

INFLUENCE OF POLITICS ON HEALTHCARE DELIVERY IN NIGERIA

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Abstract

Influence of politics on health care delivery is crucial to achieving an enhanced health benefits, patient safety and a positive patient experience of health care. This article provides insight on influence of the health care delivery in Nigeria and aim to uncover the activities of government associated with the provision of health care delivery. The slow pace of development of health policies and budgetary allocations in health care delivery in Nigeria is evidenced by the poor quality of health services as well as the poor health status of the population. The pace of access of health care delivery in Nigeria is unsatisfactory. There is a need to galvanize the efforts of relevant stakeholders including the patient in charting a new agenda for health care delivery improvement in Nigeria.

Key words: Health Care Delivery, Influence of politics

Introduction

Politics has a significant influence on healthcare delivery, impacting various aspects of the healthcare system including access to care, funding, regulations, and the overall quality of services provided. The relationship between politics and healthcare delivery in Nigeria is complex and multifaceted, with political decisions often shaping the structure and functioning of healthcare systems in profound ways. Nigeria has the largest number of under-5 and maternal deaths in the world, and is not currently on track to achieve key health Sustainable Development Goals (Ogbuoji & Yamey, 2019). Health outcomes are poor not just in absolute terms, but also when compared to other countries with similar income per capita (Abubakar *et al.*, 2022). Nigeria is the world's 13th largest oil producer, but its spending on health as a per cent of GDP is second lowest in the world (Tulloch *et al.*, 2017)

Policy Making and Legislation in health care delivery

One of the most direct ways in which politics influences healthcare delivery is through policy making and legislation. Government policies and laws determine how healthcare services are organized, funded, and delivered. For example, the passage of healthcare reform bills can lead to changes in insurance coverage, reimbursement rates for providers, and the availability of certain medical treatments. Political decisions also affect the allocation of resources to different areas of healthcare, such as public health initiatives, mental health services, or medical research. Health policy and politics are inextricably linked. Policy is about what the government can do to shift the financing, delivery, and quality of health care, so government has the power to shape these policies in favour of quality health care delivery.

Government have put up important health initiatives over the past decade, including the National Health Act, large-scale primary health care (PHC) programmes such as the Saving One Million Lives (SOML) programme, the National Health Insurance Authority Bill of 2022, and other major reforms. These models seek to explain the success or failure of policy reforms

in low- and middle-income countries through a two-part framework, combining analysis of the characteristics of reform-oriented policy elites (their ideas, training, professional backgrounds, ideological commitments, and personal attributes) with the political context, most notably the relative power of actors and groups in favour and opposed to the reforms. This approach recognizes that health policy elites have agency in setting the reform agenda, while acknowledging that they are constrained by the political context in which they operate in order to identify factors that explain the relative strength of different interests, can be drawn on the concept of the ‘political settlement’ and its relationship to service delivery (Kelsall *et al.*, 2016; Bukenya & Golooba-Mutebi, 2020). The political settlement is defined by Khan (1995) as ‘the “social order” based on political compromises between powerful groups in society that sets the context for institutional and other policies. This underlying political settlement forms the basis for the relative power of different interests in the health sector. The need to classify Nigeria’s political settlement according to the typology presented by Kelsall *et al.* (2016), and use this to inform the analysis of the outcomes of specific health policy debates are downstream of the fundamental political equilibrium in society. Therefore, combining a focus on the proximate determinants of policy adoption with analysis of the political settlement can enable a fuller picture of both the short- and long-run dynamics of health policy change. Access to medical care is important for health, and the state’s involvement in the provision and regulation of health services delivery has impacts that can go far beyond individual or even population health. Moran’s (1995) work delineating the “three faces of the health care state”—the state’s role in patient care, production of medical goods and services, and allocating resources such as jobs and financing associated with health care—helped to orient a generation of comparative health policy researchers toward the politics of medical care policy. But health status matters too: for people (Sen 2002, Walzer 1984), for states and societies (Hall & Lamont 2013, Murray *et al.* 2000, (Pickett, 2011), and for particular phenomena in which political scientists are often interested, such as economic growth (e.g., Bhargava *et al.* 2001) or political engagement (Anderson *et al.* 2021). Medical care is, counterintuitively to many, one of the less important drivers of health (House 2016, McGinnis *et al.* 2002, McKeown 1979). This is because illness and early death result from a combination of exposure to health threats, vulnerability to those threats, and treatment of their effects. Access to medical care can determine if, when, and how an illness is treated (if it is treatable)—but, with the partial exception of vaccines, medical interventions do not protect against either exposure or vulnerability to a risk factor (Lynch 2020). This means that a wide variety of factors beyond medical care—for example, nutrition, the prevalence of pathogens, social and physical environments, health behaviors, and occupational safety—all have major impacts on health, as do the numerous public policies and economic forces that influence the distribution of these factors. These nonmedical determinants of health are often called “social determinants of health” (WHO 2008). The farthest upstream (i.e., most distal but also most broadly influential) causal factors, those rooted in politics and the economy, are labeled “structural,” “fundamental causes,” or “macrosocial determinants” (Link & Phelan 1995, McGrail *et al.* 2022, McKinlay 2019, Putnam & Galea 2008).

Funding and Budget Allocation in health care delivery

The allocation of funds for healthcare programmes and services is heavily influenced by political priorities. Government budgets determine the amount of funding available for public health initiatives, medical research, infrastructure development, and other essential components of the healthcare system. Political debates over budget allocations can have a direct impact on the availability and accessibility of healthcare services for different population.

Health care financing system can be referred to the process by which revenues are collected from various sources which can either be primary or secondary and include out-of-pocket payments (OOPs), taxes (indirect and direct), funding from donor, co-payment, health investments, voluntary prepayments, mandatory prepayment, which are accumulated in fund pools (Uzochukwu, et al, 2015). The pattern of health financing is closely related to the provision of services and helps determine a system's ability to achieve universal health coverage and socioeconomic development. These strategies also determine the structure and quality of health outcomes achieved by any health system (Kruk, et al, 2016). The way a country finances its health care system is an essential determining factor for achieving Universal Health Coverage (UHC) because a good healthcare financing strategy should offer adequate financial protection so that no household suffers from a burden of financial expenses (Uzochukwu, et al, 2015).

An important aim of UHC is to ensure that all have sufficient access to healthcare needs without significant OOPs at the point of obtaining care (Fusheini & Eyles, 2018). This is usually achieved by risk pooling through tax funded or Social Health Insurance (SHI) schemes. In Nigeria, healthcare financing revenue is mainly obtained from pooled and un pooled sources. The pooled sources are raised from direct and indirect taxation, budgetary allocation, and donor funding (Uzochukwu, et al, 2015). However, the un-pooled sources which include OOPs in the forms of payment for medical products and services contribute over 70% of total health expenditure (Uzochukwu, et al, 2015). This extreme reliance on OOPs creates a significant barrier to health services access and leaves a large percentage of the population running the risk of impoverishment (Fenny et al, 2018), as OOPs above 40% is deemed catastrophic health payment. Due to this, Nigeria faces a disproportionate distribution in health system financing. Over the years, healthcare financing in Nigeria has been described as inadequate with budgetary allocation to health barely exceeding 7% of the nation's total budget. This allocation clearly falls below the April 2001 Abuja declaration of allocating a minimum of 15% of national budget to health (World Health Organization, 2020).

In a report released by WHO in 2011, Nigeria and 26 other countries were listed under the category of insufficient progress towards Abuja Declaration while only 3 countries were listed as on track with respect to the health Millennium Development Goals. Furthermore, there is an uneven allocation of finance and facilities in the three tiers of healthcare system in Nigeria i.e. primary, secondary, and tertiary health care. In addition, the inadequate budgetary provision for health has resulted in the lack of adequate manpower and facilities to provide quality care for the citizens. Moreover, there is an obvious deficiency in the number of these facilities which has significantly affected healthcare provision. For instance, for TB, the financial imposed by

OOPs often discourage treatment adherence resulting into poor outcome with impact on country's economy (Adebisi, et al, 2019). By 2013, only five of the African Union countries have been able to meet the target of the Abuja declaration including Rwanda, Botswana, Zambia, Togo, and Madagascar. Swaziland was able to meet the Abuja target by 2015 with South Africa also nearing the target at 14%, both countries alongside Angola, Botswana, Lesotho, Namibia, Malawi, Mozambique, Seychelles and Tanzania are also able to keep OOPs below 20% (Adebisi, et al, 2019).

The healthcare budget for the year 2018 had a significant boost as a result of the increased allocation to the Ministry of Health and the release of NGN55.15 billion by the National Assembly for the implementation of the National Health Act which was passed in 2014. Furthermore, in 2019 and 2020, the health budget fell below 5% which reflects a decline in health expenditure compared to previous years. From our analysis, if the Abuja declaration was implemented, additional allocations of NGN 4.99 trillion, approximately 13 billion USD as of 5 June 2020, should have been injected into the health sector between 2014 and 2020. The inadequate budgetary allocation for healthcare has significantly influenced recurrent and capital health expenditure. It is worthy to note that the insufficient allocation will significantly affect capital expenditure which is a large determinant of the development of any health system.

Health Care Expenditure in Nigeria

There is a growing international focus on the need for adequate domestic government spending on a range of social services and the health sector attracts major focus in recent times (McIntyre, et al, 2017), especially in low-and-middle-income countries under which Nigeria is categorized. The rationale behind this contemporary focus is captured in the core objectives of the universal health coverage. The United Nations System Task Team on the Post-2015 United Nations Development Agenda noted that "Ensuring people's rights to health and education, including through universal access to quality health and education services, is vital for inclusive social development" and this requires investment to "close the gaps in human capabilities that help perpetuate inequalities and poverty across generations". The universal health coverage initiative is a strong drive towards achieving United Nations development Agenda as expressed. As Sustainable Development Goals (SDG 3.8) aptly stated, every country should be able to "achieve UHC including financial risk protection, access to quality essential health services and access to safe, effective, quality and affordable essential medicines for all" (United Nations, 2015).

Since, a key element of UHC includes financial protection from the costs of ill health and access to and use of needed health services within a country, reducing the reliance on out-of-pocket payments for health care is important for financial protection (Saksena, 2014). This implies that government expenditure to the health sector is crucial in achieving financial protection. In fact, the 2010 World Health Report stated that: "It is only when direct payments fall to 15% - 20% of total health expenditures that the incidence of financial catastrophe and impoverishment fall to negligible levels". Hence, government expenditure in Nigeria is crucial in the realization of UHC objectives of financial protection.

Health financing for UHC is often assessed by whether countries spend enough on health; and raising sufficient revenue for health is the first fundamental factor determining a country's ability to deliver such basic health services. However, another important factor to consider is whether countries maximize their limited resources efficiently to improve health outcomes (Hafez, 2018). From the forgoing, Nigeria health expenditure over the period under review is not sufficient enough to bolster confidence in realizing the goals of UHC, except robust allocations are made to the health sector, and efficient use of scarce resources is implemented, achieving UHC for Nigeria might be a mere mirage.

Regulatory Framework to Health Care Delivery

Politics also plays a crucial role in shaping the regulatory framework that governs healthcare delivery. Government agencies are responsible for developing and enforcing regulations that ensure the safety, quality, and effectiveness of healthcare services. Political decisions regarding regulatory policies can affect issues such as patient safety standards, licensure requirements for healthcare professionals, drug approval processes, and the implementation of new technologies in healthcare. Oikonomou, E. et al. (2019), stated that regulation is an important entity in healthcare and healthcare insurance. The role of regulatory bodies is to protect healthcare consumers from health risks, provide a safe working environment for healthcare professionals, and ensure that public health and welfare are served by health programmes. Regulation works at all levels, and the regulatory standards are developed by government and private organizations as well.

Regulations are necessary to standardize and supervise healthcare, ensuring that healthcare bodies and facilities comply with public health policies and that they provide safe care to all patients and visitors to the healthcare system (Grimm, N. et al. 2021)

Regulatory agencies thus monitor individual and corporate healthcare practitioners and facilities; inform the government about changes in the way the healthcare industry operates; ensure higher safety standards; and attempt to improve healthcare quality and follow local, state, and federal guidelines.

Access to Care to health care delivery

Political decisions can significantly impact access to care for different segments of the population. Policies related to insurance coverage, Medicaid expansion, and subsidies for low-income individuals can influence who has access to essential healthcare services. Additionally, political debates over issues such as reproductive rights, immigration policies, and other healthcare rights can have implications for access to specific types of care. Primary health care is set-back due to weak governance and accountability systems, poorly remunerated health care workers, and transparency mechanisms and procurement laws which are weakly enforced. The suggestion that the Nigerian health sector is one of the worst sectors in terms of corrupt rating is plausible given the estimated 25% of the country's current health expenditure of about 221 per capita in purchasing power lost due to corruption. This includes both private and public health expenditure [Garuba, Kohler, Huisman, 2009]. Notably, where corruption exists, the implementation of actions to ensure effective delivery of health care often fails [Tormusa , Idom , 2016]. This is reflected in the increased cost of health services, stock-out of essential

drugs and avoidable mortalities in health facilities, especially at the PHCs in the country [Bruckner, 2019]. The Federal Ministry of Health's ability to effectively superintend the health sector is weakened due to the lack of adequate information on health outcomes, health resources, costs and the utilization of services across the various tiers including the federal, state and local levels. Our considerations on what is needed to position the country for the attainment of the Universal Health Coverage Targets include revamping and positioning of the PHC as an effective gatekeeper in the health system, government prioritization of a benefit package of services and even more importantly, strong actions against corruption to ensure wider delivery of quality health care in Nigeria. Critical to this, are the roles that multiple stakeholders play in the delivery of health care in the country. Stakeholders such as Federal and State Ministries of Health, the Local Government Authorities, the health workers, the National Primary Health Care Development Agency, the State Primary Health Care Development Agency, the Economic and Financial Crimes Commission, and Service Compact with All Nigerians

Quality of Care in health care delivery

The quality of healthcare delivery is also influenced by political factors. Government initiatives aimed at improving patient safety, reducing medical errors, and promoting evidence-based practices can shape the overall quality of care provided within the healthcare system. Furthermore, political decisions regarding investments in healthcare infrastructure and technology can impact the ability of providers to deliver high-quality services. The National Strategic Health Development Plan II recommends the elimination of financial hardship at the health care provider points through the operation of the National Health Insurance Fund which provides a basic minimum package of health services for all Nigerians [Onwujekwe, et al, 2020]. The package comprises emergency care, treatment of diabetes, hypertension, routine immunization, care for illnesses among children below five, emergency obstetric and neonatal care, labour and delivery, elective caesarian section and antenatal care. These interventions are to be provided without costs at the points of delivery [World Health Organization, 2020]. The operation of this package through the National Health Insurance Scheme (NHIS) is aimed at reducing health service inequity through its pro-poor operations especially in the rural communities to improve access and quality of care [World Health Organization, 2020]. The scheme is meant to offer progressive universalism in health care delivery, providing minimum services to a larger population. Funding of the NHIS aids the purchase of affordable and effective interventions to be provided by private and public providers for about 60% of the current burden of diseases [Tormusa & Idom, 2016]. This is from the remaining 50% of the basic health care provision Fund (1% of the consolidated revenue fund). The country's general fiscal space is however about 12% of the Gross Domestic Product, which implies that the Basic Health Care Provision Fund (BHCPF) 0.12% and thus the NHIS receives 0.06%. This size of fiscal space is however about 12% of the Gross Domestic Product, which implies that the Basic Health Care Provision Fund (BHCPF) 0.12% and thus the NHIS receives 0.06%. This size of fiscal space is small when compared with the average for low- and middle-income countries between 20 and 25% [Bruckner, 2020]. Funding of the scheme should thus be complemented by the larger pool of funds from the general taxes which comprises 14% of the current expenditure [Tormusa & Idom, 2016]. This will increase access to care for the most vulnerable

population. It is also more rational to explore more state government involvement in the expansion of the insurance scheme.

Public Health Initiatives in health care delivery

Politics plays a crucial role in shaping public health initiatives aimed at addressing widespread health concerns such as infectious diseases, chronic conditions, and environmental health hazards. Government agencies are responsible for developing strategies to prevent disease outbreaks, promote healthy behaviors, and address public health emergencies. Political support for public health initiatives can have a significant impact on population health outcome. The Health of the Population described Healthy People, a public health initiative that seeks to improve health outcomes in the United States. Put forth by the HHS, the 10-year plan establishes public health priorities and data-driven objectives to improve public health and well-being over a decade. The most recent iteration of the plan, Healthy People 2030, includes 23 high-priority leading health indicators (LHIs) to improve health and well-being over the lifespan. Most LHIs address factors that affect major causes of death and disease, such as the proportion of people with access to health insurance and the number of people exposed to unhealthy air. Public health policies and programmes are what drive and establish the mechanisms by which such health outcomes are achieved.

Conclusion

In conclusion, politics exerts a profound influence on healthcare delivery through its impact on policy making, funding allocation, regulatory frameworks, access to care, quality of services provided, and public health initiatives. The interplay between political decisions and healthcare delivery underscores the importance of understanding the complex relationship between these two domains in order to effectively address challenges within the healthcare system. The inadequate budgetary allocation in Nigeria to healthcare has significantly influenced recurrent and capital health expenditure. It is worthy to note that the insufficient allocation will continue to significantly affect capital expenditure which is a large determinant of the development of any health system. With the current state of healthcare budget allocation in Nigeria, efforts need to regulate and implement the policies of healthcare delivery and ensuring quality access to health care delivery in Nigeria.

Recommendations

Political commitment to improving the health of the population should be prioritized to ensure health systems goals of efficiency, equity, quality of care, sustainability, financial risk protection for all citizens is achievable.

The implementation of the Universal Health Coverage should promote access to quality health care delivery through cost-effective initiatives to ensure good health and wellbeing without discrimination.

Adequate allocation of funds should be made available for the smooth and effective implementation of access to quality health care delivery

Government should continue to strengthen the national health insurance scheme and extend its benefits to the informal sector

References

- Adebisi YA, Agumage I, Sylvanus TD, Nawaila IJ, Ekwere WA, Nasiru M, et al (2019). Burden of Tuberculosis and Challenges Facing Its Eradication in West Africa. *Int J Infect.* 2019;6(3). <https://doi.org/10.5812/iji.92250>
- Bruckner T(2019). The ignored pandemic: how corruption in healthcare service delivery threatens Universal Health Coverage. Transparency International UK, London. 2019. Accessed on May 28, 2020
- Chapman AR (2016). Assessing the universal health coverage target in the Sustainable Development Goals from a human rights perspective. *BMC Int Health Hum Rights.* 2016;16(1):33. [PubMed ID: 27978827]. [PubMed Central ID: PMC5159947]. <https://doi.org/10.1186/s12914-016-0106-y>
- Fenny AP, Yates R, Thompson R (2018). Social health insurance schemes in Africa leave out the poor. *Int Health.* 2018;10(1):1-3. [PubMed ID: 29325056].
- Fusheini A, Eyles J (2016). Achieving universal health coverage in South Africa through a district health system approach: conflicting ideologies of health care provision. *BMC Health Serv Res.* 2016;16(1):558. [PubMed ID: 27717353]. [PubMed Central ID: PMC5054620]. <https://doi.org/10.1186/s12913-016-1797-4>
- Grimm, N. et al. (2021). Healthcare Regulations: Who Does What? <https://www.yourtrainingprovider.com/healthcare-regulations-who-does-what/>. Accessed on October 18, 2021
- Hafez R. (2018). (2018) Nigeria Health Financing System Assessment. *World Bank Group: Health, Nutrition and Population.* 2018.
- Kruk ME, Gage AD, Arsenault C, Jordan K, Leslie HH, Roder-DeWan S, et al (2018). High-quality health systems in the Sustainable Development Goals era: time for a revolution. *Lancet Glob Health.* 2018;6(11):e1196-252. [PubMed ID: 30196093]. [https://doi.org/10.1016/S2214-109X\(18\)30386-3](https://doi.org/10.1016/S2214-109X(18)30386-3)
- McIntyre D, Meheus F, Rottingen JA (2017). What level of domestic government health expenditure should we aspire to for universal health coverage? *Health Econ Policy Law.* 2017;12(2):125-37. [PubMed ID: 28332456]. <https://doi.org/10.1017/S1744133116000414>
- Transparency in Nigeria's public pharmaceutical sector: perceptions from policy makers. *Globalization and health.* 2009 Dec 1;5:14. PubMed | Google Scholar.
- Piabuo SM, Tieguhong JC (2017). Health expenditure and economic growth - a review of the literature and an analysis between the economic community for central African states (CEMAC) and selected African countries. *Health Econ Rev.* 2017;7(1):23. [PubMed ID: 28593509]. [PubMed Central ID: PMC5462666]. <https://doi.org/10.1186/s13561-017-0159-1>
- Piatti-Funfkirchen M, Lindelow M, Yoo K (2018) . What Are Governments Spending on Health in East and Southern Africa? *Health Syst Reform.* 2018;4(4):284-99. [PubMed ID: 30196093]
- Universal Health Coverage in Abuja (2020). *Presidential Summit Declaration on Universal Health Coverage in Abuja, Nigeria.* 2020, [cited 3 June 2020]. Available from: https://www.msh.org/sites/msh.org/files/presidential_summit_declaration_on_universal_health_coverage_in_nigeria.pdf.

- Uzochukwu BS, Ughasoro MD, Etiaba E, Okwuosa C, Envuladu E, Onwujekwe OE (2015). Health care financing in Nigeria: Implications for achieving universal health coverage. *Niger J Clin Pract.* 2015;18(4):437-44. [PubMed ID: 25966712]. <https://doi.org/10.4103/1119-3077.154196>.
- Shareholder BS, Khan SM (2018). Out-of-Pocket Payments, Catastrophic Health Expenditure and Poverty Among Households in Nigeria 2010. *Int J Health Policy Manag.* 2018;7(9):798-806. [PubMed ID: 30316228]. [PubMed Central ID: PMC6186489]. <https://doi.org/10.15171/ijhpm.2018.19>.
- Saksena P, Hsu J, Evans DB (2014). Financial risk protection and universal health coverage: evidence and measurement challenges. *PLoS Med.* 2014;11(9). e1001701. [PubMed ID: 25244520]. [PubMed Central ID: PMC4171370]. <https://doi.org/10.1371/journal.pmed.1001701>
- World Health Organization. *The Abuja Declaration: Ten Years On.* 2011, [cited 3 June 2020]. Available from: https://www.who.int/healthsystems/publications/abuja_declaration/en/.
- World Health Organization. *State of Health Financing In The African Region.* 2013, [cited 3 June 2020]. Available from: <https://apps.who.int/iris/bitstream/handle/10665/101282/9789290232131?sequence=1>.
- Saksena P, Hsu J, Evans DB (2014). Financial risk protection and universal health coverage: evidence and measurement challenges. *PLoS Med.* 2014;11(9). e1001701. [PubMed ID: 25244520].
- Transparency in Nigeria's public pharmaceutical sector: perceptions from policy makers. *Globalization and health.* 2009 Dec 1;5:14. PubMed | Google Scholar
- Tormusa DO, Idom AM (2016). The impediments of corruption on the efficiency of healthcare service delivery in Nigeria. *Online Journal of Health Ethics.* 2016;12(1):3. Google Scholar
- Oikonomou, E. et al. (2019). Patient Safety Regulation in the NHS: Mapping the Regulatory Landscape of Healthcare. *BMJ Open.* <https://dx.doi.org/10.1136%2Fbmjopen-2018-028663>. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6615819/>
- Onwujekwe O, Orjiakor CT, Hutchinson E, McKee M, Agwu P, Mbachu C *et al* (2019). Where do we start? Building consensus on drivers of health sector corruption in Nigeria and ways to address it. *Int J Health Policy Manag.* 2020 Jul;9(7):286-351. PubMed | Google Scholar
- World Health Organization (2019). The world health report: health systems financing: the path to universal coverage. Accessed 2020 Jun 5, 2020.
- World Health Organization. Health accounts. Accessed Jul 18, 2020.
- World Health Organization. *The Abuja Declaration: Ten Years On.* 2011, [cited 3 June 2020]. Available from: https://www.who.int/healthsystems/publications/abuja_declaration/en/.
- World Health Organization. *State of Health Financing In The African Region.* 2013, [cited 3 June 2020]. Available from: <https://apps.who.int/iris/bitstream/handle/10665/101282/9789290232131?sequence=1>