) and other Elite groups in Nigeria.

Network maps were developed linking the institutions and individuals. It was discovered that a small (approximately 2% each for the state in the federation including Federal level) and tightly knight group of policy

Table 1. Health policies and plans initiated at federal level and adopted /adapted at State level.

North Central	North East	North West	South East	South-South	South West
Kwara State MDGs including roll back malaria, NIDs, Location of primary health care centres	Gombe State strategic health plan developed.	Jigawa HRH and FMCH	Abia Abia State Primary Health Care Development Agency	Rivers None	Ekiti None
Niger State National Health Policy (Federal) Committee on state health policy still in progress. Health plan to achieve vision 202020	Yobe Establishement of S PHCDA/B.	Zamfara HRH, minimum service package (MSP) and SPHCDA and PHC Service common basket policies adopted.	Anambra 1.Transformation of ANSACA to agency 2. Environmental health law	Delta None	Ogun Ogun State Primary Health Care Development Board
Nasarawa 1. NASACA 2. PHCDANS 3. MSS		Katsina HRH, minimum service package (MSP) and SPHCDA bills in progress.	Ebonyi Ebonyi State Primary Health Care Development Board	Edo None	Ondo
		Kano HRH and FMCH.	Enugu Enugu State Primary Health Care Development Board	Cross River None	Osun Child right Act
		Kaduna HRH and FMCH.	Imo Imo State Primary Health Care Development Board		Oyo None
				Akwa Ibom None	

makers, technical advisers and academics had dominated the process and content of health sector reform. This group, which was connected by multiple linkages in a complex network, was based in a small number of institutions, agencies, foundation, and development work led by DFID.

The network members were observed as following a common career progression. Revolving doors circulated members among key institutions, thereby enabling them to occupy various roles as change agents, researchers, “research know- how -fund” think tanks, reform minded people, traditional leaders, and pilot project funders, change agent program (CAP), policy advisers, and decision makers.

Implementation of costed, prioritized health plans

Across the States, the status of the development and implementation of costed (Table 4), prioritized health plans vary. The most advanced States include Kaduna, Katsina, Kano, Jigawa, Yobe and Zamfara which have developed and are implementing strategic health plans, medium term state strategic (MTSS) plans and the costed annual plans for the year 2010. It is interesting to note that all these States have health programmes funded by DFID. Cross River State has a state health plan spanning 2007 to 20011.

In Rivers State, in 2007, development partners, key stakeholders, academia and professional jointly supported Rivers State to hold a health summit that developed a blue pint for health plan.

A committee was set up to draft a 10 years State Health Plan. A Costed State Health Plan has been developed and is currently being implemented by the State MoH. Other States implementing health plans include Anambra, Abia, Ebonyi, Imo, Edo, Ondo, Enugu, Osun and Ogun. States that have developed their health plans but are yet to commence implementation include Nasarawa and Oyo. In Bayelsa, health plan development is on-going. The status of Gombe, Akwa Ibom, Delta, Kwara, Ekiti and Niger States are unclear.

As at 2009, four States, including Jigawa, Enugu and Lagos was implementing costed, prioritized health plans. In the last quarter of 2010, there is evidence to support development of milestone aimed at increasing implementation of costed plan in to Kwara, Cross River, Zamfara, Katisna, Lagos and Eboyi States. Over the past year, the Federal Ministry of Health (FMoH) and partners supported States across Nigeria to develop costed State Strategic Health Plans. This has significantly changed the scenario (Tables 2 and 3).

Table 2. Capacity for health sector reform training events across the zones/states.

North Central	North East	North West	South East	South-South	South West
Niger State About 20 managers trained	Yobe	Zamfara 5 trained in various aspect of HSR more will be trained within this year according to plan	Anambra HERFON trained four health Managers on HSR.	Delta 2	Ogun A good number of health managers have been trained.
Nasarawa NO. of health managers trained to CMD HMB, DMLS HMB,		Katsina 5 trained in various aspect of HSR more will be trained within this year according to plan	Ebonyi A good number of health managers have been trained.	Edo Three	Ondo 6
		Kano 5 trained in various aspect of HSR more will be trained within this year according to plan	Enugu A good number of health managers have been trained.	Cross River None	Osun 4
		Kaduna 5 trained in various aspect of HSR more will be trained within this year according to plan	Imo A good number of health managers have been trained.	Bayelsa One	Oyo 1. HSDP support training of health officer. 2. Four HERFON trained officers

Table 3. Proportion of state level senior policy makers/chief executives of policy institutions actively promoting health sector reforms in the State.

North Central	North East	North West	South East	South-South	South West
Kwara State There are no incentives for the senior policy makers to initiate or promote HSR in the state.	Gombe Honorable Commissioner of Health as an advocator.	Jigawa Less than 5%	Abia The state has the capacity to effectively utilize as much additional resources as possible.	Rivers Few	Ekiti Few
Niger State Less than 5 of those trained still in service.	Yobe	Zamfara Less than 5%	Anambra Not available	Delta	Ogun A good number of senior policy makers/chief executives are actively promoting health services reform.
Nasarawa 60%		Katsina Less than 5%	Ebonyi A good number of senior policy makers/chief executives are actively promoting health services reform.	Edo Few	Ondo Few
		Kano Less than 5%	Enugu A good number of senior policy makers/chief executives are actively promoting health services reform.	Cross River None	Osun
		Kaduna Less than 5%	Imo A good number of senior policy makers/chief executives are actively promoting health services reform.	Bayelsa One	Oyo Not available
				Akwa Ibom One	

Table 4. Implementation of improved systems for sustainable health financing across States.

North Central	North East	North West	South East	South-South	South West
Kwara State HYGEAIA Community Health Insurance Scheme in Afon and Songa (CHIS)	Gombe Advocacy made to State Government.	Jigawa NSHDP and MTSS currently introduced.	Abia Yes	Rivers None	Ekiti Not yet on NHIS
Niger State Harmonization of statutory Budget, MDG and Donor Assistance funds for health under way.	Yobe Supported by MDGs and NHIS.	Zamafara SSHDP and MTSS currently introduced.	Anambra None	Delta None	Ogun Yes
Nasarawa None		Katsina SSHDP and MTSS currently introduced.	Ebonyi Yes	Edo None	Ondo Yes, but not yet NHIS
		Kano NSHDP and MTSS currently introduced.	Enugu Yes	Cross River None	Osun Yes
		Kaduna NSHDP and MTSS currently introduced.	Imo Yes	Bayelsa None	Oyo None
				Akwa Ibom None	

DISCUSSION

National, State and LGAs levels elite had dominated policy through their control of resources, but more importantly through their 'control of the terms of debate through expert knowledge, support of research, and occupation of key nodes' in the network. The concerned findings was not that a small group of leaders shaped the policy debates, but rather that the leadership was not representative of the interest at stake: 'the national policy network on health sector reform had being narrowly based in a small number of institutions, led by FMoH, (including Community Initaive for family care and development (CIFcad), a Nongovernmental organization, in the nationality and disciplinary background of key individuals involved'. It was also a concerned that policy did not result from a rational convergence of health needs and solution'. Instead, the elite is described as having exercised its influence on national agendas through both coercive (conditional ties on aid in the context of extreme resource scarcity) and consensual (collaborative research, training and through co-option of policy elites) approaches.

This case contradict pluralist claims that globalization is opening up decision making for a wide range of individuals and groups (Federal Ministry of Health Abuja, 2007). The group which governs the health sector reform agenda can be portrayed as elite in that it is small in number, and members have similar educational, disciplinary and national backgrounds. Over 10 years period, this policy elite is demonstrated to have successfully established an international health sector reform agenda and formulated policies that were adopted in numerous states of federation. It was also able to do this in part because of its gateway to development assistance but more importantly, through its control of technical expertise, expert knowledge and positions and occupation of key nodal points in the network. The existence of this network does not prove the fact that an elite dominates all health reform policy.

If it were found that other policy issues in the border international policy context were influenced by individuals and institutions which were based in other countries, and staffed by decision makers with different credentials and backgrounds, we therefore might conclude that a form of pluralism exist.

CONCLUSION AND RECOMMENDATIONS

It is also clear that the process of change needs to extend beyond the redefinition of policy objectives and discussions of the ideological orientation of the health care system. Without institutional or structural change it is likely that existing organizational structures and management systems will be able to strengthening the weak and fragile National Health Care Delivery System and improving its performance. Health sector reform will therefore be concerned with defining priorities, refining policies and reforming the institutions through which those policies are implemented.

The process of reform and the difficulty of implementing policy and institutional change have been relatively neglected compared with the debate about the content of reform. This focus on content not only ignores the

question of the feasibility of implementing change, but runs the risk that health sector reform becomes equated with one particular set of prescriptions—such as the introduction of managed-market mechanisms, user charges, reducing the size of the public sector, cost effective packages of services, and privatization.

As a result the need for creative solutions to deal with urgent and intractable problems can easily get lost in discussions about the rights and wrongs of particular strategies. There is a need for rational debate and systematic analysis. In the first instance, this requirement must be addressed by descriptive information on reforms using a taxonomy that aids the analysis of the implementation and impact of reforms. Such a framework should allow a synthesis of the benefits and drawbacks of reforms that can assist each country's attempts at producing better health from the level of investment within that country.

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