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A New Thrust in Health Delivery System in Nigeria: An Appraisal of the Strategic provisions of the National Health Act 2014

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Abstract

There is no doubt that our health service delivery system has deteriorated over the years despite political promises to revamp the sector and the claim of imaginary millions of naira already sunk into the sector. It is a known fact that public hospitals have become nothing more than consulting clinics; a situation which has denied the poor and the needy in the country of much needed health care; while the rich and the political class seek medical care outside the shores of the country. The Constitution of the Federal Republic of Nigeria, 1999 worsens the matter by reducing the right to health to a mere aspiration, fundamental objective and directive principle of state policy to be attained in no foreseeable future. Thus, the supreme law of the land has refused to recognize the right to health as a natural and inalienable right endowed on every human being; as if one can conveniently enjoy the right to life without good health[1].

Key Words: Health Delivery System, Strategic Provision, Nigeria

The domestication of the African Charter on Human and People's Rights, in Nigeria[2]; which was viewed as a remarkable paradigm shift from the traditional resonance which held the right to health as unattainable, failed to synergize the proactive approach envisioned by the Act. This is aptly illustrated by the decision in the case of **Gani Fawehinmi v. Abacha[3].** The Court of Appeal correctly held that since human rights; provisions of the African Charter were protected by International Law, the Federal Military Government could not legislate out of it, and military ouster clauses could not affect the operation of the African Charter. This judgment alone would have made the right to health a justitiable and fundamental right in Nigeria since 1996. But then, the breath in this judgment was taken away on appeal to the Supreme Court. The Supreme Court held the Constitution superior to the Charter and since the constitution could be suspended by ouster clauses, the charter became only a piece of paper. Thus the search for a legal framework that would provide for an enforceable right to

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[1] See S. 17(3) (c) and (d) of the Constitution of the Federal Republic of Nigeria, 1999 (As amended)
[2] African Charter of Human and People's Rights (Ratification and Enforcement Act Cap A9 Laws of the Federal Republic of Nigeria 2014)
[3] (1996) 9NWLR 719

health led to the promulgation of the National Health Act, 2014. This work attempts an appraisal of the strategic provisions of the National Health Act 2014.

Regulatory Bodies

The Act has made the Federal Ministry Health, the chief regulatory body for the enforcement of the Act. It is clear by the functions of the body as contained in Section 2 of the Act; that health care delivery system in Nigeria is state controlled. What this imports is that the state or government has taken the responsibility for providing health care to her citizens. This is also in line with Article 16(1) and (2) of the African Charter on Human and People's Rights (Ratification and Enforcement) Act, 2004 which, apart from providing that every individual shall have the right to enjoy the best attainable state of physical and mental health, goes further, to make create the duty for every country to take measures to protect the health of her people and to ensure that they receive medical attention when they are sick. It is natural for citizens to look up to the state to render such services; government being an incident of the social contract.

The duty imposed on the Ministry of Health by Section 2(2) (a) of the Act is to prepare annual strategic, medium term health and human resources plans. This is important to actualizing the philosophical basis of the Act, besides, for the scheme to always remain on track, partnership with private section must be embraced. This provision therefore, saddles the minister of health with the duty of ensuring the successful implementation of the Act.

Class of Person affected by the Act

It is trite that law is useless without the coercive impetus. It is apt to pose the question; who is entitled to enforce the provisions of the Act or benefit from? The saying that, health is wealth is not novel to our jurisprudence rather what we have missed over the years, is the right to health backed with the right to enforce such right. The human right to health means that everyone has the right to the highest attainable standard of physical and mental health, which includes access to all medical services, and general system of health protection. This is the philosophical basis of the Act and it is in consonant with international

law[4]. Section 15 of the Act, can be interpreted as aiming at making health services available to every Nigerian but not without cost. We shall look at this again under the nature of health right provided by the Act. Section 1(1) (c) of the Act makes it clearer, that the provision is for persons living in Nigeria; as a result of which every such person can look up to the state for the provision of health care service subject to the cost of such services.

Availability of Facilities

Health facilities are crucial to the enjoyment of this right. To this end the Act, has structured the National Health System in Nigeria to comprise the following:

a. Federal Ministry of Health

b. Ministry of Health in every state and FCT

c. Parastatals under the Federal and State Ministries of Health

d. All local government health authorities

e. Ward health committees

f. Village health committee

g. Private health care providers

i. Traditional health care providers and

j. Alternative health care providers

The institutions listed from (a) to (f) above are necessary and capable of taking health care services to the grass root, provided that the provision is honoured in implementation. It then becomes incumbent on the state to ensure that these institutions exist and are adequately equipped. By recognizing the institutions listed as (g) to (j) above, the Act is desirous of creating a partnership between the public and the private sectors and fashioning them into formidable forum for health care delivery. A virile health sector must be able to create an atmosphere for interface between the public and private sectors. In implementing the National Health Act, 2014, co-operation between the public and private sectors becomes a

[4] See Article 25 Universal Declaration of Human Rights, 1945 Article 12 of the International Covenant on Economic and Cultural Rights and Article xi(1) of the American Declaration on the Rights and Duties of Man, 1948

delectable assignment. The Act has this factor in contemplation[5]. It becomes necessary in this regard for the regulating body to ensure that the private sector has community services to render and not just to maximize profits. Non governmental organizations are to be encouraged to participate and contribute their quota to the health delivery system. The participation of social workers and charities abroad should be emulated in order to actualize the good intentions of the Act. In consonance with the adage that says that health is wealth; the Federal Government should not just build hospitals and health centres but must equip them with the essential drugs and well trained personnel and ensure affordable services so that people would have faith in our health care system.

Exemption from payment for health services

Certain health issues require huge amount of money to be tackled and hence assistance is called for. By virtue of Section 3(1) of the Act, the Minister of Health in consultation with the National Health Council may determine who qualifies for free health service at public establishments taking into consideration the available range of exempt health services, categories of exempted persons, impact of exemption on the scheme and the vulnerable group of persons.

The import of this provision is that exemption from payment for health services is not even automatic to the persons falling within the exemption category. This is understandable, as the successful running of the scheme depends on availability of funds, but then certain persons ought to be given priority, even when the effect of exemption calls for suspension of the 'privilege'. Such persons should include pregnant women and people with terminal diseases.

Committees and Bodies

The Act has provided for several committees and bodies and vested on them certain functions which are likely to conflict. There is need to review the number of the committees and bodies and scrutinize their functions to avoid conflict. This would guide against necessary bureaucratic bottle necks.

[5] See Section 1(1)

Funding

Section 11 of the Act makes provisions for establishment of a fund to be known as Basic Health Care Provision Fund. Three specific grants are to make up this fund and they are:

i. Annual grant of not less than 10% of the Federal Government Consolidated Revenue Fund
ii. Grant from International donor partners; and
iii. Other sources

These sources are not certain except for the Federal Government annual grant which may be more but not less than 1% of the consolidate revenue fund. The success of the type of health system anticipated by the Act cannot be delivered without adequate funding. 5% of this fund is to be applied for the provision of basic minimum package of health services to citizens. It is also salutary that 10% of the fund is to be used for the development of Human Resources for primary health care. Another interesting part of the provision is the requirement that any state or local government which wants to benefit from the fund should contribute not less than 25% of the total cost of projects, as their commitment in the execution of such projects. This is obviously not a good regulatory measure. When a state or local government fails to contribute, their citizens would invariably be denied access to health care which the Act intends to avail them. State contribution should not be optional but mandatory. It is suggested that states as well as local governments allocated contributions to the scheme be deducted at source from their monthly revenue allocation. The National Assembly upon request by the Ministry of Health shall determine when supplementary budget shall be made in respect of the Basic Health Care Provision Fund. The money so deducted shall be paid into a trust fund to be managed by states or local government concerned and supervised by the National Primary Health Care Development Agency. This agency can as well handle the functions assigned to the National Tertiary Health Standards Committee[6].

[6] See Section 9 and 10 of the Act

Emergency Treatments

The Act has not just provided that a health care provider, health worker or health establishment shall not refuse a person emergency medical treatment for any reason whatsoever but has also made contravention of this policy a criminal offence punishable by a fine of the sum of N100,000.00 or to imprisonment for a period not exceeding six months or to both[7]. This provision will not just arrest the unwholesome practice of demanding fees from a patient in a critical health condition before the patient is treated, it will also save unnecessary deaths resulting from such practices. It is also suggested that any Magistrate/Judge within the jurisdiction where such contravention occurs should assume the duty of an ombudsman and should take steps to ensure that this provision of the Act is implemented to the latter. This provision has in effect created a civil right in favour of any patient falling within this category.

Abusive Patients

On the contrary, the fact that a patient is abusive is not reason enough for him not to be treated. This condition should be expunged from Section 21(3) of the Act. It is also commendable that action against a negligent health worker can be maintained within the ambit of the Act and not necessarily having recourse to common law rule of tort. Health workers should be duly and adequately enlightened as to their statutory duties and consequences for breach of the duties, as one of the measures for their capacity building.

Human Experimentation and Donation of Organs

The major issue arising from these areas is that of consent. A person who is willing to allow his body to be used for any experiment; must not just give his consent but must do so in writing after the purpose and effects of the experiment is explained to him. The Act requires that since a minor cannot legally give consent, his body can only be used for experiment where it is in his own best interest[8]; and the written consent of his parents or guardians duly obtained. The problem with this provision is that there is no penalty for

[7] See Section 20 ibid
[8] See Section 3.2

contravention or attempt to contravene it. Such penal clause is necessary for effective implementation of the provision.

Sections 48 and 51 of the Act have generated controversy hinging on whether or not the provisions violated the fundamental right of a person from who tissue, blood or blood product is to be removed as well as a person from who tissue is to be removed for purpose of transplanting same in another living person. Without going into the debate, it is clear that Section 48 makes the consent of a-would be tissue or blood donor, a condition for the removal of the tissue or blood. It is a criminal offence for the health worker to do so without the consent of the donor. To make this regulation meaningful, there is need to insist that such consent be given in writing, so as to avoid duress or coercion of any kind.

The inelegance of the provision of Section 51 of an Act is actually the problem in this regard. Whereas, the consent required before a person's tissue is removed for transplantation in another person; is that of the medical practitioner in charge of clinical services or the person in charge of the hospital, it cannot simply be left to assumption that those who drafted the law intended for the condition in Section 48 to apply to Section 51, that reason is not supported by any legal precedent. In fact by our canons of interpretation the express mention of a thing means the exclusion of what is not mentioned; aptly captured by the *latin maxim expressio unius est exclusio alterius*. It then follows that the consent of the person whose organ is to be removed is fundamental and as such it can neither be ignored nor presumed. Based on this premise, it constitutes a violation of a person's fundamental right for his organ to be removed and transplanted into the body of another living person without this consent.

For proper implementation of this provision, Section 51 must be amended to include the consent of the person whose organ is to be removed. Again, the medical officer or owner of the hospital within the contemplation of the provision must first seek and obtain the consent of the donor or his next of kin; where the-would be donor is not in a position to give his consent.

Overseas Treatment

The Act has not prohibited public officers from seeking medical attention abroad; rather, what it has done is to deny such persons state sponsorship of their treatment abroad[9] except in exceptional cases. The law in this regard is fair at least it reduces over dependence on foreign health care system by public officer holders. If the right to medical treatment is taken seriously it must also be interpreted to include the right of the ailing person to seek medical attention abroad. What this provision actually sets out to achieve is to ensure faith in our health care delivery system by making public officers to pay attention to our local health system as a way to nurturing it and to check waste of public funds.

Suggested Practical steps to implementation of the Act.

The Federal Government should not stop at making the health care system envisioned by the Act; mandatory for states but must ensure that every state and every local government implements it. The various committees of the National Assembly must take it up as duty to exercise their oversight functions in this regard by closely monitoring the public hospitals and health care centres.

The Act being a National Law which seeks to cover the field can be complemented by having the states locally domesticate it. All the states of the Federation should be mandated to domesticate the Act so that the implementation of the law would get to the grass root. The National Health Act has become law; even though its implementation is yet to kick start. The Act has recognized the right to health as justiciable right to some extent and this can be activated through litigation and judicial activism.

[9] Section 46 ibid