Healthcare Policy and its Effect on Healthcare Delivery in Nigeria

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DOI: 10.56201/ijhpr.v8.no4.2023.pg1.13

Abstract
This paper looked at the Nigerian health sector's current difficulties and challenges in service delivery. It also attempted to identify the effect of the issues and challenges on the Nigerian citizens' health condition. The article used secondary data to elicit facts and information about difficulties, challenges, and problems related to healthcare delivery in Nigeria by examining literatures. A screening technique was used to select the literature for this study. First, based on the topic and goal of the paper, a search was conducted. Second, using the inclusion and exclusion criteria, the title and abstract of potentially relevant articles were reviewed, and those with similar contents were utilized for the paper. The findings of the paper indicated that constellation of social, economic and environmental issues are being faced from hospitals, ranging from brain drain, low pay, outmoded infrastructure, inadequate medical facilities and underfunding of the hospitals. In addition, there are insufficient health policies to address these issues. The research also found that, despite the existence of numerous policies, none have been successfully applied to address these serious issues. The implication of the paper is that it is a relevant call for action in the health sector and practicable through an initial vulnerability assessment of the health sector and political support will be essential in driving policy by ensuring appropriate sanctions against corrupt practices were necessary to produce a measurable impact. Strategic initiatives, such as redesigning Primary Health Centers (PHCs) and emphasizing the supply of the basic minimum package through national and state-driven insurance schemes, are crucial in bridging policy gaps for optimizing health care delivery, according to the study.

Key words: *Health, healthcare, healthcare delivery, health policies, government, Nigeria etc.*

Introduction

According to Guillem and Luis (2016), the health sector is acknowledged as a significant factor in the development of human capital in all nations. The World Health Organization asserts a correlation between bad economic growth and a number of physical health indicators that are detrimental to it, including high mortality, a short life expectancy, high levels of poverty, and an unhealthy lifestyle. The implementation of new health programs that boost social and economic activities and status after the control of otherwise unfavorable health conditions has been shown to have an impact on economic development through increased productivity, increased man-hours of work, and the development of uninhabited regions. Health initiatives have once again been linked to improved creativity and entrepreneurship as a result of people's shifting perspectives on contributing to economic growth (Andres, Iris, & Guerra-Turrubiates, 2015). Better health reduces mortality, which, in accordance with theoretical models and empirical studies, contributes roughly 11% of recent economic growth in low- and middle-income nations as reflected in their national income accounts (Dean & Lawrence, 2016). In a different light, the health industry contributes significantly to the economy of every country and employs a sizable portion of the labor force.

Despite the fact that Nigeria's health sector has helped the country expand economically, a number of issues have prevented the nation from making the progress and producing at its highest level for economic growth (George & Daniel, 2014).

Nigeria is ranked 142 out of 195 countries in a Lancet study that ranks health system performance using access and quality of healthcare as criteria. The World Bank reports that Nigeria also has a poor index for the coverage of universal health care services (Fullman, Yearwood, Abay, Abbafati, Abd-Allah, Abdela et al., 2016; World Bank, 2017). Despite the fact that the National Health Act guarantees all Nigerians access to healthcare through a fundamental minimum package of healthcare services, the package has encountered significant difficulties in terms of implementation and dissemination, with several state governments falling behind in doing so at the ward level (FGN, 2018; Wright, 2015). Additionally, because people favor going to hospitals, basic healthcare facilities are underutilized and ignored. Due to weak connections between the many tiers of the health system, the PHC's gatekeeping role has become outdated. In many cases, patients prefer to visit secondary and tertiary health clinics, but because they are more expensive, it is harder for the poor to access health care (FMOH, 2019; Abimbola S, Oyedeji, 2014; Okpani A, Abimbola, 2015).

Underpaid healthcare workers, inefficient governance and accountability systems, and improperly applied procurement and transparency regulations are all having an adverse influence on primary health care. The claim that Nigeria has one of the most corrupt health systems seems plausible given the predicted loss of 25% of Nigeria's current health spending of about $221 per capita due to corruption. Onwujekwe, Orjiakor, Hutchinson, McKee, Agwu, Mbachu, et al., 2020; WHO, 2020; Tormusa & Idom, 2016) encompass both private and public health costs. Notably, where there is corruption, efforts to advance the provision of quality healthcare, infrastructural facilities and other essential services always typically fall short of success (Tormusa & Idom, 2016; PAUL, Ogole & Ojo, 2017; PAUL, Yakubu & Apeh, 2020). In other words, PAUL and Ofuebe (2020) say “it is observed that the menaces of infrastructural deficits are persistent and unabated” due to corrupt practices. This is demonstrated by increased health care costs, a lack of necessary pharmaceuticals, and avoidable deaths in hospitals and other healthcare facilities, particularly

primary health care clinics (PHCs) across the nation [Onwujekwe et al., 2020; Bruckner, 2019]. Lack of proper data on health outcomes, health resources, costs, and service use at all levels, including federal, state, and local, limits the Federal Ministry of Health's ability to effectively oversee the health sector (Hafez, 2018). Our considerations for what is necessary to position the nation for the achievement of the Universal Health Coverage Targets include redesigning and establishing the PHC as an efficient gatekeeper in the health system, government prioritization of a benefit package of services, and, most importantly, stern actions against corruption to ensure wider delivery of high-quality healthcare in Nigeria. This requires the participation of numerous stakeholders in the nation's health care system. Stakeholders include medical professionals, the Economic and Financial Crimes Commission, the National Primary Health Care Development Agency, the State Primary Health Care Development Agency, and the Service Compact with All Nigerians.

In this study, the nature and scope of the problems with health and medical services as they relate to Nigeria's economic development are discussed. Both different policies and methods for implementing change are covered. Against this background, this paper evaluated healthcare policy and its effect on healthcare delivery in Nigeria.

Methodology

The paper adopted secondary sources of data, and relevant literatures on healthcare delivery in Nigeria as well as a review of policies aimed at improving healthcare in Nigeria

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The Policy Framework for Addressing Healthcare Delivery in Nigeria

In Nigeria, there are numerous legislative suggestions have addressed the challenges of Nigeria's healthcare delivery system. However, there have been few or no effective implementation strategies. We'll take a close look at some of these policy alternatives.

Redesigning and repositioning primary health care centers: Due to its pro-poor services, primary health care centers (PHCs) are widely accepted to be an effective and equitable method of healthcare delivery. In order to achieve universal health care, the Nigerian government stressed the importance of PHC revival across the nation's 774 Local Governments (Federal Republic of Nigeria, 2019). Similar to this, PHCs typically get funding that has been prioritized by the government for preventative measures like immunization, malaria control, and HIV/AIDS control (Uzochukwu, 2018). Due to the financial security it offers through decreased health-care costs, PHC investments, in the opinion of the WHO, would lead to greater equity and efficiency in the healthcare system (Fore & Gurrfa, 2019). This indicates that a plan to modernize PHCs so they can carry out their gatekeeping responsibility of seeing more patients would lead to a more efficient use of resources in the Nigerian healthcare system. In addition, due to the mandatory transfer of funds through the Basic Health Care Provision Fund (which receives 50% of the 1% consolidated revenue for strengthening the PHC), funds that are not used right away due to a delayed release of funds, low uptake, or low demand can be carried over (Federal Republic of Nigeria, 2017). The amount to which this form of funding is used, as well as how well it is used, are still up for debate. There is a glaring feasibility gap in the restoration of PHCs as a result of the nation's economic issues, which could breed mistrust among stakeholders. The nation experienced a recession in

2016–2017, from which it is still slowly emerging, and is currently grappling with the COVID–19 epidemic's significant economic impact once more (Ozili & Arun, 2020).

Prioritization of the basic minimum package of health services by the government: The National Strategic Health Development Plan II recommends that the National Health Insurance Fund, which provides a basic minimum package of health services to all Nigerians, be used to eliminate financial hardship at health care provider points (FGN, 2018). Emergency care, diabetes and hypertension medication, regular vaccination, care for diseases in children under the age of five, emergency obstetric and neonatal care, labor and delivery, elective caesarian section, and prenatal care are all included in the package. At the point of delivery, these interventions will be offered free of charge (Onya & Elemanya, 2016). The National Health Insurance Scheme (NHIS) is in charge of implementing this package, which aims to reduce health service disparity by providing pro-poor services, particularly in rural areas, to enhance access and quality of treatment (Onya & Elemanya, 2016). The plan is designed to provide gradual universalism in health-care delivery while also delivering basic services to a wider population. The NHIS funds the procurement of cheap and effective interventions for roughly 60% of the existing illness load, which will be supplied by commercial and governmental providers (Hafez, 2018). This money comes from the remaining 50% of the Basic Health Care Provision Pool (1% of the consolidated revenue fund) (Uzochukwu, 2018). However, the country's overall fiscal space is around 12% of GDP, implying that the Basic Health Care Provision Fund (BHCPF) accounts for 0.12% of GDP and therefore the NHIS receives 0.06 percent. When compared to the typical fiscal space for low- and middle-income nations, which is between 20 and 25 percent, this fiscal space is modest (WHO, 2020). The scheme's funding should consequently be supplemented by a bigger pool of cash from general taxes, which account for 14% of current spending (WHO, 2020). The most vulnerable people will have easier access to care as a result of this. It's also more logical to look at additional state government engagement in the insurance scheme's expansion.

The state government's decision to prioritize the basic minimum package through payroll tax funding of social health insurance is based on the state governments' constitutional sovereignty (Okpani & Abimbola, 2015). State governments are required to donate 0.5-1 percent of their consolidated funds to the PHC, with the remaining 50% passing through the National Health Insurance Fund, which they manage. However, the state-led plan is now in various levels of implementation, with just 24% of states having completed the process. This disparity is due to variations in the pools of each state (Uzochukwu, 2018). Furthermore, after accreditation, operationalizing the scheme entails an agreement between the providers and the insurance scheme (purchasers) on the types of services and tariffs, and because accredited facilities are the sole selected providers regardless of location, equity will be constrained, particularly if the facilities are not accessible. Decentralizing the administration of the health insurance plan has been proposed to minimize delays associated with a bureaucratic central administration as well as complaints about service inadequacies while assuring quality improvement (Abimbola & Oyedeji, 2014).

Pragmatic and strong actions against corruption in the health sector: A recent comprehensive analysis of corruption in the Nigerian health industry (Onwujekwe et al., 2020) found the most frequent kinds of corruption in the field. Drug malpractices, absenteeism, bribery (informal

payments), and money misappropriation are only a few examples. With the shift in the political atmosphere in the nation, the publication of a policy on tough anti-corruption measures comes at a good moment. The present administration is committed to fighting corruption, and it has been suggested that more comprehensive and transparent methods, as well as citizen participation, would be required to achieve this goal (Onya & Elemanya, 2016). Anti-corruption initiatives in the health sector are viable initiatives that African nations have adopted and tailored to their own circumstances and pressing needs. Uganda, Malawi, and Tanzania are examples of nations where implementation has been effective (UNDP, 2017). In Uganda, an anti-corruption campaign affected government decision-making, resulting in the approval of a distinct budget line for the National Medical Stores, ensuring less fragmentation and fewer bottlenecks for medication procurement with higher resources. It was observed that more work is still needed to implement punishment and follow-up on incidents of corruption in the country due to poor law enforcement (UNDP, 2017).

The success of anti-corruption activities based on "bottom-up" techniques has been demonstrated in Uganda, a low- and middle-income country that ranks 137 on Transparency International's corruption perception scale (UNDP, 2017). In a study done in communities that used a PHC, the facility had a 50 percent absenteeism rate. Members of the community decided to create an action plan to oversee the facility's improvement of health outcomes, which resulted in a 30 percent reduction in newborn death, a 20% rise in outpatient visits after a year, and a 28 percent reduction in infant mortality after four years. This was primarily due to informal community censorship and criticism of the action plan when required, but without further government financial backing or medication supply to the institution (Bjorkman, De Walque & Svensson, 2017). Evidence from the literature suggests that particular efforts to enhance governance at the community level through monitoring at public hospitals can successfully check absenteeism when assessing the feasibility of a policy against corruption (Bjorkman, et al., 2017). Similarly, when remunerations and resources improve, the temptation to seek bribes decreases (Onwujekwe et al., 2020).

We think that adhering to the WHO's proposal for a legislative framework and a welcoming atmosphere for universal health coverage (UHC) would help us achieve our goal (Hussmann, 2017; WHO, 2018). Nigeria will need to put in place anti-corruption regulations for the health sector.

This will help to encourage a "top-down" approach to governance. Developing collaborative action plans at the community level will also help to encourage complementing "bottom-up" initiatives. A rigorous adherence will eliminate the possibility of officials who believe they are above the law evading punishments and dismissals if proven guilty. SDG 16.5 would be met if the health sector had effective top-down governance. Anti-corruption measures might be introduced in stages, as the WHO advised in the case of good pharmaceutical governance. Abinitio, a common strategy is to undertake a thorough vulnerability assessment, identify areas of importance in the health sector, and drive robust measures (Hussmann, 2017). Public spending and financial accountability indicators, as well as public expenditure monitoring surveys and reviews, can be used to track and quantify corruption in the health sector (Hussmann, 2017). This would also reduce inefficient expenditure on low-cost-effective interventions and, as a result, waste.

National Health Policy 2016: Nigeria's first comprehensive national health policy, released in 1988, was the National Health Policy and Strategy to Achieve Health for All Nigerians. After then, in 2004, it was updated (UNDP, 2017). The Federal Government, on the other hand, saw it as necessary to develop a new national health policy to reflect new realities and trends, such as the unfinished agenda of the Millennium Development Goals (MDGs), the new Sustainable Development Goals (SDGs), emerging health issues, particularly epidemics, the provisions of the National Health Act 2014, and the new PHC governance reform of bringing PHC Under the Control of the Federal Government. This is consequent upon the fact that there are challenges with policy formulation and implementation processes in Nigeria (Paul, 2019). This has made it critical to establish policies to effectively adapt to globalization, climate change, the insurgency issue, and its influence on Nigeria's health system (Uzochukwu, 2018). Furthermore, the country's experiences with the Revised National Health Policy of 2004 and the National Strategic Health Development Plan (2010-2015) provided a foundation for developing a new National Health Policy.

The National Health Policy is part of Nigeria's national development plan, which includes Vision 20:2020, which outlines the country's economic growth and development objectives from 2009 to 2020. This is key for the measurement of the nation's well-being (PAUL & Adoji, 2022). In the health sector, Vision 20:2020 advocated establishing at least one general hospital in each of the 774 LGAs to provide access to high-quality, affordable health care. The National Health Sector Reform Programme (2004-2007) was used to put the Revised National Health Policy into action, followed by the National Strategic Health Development Plan (2010-2015) and yearly operational plans. Since then, Nigerians have been working to revive primary health care delivery in order to provide cheap and accessible health care to all Nigerians. Following the passing of the National Health Act of 2014, this new health policy arrives at an ideal moment. As a result, the Act establishes the legal foundation for the new National Health Policy (Uzochukwu, 2018).

A Situational Analysis of Healthcare Delivery

Both the public and commercial sectors in Nigeria provide health services through basic, secondary, and tertiary health institutions. Despite the fact that basic health care is at the heart of the Nigerian health system, the supply, financing, and administration of primary and secondary health care services in Nigeria leaves much to be desired. The presence of health facilities does not imply the presence of high-quality healthcare services. A substantial portion of the population does not have access to some services.

Due to persistent industrial action by all cadres of health care personnel at public institutions, health care services are constantly disrupted. Despite the fact that the private sector has played a critical role in making health services available, the private sector remains poorly integrated into the Nigerian health system. Many health institutions are located in remote regions, particularly in rural and difficult-to-reach areas which "are characterized by depressingly meagre annual per capita income, pervasive and endemic poverty, manifested by widespread hunger, malnutrition, etc" (Moghalu, 1992 cited in PAUL, Agba & Chukwura, 2014). The cost of services, distance to the health facility, and the attitude of health professionals are the most frequent barriers to public access to health care which hindered the achievement of MDGs and about challenging

the realisation of the SDGs (Paul & Ogwu, 2013; Okpani & Abimbola, 2015). The quality of health care is typically low, and the public lacks faith in it. As a result, some people are seeking medical treatment outside of the nation or skipping primary and secondary health facilities in favor of tertiary health institutions. Clinical disease diagnostic and management competency is disproportionately high, whereas clinical guidelines adherence is poor (Onwujekwe et al., 2020). Even in cases where quality is high, service consumers' perceptions may not match the actual level of care provided. This might be due to health personnel' bad attitudes, a lack of clarity in standards and procedures, and insufficient execution of these rules and other legislation (SDI, 2014). While state ministries of health (SMOH) provide licenses to guarantee that institutions meet requirements, there is no oversight of the quality of private-sector services (Ozili & Arun, 2020). Quality and standards are not regulated by any institutional structure. While the National Health Act of 2014 requires health institutions to acquire a certificate of standards, the Act does not specify the conditions for this certificate. Regulations establishing these criteria have likewise yet to be passed. Service coverage remains poor, with no improvement over the last ten years.

Other issues with health services include the curative skewness of health care given at all levels, inefficiencies in service production, the lack of a minimum package of health services, and ineffective referral networks.

HIV/AIDS, Malaria, Immunization, Population, Reproductive Health, Control of Onchocerciasis, Tuberculosis, and Leprosy, Blood Transfusion, Female Genital Mutilation Elimination, Adolescent Health, Food and Nutrition, Child Health, Drug and Food Hygiene and Safety are all covered in the current national health policy. The major thrusts of health policy are national health systems and management, national healthcare resource, national health information system, partnerships for health development, health research, and national health care laws. Stakeholder input on how the national health policy should be organized resulted in this. The public's reaction to the new national health policy remains unknown. Though Nigerians' health has improved, the difference is minor. It remains to be seen if Nigeria, like other countries, will be able to achieve the Sustainable Development Goals (SDGs) (Bolaji, 2016; UNDP, 2020).

The new national health policy's overarching policy objectives of fairness, accessibility, affordability, quality, effectiveness, and efficiency remain unresolved. The Nigerian health-care system is based on primary care, which has proven ineffective in tackling the country's many health problems. Priority public health issues including noncommunicable diseases, injuries, pregnancy and child health, and so on are rarely handled with cost-effective solutions. Inter-sectoral collaboration and coordination among the several ministries responsible for health care remains a major problem. The World Health Organization has stated that the number of malaria cases is increasing (World Health Organization, 2015). Despite this, national health systems are ineffectual and wasteful, and their management is incompetent and wasteful. The distribution of human resources in urban and rural regions is not equal. Over 70% of doctors live in urban areas, whereas only 48% of the population does, putting 52% of rural residents at the mercy of insufficient medical personnel (World Health Organization, 2015).

A major issue with the sort of health care provided in various regions of Nigeria is that many of these programs use a vertical rather than an integrated strategy. Vertical programs (also known as stand-alone, category, or free-standing programs, or the vertical method) are situations

in which a specific health problem is solved by using single-purpose technology to implement specified interventions. In contrast, integrated programs (also known as horizontal programs, integrated health services, or horizontal approaches) aim to address overall health problems on a broad scale and over time by establishing a permanent system of institutions known as =general health services (Msuya, 2015), which may include a variety of managerial or operational changes to health care (Briggs & Garner 2016). Little is known about how to swiftly scale up health services in the face of pressing public health issues and incorporate vertical, single-disease programs into the larger health system. In Nigeria, there is a scarcity of scientific evidence on the organization and delivery of health care (WHO, 2019).

One key area is to create effective and efficient methods to dealing with special-needs groups, such as dispersed rural communities and those living in urban slums, in order to enhance their access to effective services. More study is needed to develop strategies to assist health care providers in ensuring that patients are taking their medications. More study on ways to enhancing medication supply, such as cost-recovery systems and interventions to increase prescribing and dispensing, is needed. These initiatives should not be limited to the formal health sector; drug merchants, who are significant providers of health-related items in Nigeria, should also be included. Another difficult area is assessing the creation and execution of quality-assurance measures in the health-care system.

All Nigerian people have a basic right to good health (Abdulraheem, Olapipo & Amodu, 2014). Improve access to quality health services by establishing a quality assurance system with a focus on establishing a system of registration and regulation of alternative and traditional medical practitioners; ensuring that essential drug consumption is met primarily from local production; utilizing Nigeria's medicinal plant resources for health care delivery; and ensuring that good quality health care is available. Despite the fact that primary health care has demonstrated dedication throughout time, degradation in government facilities, low pay, and bad working conditions have resulted in inadequate service delivery (Abdulraheem et al., 2014)

The problem is how to maintain the high expenses associated with rising demand in the healthcare industry. The process of determining when, how, why, and by whom demand originates, and then deciding on the best means of dealing with it, has been characterized as the process of developing and using the most efficient, suitable, and equitable strategy to dealing with it (Pencheon, 2018; Fabiana, Michele, Carla, Luciana, Roberta, et al., 2016) As a result, the Federal Government of Nigeria established SERVICOM (Service Compact With All Nigerians) in June 2003 in acknowledgment of people' rights and entitlements to effective service delivery. Nigerians now have the right to demand decent service thanks to SERVICOM. The charters inform the public on what to expect from the service and what to do if it fails to meet their expectations (Dipo, 2014).

This quality assurance platform, among others, is supposed to ensure that quality services are built around their customers' demands and delivered by qualified employees who are attentive to their needs. List the fees that must be paid (if any), and make it illegal to ask for or make extra payments. Maintain "suggestion boxes" in the clinical area to allow the submission of recommendations for service improvement. Deliver contact information for the agencies and government authorities to whom complaints about any failures to provide such services (or any bribe requests) should be sent; Publicize these data in prominent, public areas in all facilities where the agencies deliver services, as well as on the Internet; Conduct and publish citizen surveys on a

regular basis to evaluate patient satisfaction and the extent to which certain Ministries and Agencies are seen to be following their SERVICOM obligations; and to periodically evaluate and update the obligations included in their SERVICOM Charters in light of experience and new developments. This is despite the fact that SERVICOM has so far failed to meet its public-facing obligations (Dipo, 2014)

The Public-Private Partnership in Healthcare Delivery Approach

Healthcare Policy in Nigeria and worldwide, access to inexpensive and high-quality healthcare is important for economic growth and development. However, the country's health indices are too low and continue to fall short of government objectives, resulting in a low health rating. According to Eneji, Juliana, and Onabe (2016), the country has been neglected for decades, putting the country's health and production at risk. Over the years, annual public sector financial expenditures to the health sector have been modest, frequently falling short of international standards. This exacerbates the country's healthcare problems.

Over 90% of the population is served by Nigeria's healthcare system, which is characterized by a subpar public sector and is financed in more than 70% of instances by out-of-pocket expenditures. The public sector, which provides services to more than 90% of the population, is supported by the fiscus. This report recommends that the nation's health sector adopt a strong Public-Private Partnership model as the challenges in the healthcare sector become increasingly alarming. A public-private partnership is a government-sponsored initiative that makes use of private funding to support the delivery of social infrastructure assets and/or public services (Tan & Overy, 2014). According to the Africa Research Forum (2013:1), "it encompasses efforts that form a contract between a public-agency and a private business (for-profit or not-for-profit) for the supply of services, facilities, and/or equipment." In 1792 A.D., the Perrier Brothers were given a concession to distribute water in Paris, starting the first public-private partnership in France. Public-Private Partnership was first instituted in the UK by the British Conservative government in 1992, and it has since spread across the globe (Hearne, 2019). As a neoliberal philosophy of state interventionist approach, public-private partnerships are essential for promoting government participation through private cooperation in the provision of social goods and other sorts of infrastructure development. It is currently widely used throughout Africa, including South Africa, Egypt, Ghana, and Botswana. It has been used to improve health outcomes in industrialized countries like the United Kingdom, Germany, Spain, and the Netherlands.

Conclusion/Recommendations

The fulcrum of any system and the cornerstone of organizational functionality are policies. Health policy needs to change with the times in order to ensure that the vast majority of people are healthy. In the greatest interests of the people, issues with access, inadequate community engagement, and underfunding should be given top priority. It is necessary to increase the health care managers' knowledge of practical strategies for enhancing management capacity. All governmental levels must create specific management development programs that build on prior efforts and address real-world problems. Which area of knowledge, skills, management systems, or the working environment needs the most attention is one factor to take into account while

creating a strategy. Which business leaders should be initially targeted? When several therapies are required, which actions are the most important to start with? Who should be given an invitation to attend? What effects does this have on resources?

Strategic actions like restructuring PHCs and focusing on the bare minimum package delivery through National and State-driven insurance schemes are needed to close policy gaps for improved health care delivery. UHC, however, will continue to be a pipe dream unless Nigeria implements serious anti-corruption measures. Although updating PHCs is in line with international recommendations as a practical route to UHC, the nation's economic situation makes it less feasible. Broader coverage would also benefit from giving the fundamental minimum package priority through State operationalization of cost-sharing systems, but state implementation is lagging. A preliminary vulnerability assessment can help in achieving this timely call to action in the health sector. Political support will be essential in advancing this plan by ensuring that sufficient sanctions against corrupt practices are executed in order to have a discernible impact, even though further local data is required to guide specific steps.

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