ISSN 1117-9481

ILORIN JOURNAL OF SOCIOLOGY

Volume 11, No.1&2, MARCH 2019

Published by the
DEPARTMENT OF SOCIOLOGY
UNIVERSITY OF ILORIN, NIGERIA

VOLUME 11, NUMBER 2, MARCH, 2019

THE NATIONAL HEALTHCARE POLICIES IN NIGERIA: TRENDS AND CHALLENGES

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Abstract

The economic and social growth of any country depends greatly on the viability and the sustainability of the health sector. This is because a nation of sick people may certainly not live up to the task of nationhood in the 21st century. In Nigeria, the current state of the country's healthcare system can be said to be quite worrisome because of health indicators and statistics that are appalling. Although, report has shown that successive governments in Nigeria had made several deliberate efforts to initiate and sustain health sector reforms over the past many years. However, research has also shown that implementation of health care policies in Nigeria is faced with a number of challenges. A cursory look at the trends of reforms of the sector shows poor health outcomes and poor basic health indicators. It is against this backdrop that this paper examined the trends and challenges of healthcare policies in Nigeria. The paper argues that the Nigerian health sector is bedeviled by a myriad of challenges that resulted from lack of proper planning cum policy disconnections. Conclusively, the paper suggests that there is the need for an all encompassing healthcare policy in Nigeria devoid of corruption and political reluctance.

Keywords: Health; Policy; Healthcare Policy; Health Sector; Nigeria.

Introduction/Problem Statement

A healthcare policy can be considered as an organizational framework for the distribution or servicing of the healthcare need of a given people (Asuzu, 2004). It is a fairly complex system of inter-related elements that contribute to the health of people and it is often influenced by the political system in the society. Thus, it is safe to say that who participate in the system, how the policy operates, the legal framework and ethical issues guiding the health care policy or system are all determined by the socio-political system of the given society. For instance, the provision of healthcare service in a capitalist state is determined by the forces of demand and supply. In this system the role of the state is minimized and health care service is usually dominated by the private individuals or group of individuals. In a socialist system, the provision of health care is the role of the government. In this system, government in addition to other services shouldered the responsibility of funding and budgeting for health care services. However, it must be noted that for some time now, regardless of political system, governments all over the world are getting more involved in health care policies and service delivery. A very conspicuous example is the healthcare reform (OBAMACARE) of former president of United State of America, Barrack Obama.

Report has shown that the Federal Government of Nigeria had made several deliberate efforts to initiate and sustain health sector reforms over the past many years. The reform of the sector is predicated upon the fact that it is characterised by poor quality and challenges in the provision of public sector health services, resulting in poor health outcomes and poor basic health indicators (African Development Fund 2002). The essence of the systems' reform is because the systems, prior to the time of reform, probably were not working properly or were found not to be producing the optimal health status as deserved by the people (Asuzu, 2004) .

The current state of the country's healthcare system can be said to be quite worrisome, judging by the health indicators and statistics that are abysmal. Despite the recent accolades received by Nigeria on how it was able to manage the Ebola Virus Disease outbreak, the challenges facing the health sector is still there. Meanwhile, the Permanent Secretary, Federal Ministry of Health, in 2014, Linus Awute, disclosed in an interview with journalists in Abuja, recently that there were moves to maintain the global commendation of Nigeria on Ebola Virus containment and Nigeria's involvement and leading role in the containment process going on in Sierra Leone, Guinea and Liberia. He revealed that the Health Ministry had begun the harmonisation of The National Strategic Health Development Plan Framework (2009-2015 NSHDP) with the vision of the Buhari-led government on healthcare to achieve Universal Health Coverage for Nigerians within the shortest possible time. While expressing optimism that the current arrangement would turn around Nigeria's health sector for the better, Awute affirms that Federal Government should be able to bring the principle of equity into healthcare by ensuring that rural poor have access to affordable and reliable healthcare through Universal Health Coverage. "We are going to achieve Universal Health Coverage, not only through the normal statutory budget fund but by effective internal domestic resource mobilisation to be driven by Social Health Insurance policy as well as Voluntary Contributory Social Health Insurance Programme which had been launched and is awaiting buy-in of the state governments to accelerate the process" (FMoH Nigeria, 2014).

It would be recalled that the NSHDP framework (2009- 2015) was launched in July 2009 with the aim of harmonising Federal, States and local governments' health plans, thereafter serving as the basis for national ownership, resource mobilisation/allocation and mutual accountability by all stakeholders; government, development partners, civil society, private sector and communities. The framework was based on the principles of the Four Ones which include one health policy, one national plan, one budget, and one monitoring and evaluation framework for all levels of government. It also provides the template to concretise the health sector development component of the government, Vision 2020 and a platform for achieving the MDGs. The measure, according to the Awute, is to guarantee equity in ensuring that poor rural dwellers have access to affordable and reliable healthcare. The vision, he noted, would be driven by the community-based Social Health Insurance Programme as well as the Voluntary Contributor Social Health Insurance Programme which have already been launched by the ministry. He, however, noted that the recent state visit of President Buhari to the United States of America (USA) has started yielding positive results in the health sector. According to him, the health sector has started to feel the positive impact of that visit as there are emerging new partnership undertakings between key agencies of the United States and other global organisations who are now keying into the programme of the Nigeria health

sector. He maintained that one of the key elements of the bilateral relationship between the United States and Nigeria is international health security for which Nigeria's scorecard has been rated very high in the Global Community.

However, research has shown that implementation of health care policies in Nigeria is faced with a number of challenges over the years. Gustafsson-Wright and Van der Gaag (2008) submitted that Nigeria's health indicators have stagnated or even deteriorated during the past decade. More so, Abdullahi, Fawole & Saliman (2011) report that a distinct feature of the country's healthcare service delivery and management is its decentralization at the three-tier levels involving the primary, secondary and tertiary institutions, managed by the local, state and national governments, respectively. Both the public and private sectors are participants in healthcare delivery. Health infrastructure, being a part of a larger health system, includes the health policy, budgetary allocation implementation and monitoring (Adebanjo and Oladeji 2006).

Owing to the trends and challenges above, the importance of discussing the healthcare policies in Nigeria cannot be over-emphasized because health they say is wealth. In order for the country to witness sustainable growth and development, there is the need to have a viable and robust healthcare system. Unfortunately, the variety of healthcare policies and types in Nigeria has been elaborated upon in several studies to be polemic (Owumi. 2005; Erinosho, 2006; Abdullahi, Fawole & Saliman 2011). This had been said to be a constant source of concern which have generated issues of national discourse. Evidently, this shows that the country's health sector is still plagued by various challenges and this demands a consideration of the way forward from the academic and concerned authorities. It is against this backdrop that this paper examines healthcare policies of Nigeria with the aim of identifying major challenges over the years and suggesting possible solutions.

Trends of the Healthcare Policies of Nigeria

Prior to the introduction of orthodox medicine, traditional medicine used to be the dominant medical system available to millions of people in Africa, particularly Nigeria in both rural and urban communities. However, the arrival of the Europeans marked a significant turning point in the history of this age-long tradition and culture. With the advent of our contact with the west, Nigeria began to operate a pluralistic health care delivery system with the orthodox and traditional health care delivery systems operating alongside each other, albeit with hardly any collaboration. Before independence in 1960, a 10-year developmental plan (1946–1956) was introduced to enhance healthcare delivery service. Several health schools and institutions (Ministry of Health, several clinics and health centers) were developed according to this plan. By the 1980s, there had been great development in healthcare service through establishments of general hospitals and several other health centers (Awosika, 2005).

More recently, report shows that both the private and public sectors provide orthodox health care services in the country. For instance in 2005, federal ministry of health (FMOH) estimated a total of 23,640 health facilities in Nigeria of which 85.8% are primary health care facilities, 14% secondary and 0.2% tertiary. Percentage distribution shows that 38% of these facilities are owned by the private sector, which provides 60% of health care in the country (FMOH, 2005). Meanwhile, the report shows that 60% of the public primary health care facilities are located in the northern zones of the country and they are mainly health posts and

dispensaries that provide only basic curative services. The Private Out-Of-Pocket Expenditure (OOPE) in Nigeria accounts for over 70% of the estimated $10 per capita expenditure on health (FMOH, 2004), limiting equitable access to quality health care. The public health service is organized into primary, secondary and tertiary levels. While the Constitution is silent on the roles of the different levels of government in health services provision, the National Health Policy ascribes responsibilities for primary health care to local governments, secondary care to states and tertiary care to the federal level. At the same time, a number of parastatals, based at the federal level, for example, the National Primary Health Care Development Agency (NPHCDA) are currently engaged in primary health care services development and provision; the latter is evidently part of its mandate. Although national policies, formulated by the Federal Ministry of Health provide some level of standardization, each level is largely autonomous in the financing and management of services under its jurisdiction.

Consequently, it is evident from the reviewed reports above that successive governments had made deliberate attempts to rehabilitate the health sector through a series of reforms and in turn churn out series of policies towards strengthening the health sector and thereby better the lives of the general public. For example, the National Health Policy, developed in 1986, was promulgated in 1988 and reviewed in 1996. In the policy, for effective primary health care implementation a number of strategies were recommended. The main policy thrust focuses on National Health System and its Management, Management Health Care Resources, National Health Interventions and Services delivery, National Health Information Systems, Partnership for Health Development, Health Research and Health Care Laws (Inem, 2005). The policy document is a result of several consultative processes, incorporating views from stakeholders and reflecting new realities and trends in the national health situation, including regional and global initiatives such as NEPAD and the WHO.

Meanwhile, the Revised National Health Policy, which was developed in 2004, clearly states the priority health issues for the nation in its overall objective. The overall objective is to strengthen the national health system such that it would be able to provide effective, efficient, quality, accessible and affordable health services that will improve the health status of Nigerians through the achievement of the health related focus of the millennium development goals MDGs (FMOH, 2004). The health policy has a pivotal goal, which is, to bring about a comprehensive healthcare system based on primary healthcare that will promote, prevent, protect, restore and rehabilitate every Nigerian within the available resources towards ensuring the productivity and social wellbeing of all. Therefore, one can conclude that the overall goal of the policy is the attainment of enhanced standards of health by all Nigerians in order to uphold a healthy and productive life. The guiding principles of the policy, among others, include emphasis on primary healthcare and introduction of basic health services scheme, mainstreaming of gender issues in planning and implementation and a special focus on health systems development (African Development Fund 2002).

The various National Health Policies in Nigeria overtime further shows the importance of health of the citizens to social and economic development of the nation. Thus, important reforms of the health sector have been embarked upon with a view to attaining sustainable healthcare system and other national health policy targets. Usually, the hope is that these would enhance more effective, affordable and efficient health services, improved performance of the healthcare system and ultimately in the achievement of a better health

status for the citizenry. In view of this, Awosika, 2005 and the CIA World Factbook, 2015 report that the federal government of Nigeria launched its primary health care plan with the following major objectives in August 1987:

1. Improve collection and monitoring of health data
2. Improve personnel development in the health care
3. Ensure the provision essential drug availability
4. Improve on immunization programs
5. Promote treatment of epidemic diseases
6. Improve food supply and nutrition
7. Improve material and child care, and family planning
8. Educate people on prevailing health problems and the methods of preventing and controlling them.

However, several studies have shown that this health care plan made little impact on the health sector, as it continued to suffer major infrastructural, and personnel deficit, in addition to poor public health management (Abdullahi, Fawole and Saliman 2011; Ogunbekun, 1991).

Subsequently, the Olikoye Ransome-Kuti's tenure as health minister brought back some needed focus on primary healthcare, with the publication of a National Health Policy in 1988. But the centralised regulation of the military regime of primary healthcare created its own problems which the country lived with. As it appears, like with everything else in Nigeria, decentralisation, true federalism and inter-state competition works better for the citizens. The 1988 health policy was refined, revised and updated under the tenure of Health Minister Eyitayo Lambo in 2004 and was globally acclaimed as a near-perfect blueprint for provision of standard healthcare in a growing nation (Adebanjo et.al 2006). On paper, the policy had all that was needed to make the health sector in Nigeria functional and world class. It had a three-tier health structure, with primary healthcare, PHC, including refined traditional medicine as the foundation, secondary health care, SHC, with general hospitals as the supporting pillars, and tertiary healthcare, THC, consisting of university teaching hospitals, federal medical centres and specialty hospitals at the apex. The policy gave the responsibility of implementing PHC to local governments, SHC to state governments, and THC to the Federal Government. Unfortunately, report has shown that the policy framework has been characterised by weak implementation and diversion of funds to recurrent spending as power change guards (Adebanjo et.al 2006).

From all available evidences, it becomes glaring that inconsistent implementation of the basic structures in healthcare policy frameworks in Nigeria often leads to the situation where people visit secondary healthcare (SCH) centers for their primary healthcare (PHC) needs, causing doctors trained for SHC to devote 80 per cent of their time conducting PHC in the outpatients' departments of hospitals (Akinwumi, 2010). According to Akinwumi, (2010) and Abdullahi, Fawole & Saliman (2011) the condition is further worsened by inadequate facilities and low remuneration of public sector healthcare workers. These resulted in the mushrooming of private hospitals and clinics with only a fraction well-equipped, but could only be afforded by an opulent and sometimes foolish few. So in spite of all these efforts, the sector challenges remain. As an effort by the federal government to revitalize the worsening state of health, the Nigerian health insurance scheme (NHIS) that was established in 2005 by

Decree 35 of 1999 provided for the establishment of a governing council with the responsibility of managing the scheme (NHIS, 1999). However, Awosika, (2005) noted that the scheme was first proposed in 1962 under a bill to parliament by the then Minister for Health.

The objectives of the scheme cited in Abdullahi et.al. (2011) were to:

1. Ensure that every Nigerian has access to good health care services
2. Protect Nigerians from the financial burden of medical bills
3. Limit the rise in the cost of health care services
4. Ensure efficiency in health care services
5. Ensure equitable distribution of health care costs among different income groups; equitable patronage of all levels of health care
6. Maintain high standard of health care delivery services within the scheme
7. Improve and harness private sector participation in the provision of health care services
8. Ensure adequate distribution of health facilities within the Federation
9. Ensure the availability of funds to the health sector for improved services.

The objectives and functions of the NHIS according to Akande (2004) and Abdullahi et.al. (2011) have hardly attained any height as health care delivery continues to be limited; not equitable and does not meet the needs of the majority of the Nigerian people. This is indicative of the high infant mortality rate/poor maternal care, very low life expectancy as at 2010, and periodical outbreak of the same disease, as well as the long period of time spent for control of the various outbreaks.

Challenges in National Health Policies of Nigeria

Despite the success of the containment of the EVD in 2014 by Nigeria, the health sector is not immune from several challenges. The challenges facing the health policy in Nigeria range from socio-economic to political. The Nigerian health care system has suffered several downfalls as a result of policy summersault (Asangansi & Shaguy 2009). According to Mallam Nasir El-Rufai, the Kaduna State Governor in an interview with Thisday Newspaper of Feb., 2015, he affirmed that:

> *Our health sector is bedeviled by a myriad of challenges that resulted from lack of planning; policy disconnections, inadequate capital spending, poor pay, outdated technologies, poor infrastructure, sharp disparities in the availability of medical facilities across the country, coupled with the severe political and economic stresses of the past years. The net effect is inadequate medical supplies, drugs, equipment, and personnel. Similarly, poor sanitation and water supply in our rapidly growing cities have increased the threat of curable, avoidable and other infectious diseases, while health care facilities are generally unable to keep pace with urban population growth. One needs not visit hospitals without doctors or drugs, or evaluate the poor quality of health personnel, nor undertake a computation of the lost production to poor health to underscore the fact that our national development aspirations will remain just that aspirations if we do not embark on a concerted improvement of our human capital, especially revamped*

> *education and improved healthcare with sound and make health care policies that are of international standard and people oriented.*

This paper draws serious inspiration from the words of this governor. Therefore, attempt was made to dissect his words, itemize the challenges raised and discuss them in detail. Succinctly, the challenges facing Nigeria's health sector and the national policy on health care include but not limited to disease outbreaks, constitutional ambiguity, infant and maternal mortality, dead infrastructures, brain drain, poor institutional arrangements, defective functional relationships and management mechanisms. The poor performance of the national health system also partly reflects a lack of clarity or consensus about which level of government is responsible for what function.

- **Constitutional Impediments**

The Nigerian Health System though has its intrinsic complexities is needlessly cumbersome. For example, the prevailing system has outlined in the 1999 Constitution place health on the concurrent list, meaning that all tiers of government have a defined role/ responsibility to play at providing for the health needs of the populace. Generally, it is noted that the primary level of health care delivery is taken as the responsibility of local councils; the secondary level of care is noted as the responsibility of the state governments while the federal government is in change of the tertiary level of healthcare delivery. Of course, for multifarious reasons, the outlined responsibility above have a lot of intermingles with respect to who is in charge at certain levels of health care provision. For example, a number of state governments have their own tertiary health institutions like teaching hospitals, while the federal government itself has created a number of institutional intervention agencies to come in at the primary level of health care. It is however, disappointing that such tertiary levels institution within the primary purer of the federal government such as the teaching and specialist hospitals and centers are not truly centers of excellence as a number of them are far from in reality.

In Nigeria today, even the "expertise" is said to be available in respect of these so called centers of excellence are lacking in tools that make them truly worthy of being referred to as tertiary health institutions (Adebayo, 2014). On this, one ask that of what relevance is a tertiary health institution that is lacking in modern diagnostic tools like the CT scans and MRI gadgets among others. A very disheartening situation among others was the case of john Nwofia, a Nigerian psychiatrist living in Nashville, United States, US, whose younger brother was diagnosed with acute liver disease and perthyroidism in America in 2010. Before then, Nwofia said he and other family members had tried unsuccessfully to get a diagnosis in Nigeria. Narrating his experience to an online health magazine, Nwofia said;

> *My younger brother was diagnosed with acute liver disease and hyperthyroidism. We spent hundreds of thousands of naira doing one test after the other. My very good friend and colleague, Dr. Ezekiel Ogunleye, thoracic surgeon at LUTH (Lagos University Teaching Hospital), took charge of it. Every test he ordered had to be done at three different sites, including abdominal ultrasound and other laboratory tests. He explained that, "this is because he could not trust one laboratory and had to depend on two out of three laboratory and had to depend on two out of three laboratory*

results being close for him to use it. We got a CT scan but it was from an outdated 8-slice machine that was not sensitive enough. In the end we needed a test called a MRCP but we could not find a place in Lagos to get it done. The other option was for a procedure called ERCP but no gastroenterologist we knew of in Lagos could perform it. The other option was to open him up surgically in his almost moribund state to look for a cause, which by then we were worried it could be a tumour. We knew that his chances of making the surgery then were bad due to his state. We then made the difficult decision to fly him to the US. There, we had a 64-slice CT scan and MRCP and both were negative. All he had was an acute liver injury due to a commonly used anti-malarial. He responded well to high doses of steroid and is now back home. He would have definitely died in Nigeria (Adebayo, 2014: 16).

- **Infant and Maternal Mortality**

Nigeria has one of the highest rates of infant and maternal mortality in the developing world and this translates to 10 percent of women dying from complications of pregnancy and childbirth (WHO, 2000). There is no doubt that maternal health is a critical issue in Nigeria's economic and social development. The intervention programmes in child survival in the country to a large extent have not made the expected impact. According to a report by the Federal Ministry of Health in 2008, even though only 2% of the global population is in Nigeria, the country, has an estimated infant mortality rate of 75 per 1000 live births, child mortality rate of 88 per 1,000 live births, under 5 mortality rate of 157 per 1,000 live births10 and a maternal mortality ratio of 800 per 100,000 live births, contributes a disproportionate 10% to the global burden of maternal and also infant mortality (FMOH, 2008). The ministry reported that there is a wide regional variation in infant and maternal mortality across zones in Nigeria. Infant and child mortality in the North West and North East zones of the country are in general twice the rate in the southern zones while the maternal mortality in the North West and North East is 6 times and 9 times respectively the rate of 165/100, 000 recorded in the South West Zone (FMOH, 2004).

- **Brain Drain**

Emigration of health professionals out of the shores of the country is a serious challenge and threat to the health sector. Mass exodus of health professionals to developed countries in search of the "greener pastures" has been going on for quite some time now. This is a form of brain drain. Every attempt to stem the tide has not yielded the desired results. While it is conceded that the salary and welfare packages of the federal government employed health practitioners have improved considerably when matched with their counterpart in other sectors elsewhere, thanks to the doggedness of their agitations for improved emoluments, this alone will not avert the collateral trend towards brain drain outside the country of the appropriate tools to function effectively are not put in place.

- **Inadequate Health Facilities**

Health facilities are inadequate (Yohersor, 2004). This includes health centres, personnel and medical equipment. This inadequacy is worse in rural areas. The state of existing facilities is poor as a result of lack of maintenance. The implementation of various healthcare policies in Nigeria is always engulfed by numerous infrastructural inadequacies. In order words, there are infrastructural challenges that need to be addressed by the government

in order to improve the quality of healthcare services in the country and ensure easy implementation of policies. Therefore, it becomes imperative that the development and improvement of the infrastructural and social amenities such as constant power supply, adequate equipments in hospitals, information and communication technology (ICT) and good roads will go a long way in ensuring maximum implementation of major healthcare policies in Nigeria.

- **Fake and Adulterated Drugs**

Erratic supply and non-availability of essential drugs and materials is a common challenge. Manufacture and importation of fake or sub-standard drugs and false advertising have been a serious challenge and distraction in the health sector. The economic costs of these on the nation, and more seriously, the human cost are noteworthy. The menace of fake drugs is such that close to 20 percent of all drugs in circulation in the market is adulterated (Akinwumi, 2010). A good proportion of the drugs dispensed are substandard, leading to high morbidity and mortality and low health outcomes, which bear a grave consequence on the efficiency and quality care (NAFDAC, 2003). The public-funded agency charged with the responsibility of checking against the importation, manufacture and marketing of sub-standard and fake drugs in Nigeria is the National Agency for Food and Drug Administration and Control (NAFDAC). The war against adulterated and fake drugs has been a relentless one. No doubt, remarkable success has been recorded in the quest to keep such drugs off the market. It is, however, pertinent to say that challenge is far from being over due to the resilience of the culprits. What is making the task difficult is the fact that these nefarious activities are the hand work of some cartels or syndicates, who will do anything to be a step ahead of NAFDAC and its operatives. From time to time tons of counterfeit and sub-standard drugs are intercepted by NAFDAC and are destroyed. Unfortunately, the economic cost of fake drug business and the war against it is colossal. Apart from their posing serious hazards to human health, large sums of money deployed to research and development are lost just because counterfeiters distribute fake drugs that are worth far less than the genuine products. Such activities put enormous strain on the resources of other organizations involved in genuine businesses.

- **Slow Implementation of NHIS**

Another area of health care challenge is the role the NHIS plays. The National Health Insurance scheme has been in place per enactment for more than 14 years now. To date, less than 10% of the populace had been keyed into the scheme, and that percentage comprise mostly federal government employees; very few state employees and organized private sector employees have signed on. The rest of the populace are not involved and there are no signs in view that there will be a radical change soon. Even the Presidency /MDGs office's NHIS free medicare programme initiated about four years ago for pregnant women and under five children in some local council in 12 states is already faltering due to paucity of fund. For the health insurance scheme, this balance sheet scream failure and not a crawling success as the operators of the scheme and the profiteers from it want the populace to believe.

- **Corruption**

While the agitation for more funds is very sign relevant, many also posited that even when conceded that very little get appropriated to health sector than understand by desired, the budgetary allocation for this sector hardly get to the target layers envisaged during budget implementation. Most of these funds get embezzled by corrupt officials and their

collaborating suppliers and contractors. Health Insurance Affairs, 2008 reported several cases of political and financial maneuvering between healthcare providers, HMOs and various representatives of health team such as the community pharmacists and medical doctors.

Conclusion and Recommendations

The paper examined the trends and challenges of healthcare policy in Nigeria. It argues that the Nigerian health sector is bedeviled by a myriad of challenges that resulted from lack of planning cum policy disconnections, inadequate capital spending, poor pay, outdated technologies, poor infrastructure, sharp disparities in the availability of medical facilities across the country, coupled with the severe political and economic stresses of the past years. It was highlighted in the paper that quality and affordable healthcare is critical to sustainable development and progress because it is human capital that drives the other factors of production. Therefore, the paper recognizes that health infrastructure (hospitals, laboratories, pharmaceuticals, health insurance organisations and other ancillaries) are essential for the efficient functioning of a healthcare system and consequently, a productive and prosperous nation.

Some of the studies reviewed revealed that good public health is vital to the survival of any country, not only for the purpose of maintaining a healthy populace, but also as a matter of national importance. Thus, if the saying "health is wealth" is anything to go by then a healthy country is a wealthy country, with a thriving human resource the country can invest in to move the nation to greater heights. Despite having some of the very best healthcare professionals in the world, reports have shown that the lack of clear policy statements and unwilling political atmosphere cum lack of development of the public healthcare system has eroded the little confidence the general population have in the Nigerian healthcare system. Even the leaders who ought to lead by example are most guilty of this lack of faith the in the Nigerian healthcare system, thus, the reason why President Muhammadu Buhari was flown abroad for medical attention for an undisclosed ailment in 2017.

Finally, the paper suggests that there is the need for an all encompassing healthcare policy in Nigeria. This should take into consideration some of the challenges highlighted in this paper. This will involve ensuring; availability of drugs and equipment at all levels of healthcare delivery service, create budget lines for the maintenance of equipment and furniture at all levels, eradicate corruption, review cost, disseminate and implement the minimum package of care in an integrated manner and also, strengthen specific communicable and non communicable disease control programmes. Another important area for government and policy makers is to look into how to strengthen the referral system and revitalize integrated service delivery towards a quality, equitable and sustainable healthcare policy devoid of political reluctance.

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