A CASE STUDY OF THE IMPLEMENTATION OF THE 2014 NIGERIA HEALTH ACT

What can we learn for public policy reform?

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LEAP

Acknowledgement

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Acronyms and definitions

CSO	Civil Society Organisation
FMoBP	Federal Ministry of Budget and Planning
FMoF	Federal Ministry of Finance
FMoH	Federal Ministry of Health
GAVI	Global Alliance for Vaccines and Immunisation
HERFON	Health Reform Foundation of Nigeria
HMO	Health Management Organisation
LGA	Local Government Authority
MDA	Ministries, Departments and Agencies
NCH	National Council on Health
NGF	Nigeria Governors' Forum
NGO	Non-Government Organisation
NHA	National Health Act
NHIS	National Health Insurance Scheme
NPHCDA	National Primary Health Care Development Agency
PHC	Primary Health Care
SPHCDA	State Primary Health Care Development Agency

Executive Summary

This report presents the findings of a case study into the development, passing and implementation of the 2014 Nigeria Health Act. We analyse the process of change from the inception of the Bill in 2000 to progress in the implementation of the Act up to 2017.

We asked:

a) What factors enabled and obstructed the passing of the Act?

b) Which provisions of the Act have met difficulties in implementation, and why?

c) What lessons can we learn to inform future attempts at public sector reform in Nigeria, and elsewhere?

This case study was guided by the principles of political economy analysis to understand the interests shaping the reform process.

Healthcare in Nigeria

Nigeria's performance on healthcare is strikingly poor. Maternal mortality levels are among the highest in the world and life expectancy is below the African average. The private sector provides a large proportion of healthcare services and government does little to make access to healthcare affordable. Household out-of-pocket expenditure represented 72% of health spending in 2014.

Historically, patronage politics has undermined accountability for health services in Nigeria. The health system has also been highly fragmented with different agents responsible for aspects of the same service and a number of duplicative national coordination platforms. Federal government provides the state governments with health policy direction and funding but state governments have autonomy over how funds are allocated and how health services are provided. Coordination of public healthcare provision across Nigeria faces political obstacles across and between all levels of government.

Passing the Act

The 2014 National Health Act sets out a wide range of new structures, regulations, and responsibilities intended to improve public health service management and delivery. It sets out a framework for the coordination of the health system, equitable delivery of essential health services, affordable access to healthcare and the integration of a national programme for primary healthcare (Primary Healthcare Under One Roof). The Act is legally binding for Federal level institutions and sets out guidance for changes at state and local government level.

The creation of overarching health system legislation aims to improve the quality and efficiency of health services nationwide but this is inevitably a complex process. It involved the inclusion of many stakeholder groups which while important, also contributed to the slowness of the Act being approved. The process took fifteen years and ran across four election cycles, which meant that a new advocacy effort was required after every national election. The long process of developing and passing the Act demonstrated the importance of continued lobbying efforts to achieve legislative change. Reform advocates had not anticipated the high level of controversy and apathy which had to be overcome for the Act to be passed and implementation begun.

Implementing the Act

Since the passing of the Act, implementation has been slow. There have been several obstacles at the federal government level and poor progress is often blamed on the lack of leadership and interest from successive Federal Ministers of Health and Presidents. Initially progress was made in the formation of implementation committees which had responsibility for developing guidelines for the Act's implementation. However, these committees were not granted government funding and have since been disbanded. Underlying this problem are disagreements, a lack of trust and poor communication between federal government bodies: the Ministry of Finance, the Ministry of Health, the National Health Insurance Scheme (NHIS) and the National Primary Health Care Development Agency (NPHCDA). On-going tussles about how the funding for the Act should be managed and by whom, indicate why the implementation of the Act is slow: it requires a shift in control of financial resources. Few stakeholders across the health sector have shown interest in the other, non-financial features of the Act. Despite their importance for health system performance, in the absence of any additional financing, there appears to be little for politicians to gain from implementing these provisions.

A further obstacle to the Act's implementation is the lack of a viable health insurance model. The Act allocates additional funding to government managed health insurance schemes but the reputation and track record of the National Health Insurance System is poor. Consequently, state governments do not have a good health insurance model to follow and few health insurance schemes currently exist at state level.

Three years after the passing of the Act and the funding for the implementation of the Act has not yet been included in the national budget and it is uncertain when this may occur. Indeed, in the absence of federal government funding, donors are now providing support to pilots of the domestication and financing provisions of the Act to go ahead in three States: Abia, Niger, and Osun.

State-level health reform

At state level, the main difficulty in promoting the Act is the limited political salience of health reform. State Governors do not have much to gain from improving healthcare during their tenure. Until funding for the Act has been included in the national budget and is made available to state governments, there is unlikely to be interest from the states in following federal health reform guidance.

This case study examined health reforms in Jigawa State in order to draw relevant lessons from its recent history of health reforms, in particular 'Gunduma' (a decentralised system merging primary and secondary health care at district level). Considerable investment of time and money was put into a restructuring of health sector governance in Jigawa since 2001. An important lesson is the importance of creating allies and managing resistance: health reforms risk creating resentment and lead to reversal if they reduce the powers and resources of state level ministries. There is also a danger that States will domesticate the Act to create the appearance of change (SPHCDA structures) without addressing more fundamental issues (the functions the SPHCDA should play in order to deliver improved health outcomes). Reforms which change structures but do not also change service delivery incentives or cultures are unlikely to achieve improved service delivery outcomes.

Unblocking bottlenecks to reform

Public health reform faces intractable political challenges at the federal and state level and in each state which has meant that supporting the passing and implementation of the act continues to be a time and task intensive process. However, change is occurring gradually and state-level pilots are underway. The following table summarises the bottlenecks limiting the progress of the Act and suggests how advocates could address them.

Table 1: Bottlenecks and suggested responses

Bottlenecks	Suggested response
Low political salience of health reform: There is not obvious opposition to the Act, rather, political leaders in the federal ministries and state governments and civil servants have shown little enthusiasm or interest in it or health reform more generally; they are primarily interested in how new funding will be controlled and shared.	Reform advocates focus on • how to create potential for political gain from implementing these changes and disseminate material to facilitate these activities. • advocating for the domestication of the Act, using innovative ways to engage the State Governors. These will need to be sustained across election cycles.
Short institutional memory: High turnover in political positions in the health sector and in the National Assembly mean that the advocacy process has to be repeated and sustained.	Donor support to civil society and health advocates to enable them to network with and lobby relevant power holders. This could include: • offering technical assistance; • translating the Act into formats which are accessible to the state level; • engaging the media to disseminate the Act.
Lack of collaboration and trust: A poor record on health budget management and fund misuse has worsened the trust of the Ministry of Finance in the health sector. Disagreement between the Ministry of Health, the NHIS and the NPHCDA over the control of the Act's funding has delayed the development of implementation guidelines.	Donors coordinate their support and facilitate communication between federal ministry leaders who otherwise are unlikely to collaborate. e.g. mediate discussion and encourage cross-agency working by supporting the current Health Act pilot projects. The Nigerian Governors Forum could play a critical role in enabling state leaders' involvement in the domestication of the Act, communicating potential benefits of implementing it and enabling knowledge sharing.
Controversy surrounding the NHIS: The credibility of public health insurance is currently undermined by the reputation of the NHIS as dysfunctional and a source of profit for politicians, wealthy individuals and Health Maintenance Organisations.	While the NHIS is under review, support is urgently needed to enable state governments to develop their own health insurance schemes. Donors could offer independent technical assistance to states to develop insurance schemes and the Nigerian Governors Forum could enable knowledge sharing on this across states.
Confusion over access to funding: There is confusion among key stakeholders regarding how state and local governments can access additional federal funds for the Act's implementation.	Donors could support the implementation of sub-committees and respond to requests for support from the Nigerian Governors Forum and civil society organisations to hold discussion sessions on how the funds will be managed.

In conclusion: The National Health Act echoes attempts at public sector reform in Nigeria and other developing countries where, despite agreement on the need for reform, there is less agreement regarding the changes in how resources are controlled; both are critical for reform to be successful. There has been some progress in the implementation of the Act. Low political interest in healthcare is a clear challenge but national provisions are gradually falling into place and are opening the way for state domestication. The real opportunities for change lie at the state level and support for the Act will be needed here. There is not strong opposition to health reform, rather a lack of enthusiasm to act and the bottlenecks that remain will need renewed and concerted effort to be overcome. In each State it would be important to analyse who is most likely to lose or gain from the health reform and so anticipate where opposition or apathy towards reform is likely to lie. In the absence of existing political support for reform, advocacy is needed to persuade leaders that by driving the reform, there will be political or personal benefits.

The experience of the National Health Act reflects recent and established theory that public sector reform processes are not a technical challenge but a political one. Reform processes need to be led by local stakeholders and should avoid externally designed structures. Efforts by donors to improve the functioning of public services in Nigeria will need to be long-term and politically smart if they are to succeed in persuading those who control public resources to use them efficiently for greater public benefit.

1. Introduction and approach

In this report we present the findings of a case study into the development, passing and implementation of the 2014 Nigeria Health Act. The Act legislates for a significant reform of healthcare in Nigeria and so is of interest to those working on healthcare improvement in Nigeria, and potentially elsewhere. It sets out a new structure for the health system across Federal, state and local government levels and, crucially, aims to put in place the necessary arrangements for universal health coverage (UHC). To achieve UHC, the Act sets out how health financing mechanisms, governance structures, the primary healthcare system and a healthcare benefits package fit together to improve the quality and availability of health services and establish an affordable healthcare insurance system. The Act presents a framework for how healthcare could be better funded and regulated to become accessible and affordable to all.

This report examines the political process of passing the National Health Act (referred to as "the Act") and progress since 2014 in order to better understand what will enable and hinder its full implementation across the country. We look at how government and non-government actors interacted first to design the Bill and then to implement the 2014 National Health Act, within the context of the formal and informal rules that shape change. Our analysis covers the period from the inception of the Bill in 2000 to progress in the implementation of the Act up to 2017.

The ultimate objective of the Act was to set in place a formal legislation system through which health outcomes can be improved; in this report we analyse the process by which this was attempted, what aided or undermined those efforts and what has influenced the implementation of the many different elements of the Act. From this we offer insight about the extent to which the Act is achieving its objective, the way policy reform happens in Nigeria and what can be learnt about how international donors can effectively support public sector reform.

Research questions:

a) What factors enabled and obstructed the passing of the Act?

b) Which provisions of the Act have met difficulties in implementation, and why?

c) What lessons can we learn to inform future attempts at public sector reform in Nigeria, and elsewhere?

1.1 A political economy approach

Health systems have been described as complex adaptive systems, in which the nature of the system, as a whole, is the result of numerous interactions between its interdependent parts.[1] This complexity presents a serious challenge for health policy reform and despite many years of international technical assistance for public health reform, poor implementation of health policies is pervasive in many countries. This begs the question what does it take to make and implement health policies which result in healthier lives? The 2017 World Development Report (WDR) answers this question succinctly with: "better governance", defined more specifically as, the way that governments, citizens and communities engage to design and apply policies.[2]

Acknowledging the importance of governance to the success of health reform, this case study was guided by the principles of political economy analysis to understand the interests shaping the reform process. Previous assessments of the political economy of the health system in Nigeria have been framed by theory on the 'drivers

[1] *Paina L & Peters D. Understanding pathways for scaling up health services through the lens of complex adaptive systems. Health Policy Plan 2012;27:365-73*
[2] *World Bank 2017. World Development Report. Governance and the Law. http://www.worldbank.org/en/publication/wdr2017*

of change'[3], and complex adaptive systems[4]. We have built on these and incorporated principles from a wider body of theory and evidence on how politics determines the process and outcomes of public sector reform, and how international development actors can (helpfully or not) influence this.[5]

These principles state that reform programmes should:

1. Understand the root of the problem and focus on the ***function*** which institutions should perform, not their form.

2. Think about ***power asymmetries*** and ***political incentives*****:** Who is motivated to support and enable reform? Where may collective action problems and conflicting interests lie and what is the relative bargaining power of actors?

3. Be ***locally-led*** not imposed or designed by external organisations but by people and organisations with an interest in achieving change.

4. Benefit from ***long-term and flexible*** partnerships which are needed to support reform processes which are difficult to plan or predict and entail behavioural and cultural change which is not achievable in the short term.

In the case of the National Health Act, this means looking at: the functions that government organisations need to perform to deliver better health outcomes; what factors motivate or undermine performance in these functions; which actors' interests drive reform and are affected by the proposed reform; and how donors may play a role in this process.

We assume that effectiveness of a policy - or in this case the Act and its associated guidelines - depends both on how it was developed and implemented. We acknowledge that appropriate design is important and we describe that process, and then look at the equally important willingness and ability to implement it.[6] For this reason, we consider the extent to which there is political interest in the Act and consider the ability of the governance system to carry out the provisions of the Act. Drawing on theory by Andrews *et al.*[7] on public sector reform, we ask: do the federal and state Governments of Nigeria have the organizational capability "to equip, enable and induce their agents to do the right thing at the right time to achieve a normative policy objective." Or, is there insufficient emphasis on achieving the desired outputs and outcomes achieved. What do key stakeholders care about? Is the National Health Act in danger of being a case of 'successful failure' in which organizations continue to fail to achieve their intended outcomes, managing only to maintain themselves?[8]

1.2 Methods

We used mixed methods to gather secondary and primary data. The first stage of the research was a literature review to collate background information, identify key informants and formulate interview guides. Materials reviewed included academic journal articles, NGO reports, government documents, Nigerian media, and other commissioned reports where available. Consultations with an external advisor and the LEAP team in Abuja also informed the development of the research questions and interview guides.

The second stage of the research was a series of face-to-face interviews held by LEAP researchers from the Overseas Development Institute (ODI) and the Nigeria Governors' Forum. Key informants were selected based on recommendations by the LEAP team, external advisor, and the DFID advisor and through snowball sampling. Skype interviews were held with three respondents. The aim was to gather a wide range of perspectives and experiences of the passing and implementation of the Health Act from those who were or currently are involved in the process and those whose work is affected by the Act. In total, we consulted 21 stakeholders at the national level. These included current and former Federal government technocrats and politicians from the Ministry of Health, the National Primary Health Care Development Agency and the Ministry of Budget and Planning, NGOs and DFID as well as independent consultants. Some respondents raised issues about the experiences of specific states and these are included where relevant (see annex 1 for the complete list of respondents). Interview respondents were informed of the purpose of the interview and case study. Anonymised quotations in this report are shown by numeric identifiers e.g. [01].[9]

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[3] *Anyebe, Bezzano J, Foot S. 2005. Country level testing: the health sector in Nigeria. An analytical framework for understanding the political economy of sector and policy arena; 2005*
[4] *Heymans C, Pycroft C. Drivers of change in Nigeria: a preliminary overview. London: DFID-Nigeria's Drivers of Change Initiative; 2003*
[5] *E.g. Andrews, M., Pritchett, L. and Woolcock, M. (2017) Building State Capability. Evidence, Analysis, Action, Oxford University Press, Oxford; Blum, J., Manning, N., Srivastava, V. 2012. Public sector management reform: toward a problem-solving approach. Economic premise; no. 100. Washington DC: World Bank. http://documents.worldbank.org/curated/en/234741468183549966/Public-sector-management-reform-toward-a-problem-solving-approach; Andrews, M., 2013. The limits of institutional reform in development – changing rules for realistic solutions. Cambridge University Press, Cambridge*
[6] *Andrews et al. op cit*
[7] *Ibid.*
[8] *Ibid.*
[9] *The codes do not indicate the order in which respondents are listed in Annex 1.*

To understand how the Act is influencing healthcare provision at the state level, 26 stakeholders were consulted in individual and group interviews in Jigawa State. The examination of this state was not intended to be representative of all states, which is beyond the scope of this case study. Rather, the aim was to identify how the Act may have a positive impact on health service delivery in a state supported by DFID since 2001 and where there have been significant healthcare reforms. Interviewees in Jigawa included: state government technocrats and politicians, donor funded health programmes, NGOs and the media (see annex 1). We visited one tertiary hospital and two primary health care centres, one in peri-urban Jigawa and one in a more remote setting, to interview staff and observe conditions and activities. This report also draws on a complementary PERL study on Jigawa health care governance reform, commissioned to deepen our preliminary findings.[10]

The interview data were reviewed and summarized by the research team who analysed the data using key themes and discussing how to frame these to answer the research questions. The findings were triangulated through discussion within the research team and checked against the data for conflicting statements and inconsistencies. The findings and draft report were reviewed by the LEAP team. an external advisor and the lead author of the Jigawa case study to check for accuracy, relevance and analytical rigour.

1.3 Report structure

The remaining sections of this report are structured as follows:

Section 2 – Overview of the Nigerian health system context as described in the literature: political economy, health system design, challenges and key features of the 2014 National Health Act.

Section 3 – Findings from the primary research at national level.

Section 4 – Findings from the primary research on sub-national level challenges

Section 5 – Lessons and key messages from the analysis.

[10] *Piron, L.-H. and Ogunbayo, D. (2017) 'Jigawa health sector governance reform case study', PERL LEAP.*

Context

2.1 Political economy constraints on public services

Nigeria is the largest economy in Africa, with a population of over 180 million, organized through a federal political system. The Federal Government of Nigeria (FGN) and the 36 state Governments are bound by the provisions of the National Constitution (1999). The country's main source of revenue is oil but exploitation of this valuable resource has not resulted to significant improvements in employment or public services.[11] There are persistent security challenges in the north-east of the country, and major divisions in society along ethnic, regional and religious lines. Poverty is widespread but is more pronounced in the northern states.

The 1999 Nigerian constitution confers on the Federal Capital Territory and on each of the 36 states political, managerial, and regulatory autonomy. State Governments are responsible for their own affairs and make their own decisions: they elect their political leaders, appoint their civil service and determine their annual budgets and work plans. The autonomy of state governments means that federal government has little power to ensure that national policies are adopted and implemented in similar ways across all states. Yet at the same time, state governments have very little influence over Federal government decisions and most lack sufficient own revenue sources to function independently from Federal government, leading to tensions between the two levels of government.[12] Sub-national levels of government receive almost half of all federal revenue through direct grants. Much of this is spent on the wage bill of an ineffectively staffed public sector and the political debts of incumbent governors; the little which remains can be invested in improving services.[13] A widespread fiscal crisis began in 2015 when, due to declining oil receipts, the federal allocation to states was sharply decreased and, as a result, public employees in some states endured months without pay.[14]

Nigeria's performance on delivering public services is strikingly poor. For example, in 2016 only 35% of births were attended by a skilled health personnel and 31% of the population lacked access to an improved water source[15]. An underlying cause of the dysfunction and apparent neglect of public services in Nigeria is the neo-patrimonial political system, whereby political power is acquired and maintained through personal relationships and enabling private access to resources rather than delivering public goods.[16] The low political interest in improving the performance of the Nigerian bureaucracy means that public governance, including financial management, tends to be weak.[17] Political rent-seeking to sustain positions of power becomes more important for political leaders than monitoring the performance of the bureaucracy.[18] The resulting lack of budget discipline and poor budget execution have undermined the ability to link policy and public finance.[19] Social, economic, and political transactions frequently take place outside of the formal system, and policy processes are often shaped by informal arrangements.[20]

In this context, the provision of healthcare faces similar challenges to those of other basic services whereby the demand for basic services is absorbed by private sector providers. Private providers are able to service the needs of the wealthy who can afford to privately secure access to services, rather than demand the improvement of publicly provided services. This may partly be why there is limited sustained participation or pressure from civil society on government to improve public services.[21] Across Nigeria, there are often low public expectations of government functionality, which combined with public experience of low-quality public services supports widespread cynicism and mistrust of government.

However, it is important to note that the autonomy of state governments and variation between states in their economic strength, institutional history, cultural norms and other factors means that some states have far greater government capacity, varying political priorities and much better public service outcomes than others.[22]

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[11] *Lewis, P. and Watts, M. (2015) The Politics of Policy Reform in Nigeria. Doing Development Differently, February 2015*
[12] *Lewis and Watts, op cit*
[13] *Booth, op.cit.*
[14] *Downie R. 2017. Promoting Accountability in Nigeria's Health System. CSIS*
[15] *World Bank. 2016. Nigeria Country Profile. World Development Indicators database.*
[16] *Lewis and Watts, op cit*
[17] *Lewis and Watts, op cit*
[18] *Utomi P, Duncan A, Willams G, 2007, Nigeria The Political Economy of Reform. Strengthening the incentives for economic growth.* http://www.opml.co.uk/sites/default/files/Study-on-PATHS2-Capacity-Development.pdf
[19] *Ibid.*
[20] *Utomi P, Duncan A, Willams G, 2007, Nigeria The Political Economy of Reform. Strengthening the incentives for economic growth.* http://www.opml.co.uk/sites/default/files/Study-on-PATHS2-Capacity-Development.pdf
[21] *Lewis and Watts, op cit*
[22] *Lewis and Watts, op cit*

Understanding the political economy context of individual states is as, if not more, important than the wider national political economy.

2.2 The health system

Health outcomes: In recent years there have been steady but slow improvements in some health indicators such as infant mortality, but other key indicators have worsened. Maternal mortality levels in Nigeria are among the highest in the world and it is the African country with the lowest vaccination rate.[23] Life expectancy is below the African average and poor health outcomes associated with poverty are coupled with increasing burden of non-communicable diseases. There are wide rural/urban and regional disparities in health status, service delivery, and resource availability. Service coverage and health outcomes tend to be better in the wealthier, southern states.[24] A top health priority in federal government health policy is to reduce the mortality and morbidity associated with poor reproductive, maternal, neonatal, child and adolescent health (RMNCAH). The current health policy emphasises strengthening primary health care as the mechanism for this.[25] Quality of data relating to service coverage and outcomes is improving, but caution is still needed as data collected even quite recently show inconsistencies.[26]

Health system structure: In the Constitution, healthcare is on the concurrent list[27], which means that Federal *and* State Houses of Assembly can exercise legislative authority over this government function. Given the shared control over healthcare, roles and responsibilities for health systems management and delivery are difficult to define without encroaching on state autonomy but the National Health Act attempts to provide a guiding framework for this. Broadly, in terms of service provision, it is agreed that the federal level government is responsible for tertiary care, the states for secondary care and the LGAs for primary care. Management of health facilities at state level is shared by the state ministries, management boards and LGAs. The federal government provides policy guidance, planning, and technical assistance; coordinates state-level implementation of the national health policies; is responsible for establishment of health management information systems, disease surveillance, vaccine management and training health workers.[28] Since the passing of the Act, the National Council on Health (NCH) is the highest policy making body, with oversight of programme implementation; the National Primary Health Care Development Agency (NHPCDA) is a parastatal responsible for coordinating delivery of essential services and State Primary Health Care Development Agencies/Boards (SPHCDA) should be responsible for the coordination of planning, budgeting, provision and monitoring of PHC services in each state and for supervising LGAs.

Fragmentation and duplication*:* The health system has long been highly fragmented with different agents responsible for aspects of the same service and a number of duplicative national coordination platforms.[29] Officials are often unable to distinguish between the roles and responsibilities of different levels of government for programming, service delivery, human resource management and financing. For example, the Minister of Health is the political head of the Federal Ministry of Health, but there is usually also a second appointed minister, the Minister of State for Health, which – depending on the nature of the relationship between the two – can create ambiguity of responsibility. This problem is not unique to the health sector. At the state level, constitutionally the state Commissioners for Health are accountable to State Governors and not to the Federal Minster of Health. So, further confusion can be attributed to inter-dependencies whereby state level ministries, departments and agencies (MDAs) have no direct line relationship with the federal counterparts, but rely on them to give national policy direction. Functional decentralisation means that parastatal agencies have mandates for health programme implementation at the state level.

Historically patronage politics has undermined accountability for health services in Nigeria. The FMoH acknowledges that the health system is characterised by poor budgeting, and human resource distribution, weak governance and limited supplies to health facilities.[30] Health inequities, pervasive corruption, and the autonomy of Nigeria's 36 states are among the reasons hindering progress in the health service provision.[31] Capacity development activities supported by donors, such as those achieved through the PATHS (1&2) programmes, have not been backed up by adequate provision of public funds to implement and sustain systems, meaning the

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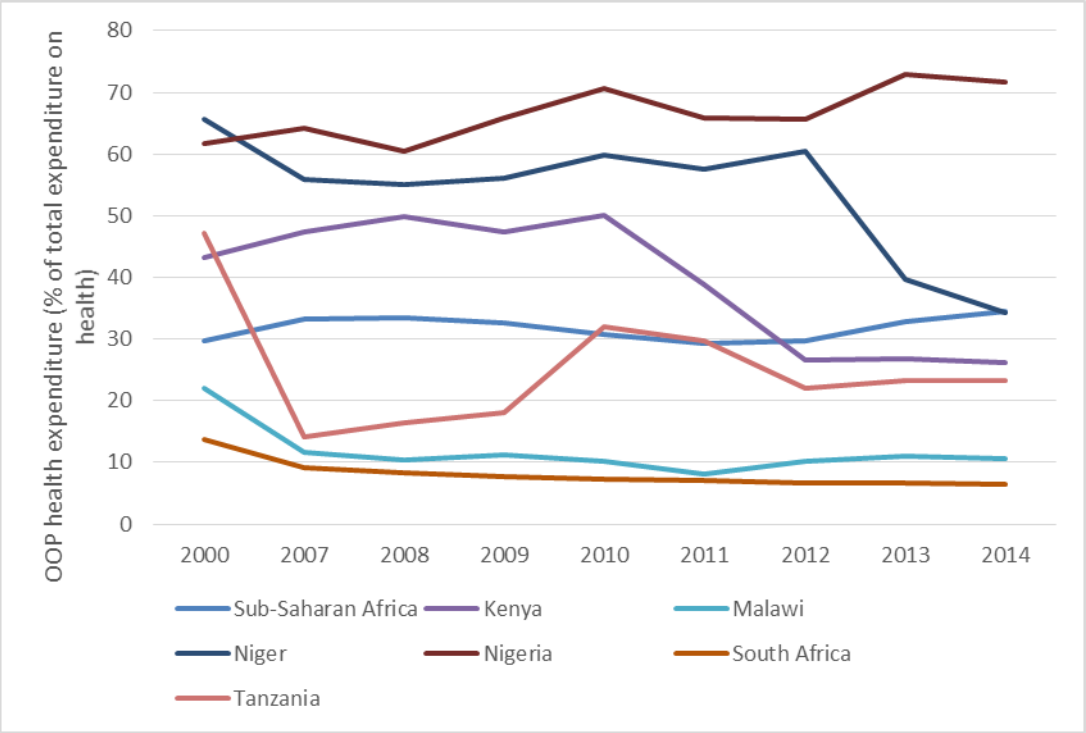
[23] *World Bank, 2015. Maternal mortality ratio (Global)* http://data.worldbank.org/indicator/SH.STA.MMRT
[24] *Africa Health Workforce Observatory. Health Workforce Profile, Nigeria. 2008*
[25] *Federal Ministry of Health. 2016. National Health Policy.*
[26] *See, for example, 2013 Demographic Health Survey and 2010 National Immunization Coverage surveys, which after allowing for methodological variation, still show implausible differences in results.*
[27] *The legislative system is categorized by exclusive, concurrent and residual lists. Items on the exclusive list are those in which only the central government has exclusive power to create legislation. Whilst Federal and State Houses of Assembly can exercise legislative authority for items on the concurrent list.*
[28] *World Health Organization. The Nigerian Health System.* http://www.who.int/pmnch/countries/nigeria-plan-chapter-3.pdf
[29] *Federal Ministry of Health. 2016. National Health Policy. Promoting the Health of Nigerians to Accelerate Soci-econonmic Development*
[30] *Federal Ministry of Health. National Health Strategic Development Plan: Federal Ministry of Health and World Health Organisation; 2010. Cited in PRRINN-MNCH, Technical Brief. Bringing Primary Healthcare Under One Roof.* http://www.prrinn-mnch.org/documents/PRRINN-MNCH1PHCUORBrief.pdf
[31] *McKenzie, op.cit*

sustainability of those efforts are at risk.[32] Those efforts included capacity development to improve health policy and strategy, support to the National Strategic Development Plans and initiatives to strengthen the NPHCDA's leadership of Primary Health Care Under One Roof (PHCUOR).

Health financing: Health services are provided by a mix of public and private providers, the contribution of private sector being relatively high by African standards. Private out-of-pocket spending on healthcare services is the norm in all income groups, (nearly 72% in 2014[33]) due to the absence of public subsidy and limited health insurance schemes. International and national NGOs are an important source of support for service delivery. Health in Nigeria is not a public funding priority and according to World Bank data, public health expenditure as a share of GDP was only 0.9% in 2014 – the second lowest level in the world.[34] Figures 1 and 2 shows that finance for healthcare in Nigeria is dominated by private out-of-pocket spending far more than most sub-Saharan African countries. Also in 2017, the proportion of the federal budget allocated to health fell to its lowest level since 2010.

The overall budget has an allocation of about 4% to health which is low by any standards in Africa and only around one quarter of the level prescribed by the Abuja Declaration of 2001 which called for a 15% budget allocation for health. Budget funds are also reported to be poorly allocated and inefficiently used.[35] Health spending *per capita* (public and private expenditure) however is not dissimilar ($118) to the sub-Saharan African average ($98).[36] At state and LGA level there has been fragmented financial management and confusion over financial control. Donors' funds for programmes operating at the local level have often been paid to federal institutions.[37] Resource allocation is skewed towards secondary and tertiary care rather than PHC, although PHC should make up the bulk of services and is at the heart of universal health coverage.[38] The National Health Act attempts to resolve some of these complications and distortions.

Figure 1: Out of pocket health expenditure in Sub-Saharan Africa.



Source: Data from database: World Development Indicators, last updated: 08/02/2017

[32] *Hayes, S., Jones, S., Abubakar, A., Chuku, K; 2016. The Independent Monitoring and Evaluation Project for the State Level Programmes (IMEP). Study on PATHS2 Capacity Development: Final Report. Oxford Policy Management.* http://www.opml.co.uk/publications/study-paths2-capacity-development-final-report

[33] *World Health Organization. 2015. Global Health Observatory Data Repository* http://www.apps.who.int/gho/data/node.country.country-NGA

[34] *World Health Organization. 2014. Global Health Expenditure database,* http://data.worldbank.org/indicator/SH.XPD.PUBL.ZS?locations=NG

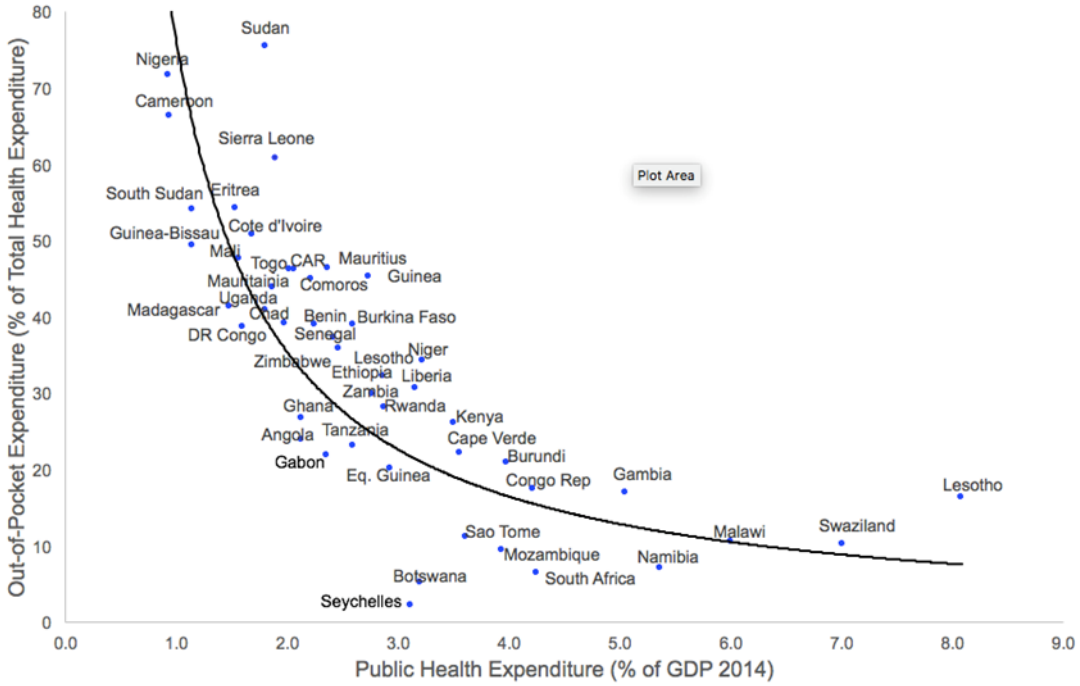
[35] *Downie, R. 2017.*

[36] *World Bank. 2015 Health Expenditure per Capita. Global Data.* http://data.worldbank.org/indicator/SH.XPD.PCAP?name_desc=false

[37] *McKenzie, op cit.*

[38] *Okpani, A. I., & Abimbola, S. (2015). Operationalizing universal health coverage in Nigeria through social health insurance. Nigerian Medical Journal : Journal of the Nigeria Medical Association, 56(5), 305–310.* http://doi.org/10.4103/0300-1652.17038

Figure 2: Public health financing replacing out of pocket expenditure in sub-Saharan Africa



Source: R. Yates. Chatham House (unpublished)

Universal health coverage: The Primary Health Care Under One Roof (PHCUOR) policy was designed to be the main vehicle for delivering Universal Health Coverage and a Presidential Summit on UHC in 2014 recommended that the Government of Nigeria work towards instituting mandatory health insurance as the payment mechanism for this. There have been ongoing efforts to establish social health insurance but progress has been very slow. The organization tasked with delivering the insurance through which UHC will be paid is the National Health Insurance Scheme, a federally funded parastatal. It covers about 1.2 million members, mainly from the formal sector, organized through a risk pooling and cost-sharing prepayment mechanism. Social insurance through the NHIS has had limited appeal to states who do not feel they have ownership. In addition to the national health insurance scheme, some community-based insurance schemes have been launched with donor support but these have failed to take hold beyond pilots.[39] [40] Insurance is still dominated by the private sector resulting in a skewing of investments towards more profitable healthcare services, particularly hospital care in urban areas. The NHIS is responsible for regulating private health insurance offered by Health Maintenance Organisations (HMOs). Private sector interests influence policy implementation as owners of HMOs use their position of power to maintain control of the cost of access to healthcare. Due to concern from Nigerian lawmakers over slow progress towards health insurance coverage and financial protection, in 2017, the President of the Senate launched a National Legislative Network on UHC. The network includes both the National Assembly and legislators from the State Houses of Assembly who have committed to pass appropriate health legislation and legal frameworks that mandate universal healthcare at all levels (e.g. laws establishing State Health Insurance/Contributory Schemes) and ensure financial risk protection, equity and improved access to quality services are introduced into all health legislations. Their commitments build on some specific provisions of the 2014 Nigeria Health Act.

[39] *Onoka C, Hanson K, Hanefeld J. 2014. Towards Universal Coverage: A Policy Analysis of the Development of the National Health Insurance Scheme in Nigeria. Health Policy and Planning.*
[40] *Okpani, op cit.*

2.3 Recent developments and health reforms

A number of significant health reforms and programmes have been introduced since the 1999 Constitution. They are described briefly here and are discussed further in sections 3, 4 and 5 with reference to the National Health Act.

1999 - National Health Insurance Scheme Decree was established by Act 35 of the 1999 Constitution. The Scheme aims to use various prepayment systems to enable affordable access to healthcare for all Nigerians. The Scheme is only obligatory for Federal Government employees.

2001 – The Abuja Declaration was made in April 2001 when the heads of state of African Union countries pledged to set a target of allocating at least 15% of their annual budget to improve the health sector.[41]

2001 – 2004 Change Agents programme was a DFID funded programme, which was broadly involved in initiating reform agendas and working with the Federal Ministry of Health to support health sector reform. The programme initiated the development of the National Health Bill and resulted in the formation of the health reform advocacy organization Health Reform Foundation of Nigeria (HERFON).

2002 – 2008, 2008 + PATHS Programme I & II (Partnership for Transforming Health Systems) was a successor to the Change Agents programme and continued to support health system strengthening – and particularly capacity development - at the state and federal level, including in Jigawa State.

2007 - Gunduma Health System was established in Jigawa to reform and integrate primary and secondary care services at the district level under one management structure.

2011 – Primary Health Care Under One Roof (PHCUOR) is a Federal Government policy which aims to reduce fragmentation in primary healthcare by creating a distinct channel for the management and delivery of primary health care services. The programme calls for the establishment of a primary healthcare authority in each state and in each local government which should work in a coordinated manner with the National Primary Healthcare Development Agency.

2016 – National Health Policy was developed following the 2014 National Health Act to reflect the provisions in the Act, the PHCUOR, a government commitment to Universal Health Coverage, to health objectives in the Sustainable Development Goals and to be better able to deal with health epidemics.

Copyright: Albert Gonzalez Farran/UNAMID

[41] *World Health Organisation (2011) The Abuja Declaration: Ten Years On.* *http://www.who.int/healthsystems/publications/Abuja10.pdf*

2.4 The National Health Act

The National Health Act was intended to overcome the issues described in section 2.2 and sets out a wide range of new structures, regulations, responsibilities for public health service management and delivery. The key clauses of the Act are described in box 1.[42]

The Act sets out a framework for coordination of the health system, equitable delivery of essential health services, protection from impoverishment from seeking healthcare and integration of PHCUOR. It is legally binding for Federal level institutions but crucially, being a national act, can only set out guidance for changes at state and local government level. It provides a legislative framework but, given the constitutional autonomy of state governments, the Act cannot prescribe how the state and local governments should implement it. Full implementation of the Act therefore requires domestication of the Act in each state.

BOX 1: KEY FEATURE OF THE 2014 NATIONAL HEALTH ACT

National Health System: *the establishment of a National Health system with a framework for standards and regulation of health service provision encompassing public and private provision and the development of a National Health Policy with guidelines for implementation.*

Basic Health Care Provision Fund (BHCPF) *– A minimum of 1% of consolidated federal government revenue and contributions from donor grants must be set aside to fund the BHCPF. 50% of the fund must be used to provide a basic minimum package of health services through the National Health Insurance Scheme (NHIS); 45% for primary health care provision and 5% percent for emergency health interventions. State governments and local government health authorities will only be able to access this fund if they each contribute 25% counterpart funding and if they have established a state-level primary health care management agency, as stipulated by the PHCUOR policy. The NPHCDA is responsible for administering, disbursing and monitoring this fund.*

National Council on Health: *The Act gives the National Council on Health greater authority by making it the highest level body for making health policy and responsible for developing the national guidelines on health and overseeing the implementation of the National Health Policy.*

National Tertiary Health Institutions Standards Committee: *Establishment of a committee to decide if and where new tertiary hospitals may be needed across the country.*

Access to emergency healthcare*: All healthcare providers are obliged to offer emergency healthcare treatment to all individuals without requiring prepayment and regardless of the cause of the injury or illness, whether known or unknown.*

Use of blood, tissues and gametes: *The Minister for Health has the authority to establish a National Blood Transfusion Service. Reproductive and therapeutic cloning is forbidden.*

Certificate of Standards: *All individuals, organizations, entities and governments will be required to hold a Certificate of Standards in order to provide healthcare services. Public and private healthcare providers are required to provide certain information on services offered and means of address in case of complaint. It includes regulation on responsibility for patient data confidentiality and access.*

A National Health Management Information System *will be established. The Federal Minister can prescribe categories of data to be submitted to the Ministry.*

Committees for health research and ethics *will be established*

Human resources for health: *The Act outlines responsibilities for training, management and adequate staffing of public health facilities.*

Rights. *The Act includes further provisions for the rights and obligations of patients and health care personnel and miscellaneous regulations.*

Implementation: *The Act enables the Federal Minister of Health, in consultation with the National Council on Health to make further regulations and create technical or advisory committees deemed necessary for the implementation of the Act.*

[42] *Federal Government of Nigeria (2014) National Health Act.*

3. National health reform 2000-2017

3.1 From Bill to Act

What was the National Health Bill initially trying to achieve?

The seeds of the National Health Act were sown about 15 years before its eventual passing into law. It emerged from two movements with different aims. The first movement was simply to respond to a much-noted gap in the 1999 Constitution which does not make explicit provisions on health services. National level respondents consistently commented that because the Constitution is silent on health matters there was a lack of clarity about the responsibilities of the three tiers of government for health, and that this was exacerbated by health appearing on the concurrent list as opposed to the executive list. The second movement was to develop legislation relating to the administration and financing of primary health care (PHC).

By 2014 when the Act was passed, its aims had become multiple, as more stakeholders became involved in what had become an increasingly inclusive process. It encompassed legal provisions for how the health system operates and is financed; a legal framework for national health policy; and, ways to address structural problems. In particular, the financial elements of the Act included clarifying the way in which funds flow from central to state level. The intended outcomes of the new financial provisions were a more coordinated and higher quality delivery of PHC, a framework for delivering universal health coverage (UHC**)** funded through the Basic Health Care Provision Fund (BHCP) and financial guidelines to define the benefit package. It was hoped that better financial management would reduce inefficiency, misuse of funds and poor coordination in the health sector through the reduction of ministerial control over budget and improved transparency in spending. Some respondents who had been involved in the development of the Bill had been (and still were) optimistic about the operational and financial scope and content of Act, even to the extent that it "*can actually change the face of the health system*" [02].

Who was involved in driving forward the Bill and what were the obstructions?

The process of the developing the Bill involved many individuals and organisations who had interests, concerns and grievances with specific provisions of the Bill. Dealing with these required multiple amendments, created a volatile environment, strained relations and made for slow progress. For example, professional bodies representing nurses, laboratory technicians and pharmacists felt their professions were undermined by the Bill. Ignoring their concerns would risk considerable repercussions in the daily operations of the health system. Resistance was also clear from religious groups relating to interventions at odds with their faiths, these included concerns relating to organ donation, embryos and so on. The financing provisions were also complex to negotiate, for example the ring-fence for funding of PHC, for which PATHS2 was a strong advocate.[43] Addressing each of these grievances was time consuming.

The advocacy efforts from the civil society coalition and most notably HERFON as well as the health sector programme PATHS 1 and 2, both DFID-funded, were instrumental in driving progress. Many of their members were high-calibre technocrats able to sustain engagement with the National Assembly and the Federal Ministry of Health, and some of them did so for 15 years. Yet the efforts and impatience of CSOs sometimes stymied progress too and both government officials and campaigners within CSOs raised this criticism; "*CSOs were sometimes insensitive to the ways politics works and undermined processes by creating conflict between key personnel. CSOs need to be part of the team, rather than activists on the outside*" (02). Overall however, the process was laudably inclusive, involving diverse constituencies from the Government ministries, NGOs, development partners, to the National Assembly, and professional associations all of which competed to influence it; "*Everyone wanted to take credit for the Bill*" (04).

Creating overarching health system legislation is inevitably a complex process, but the speed at which legislation can be created is largely determined by the strength of political commitment to reform. The long process of passing the National Health Bill into law is indicative of the persistently low political priority of the health sector in federal politics (Figure 3 depicts the key events and actors in the complex chronology of the Act). The process took fifteen years and ran across four election cycles; indeed, the latter was also a major contributor to further delays. With each new administration, a new advocacy effort was required to revitalize the process and to try to make investment in the health sector attractive to the interests of those newly in power: in one election over 50% of the National Assembly supporters of the Bill were not re-elected.

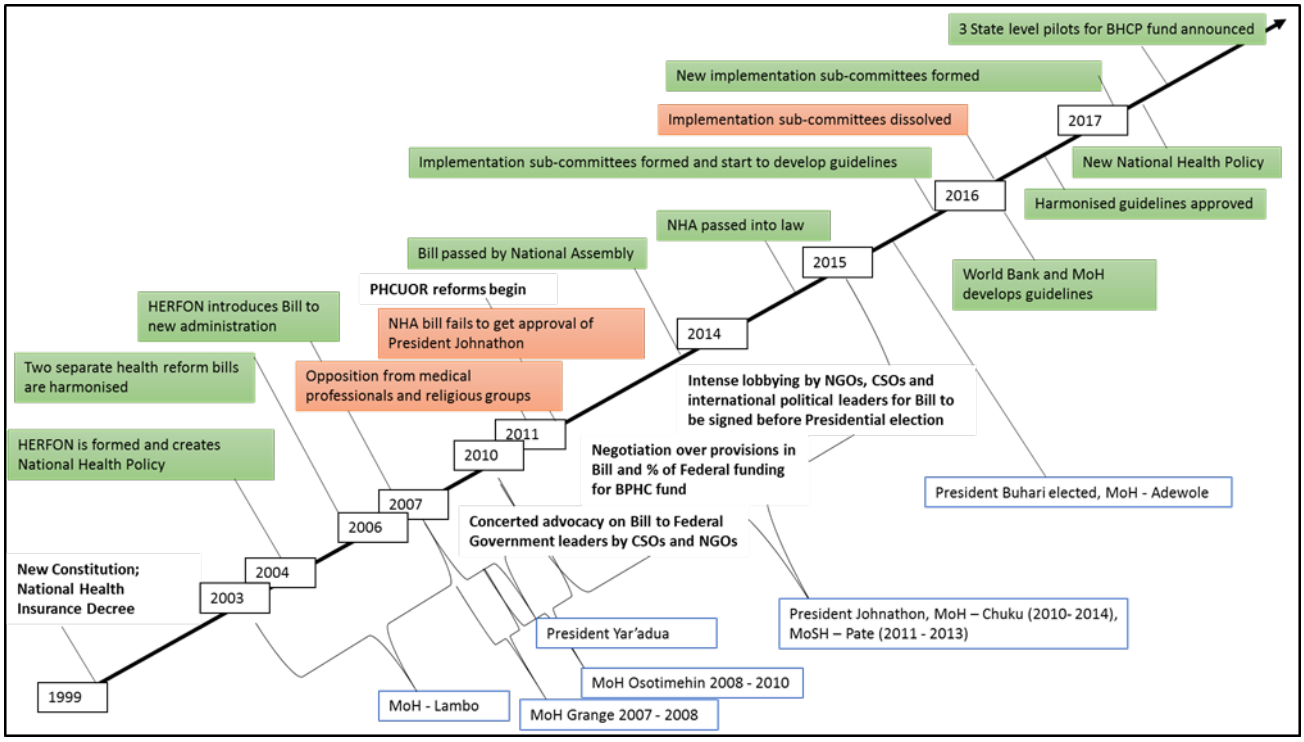
Professor Eyitayo Lambo, recognized as a "health systems reformer", was instrumental in getting the process started in the early 2000s. Lambo had been head of the Change Agents Programme (CAP), developed by DFID and the FMoH to reform the health sector; the Health Bill was one such reform. Lambo's subsequent appointment

[43] *Hayes et al. op.cit*

as Minister, in 2003, ushered in an era of positive activity for health reforms which continued until the end of his tenure in 2007. The CAP was succeeded by the Health Reform Foundation of Nigeria (HERFON), again supported by DFID. Several of our interview respondents considered HERFON's role to have been vital, "*the anchor was HERFON, if it wasn't for HERFON the Bill would not have happened*" (05). Later, another DFID-funded health programme, PATHS2 advocated for the Act to the President, various health committees, and the media. This sustained advocacy from HERFON and a coalition of CSOs (for which PATHS2 was a driving force) to high-level politicians helped to steer the Bill through numerous technical difficulties relating to content and by 2007 succeeded in getting the Bill passed by the Federal Executive Council and the Senate. However, progress stopped when the Bill reached the House of Representatives due to opposition from certain groups of medical professionals and religious groups. The issue of health being on the concurrent list complicated the process too, since it was being drafted as a national bill, yet could not be prescriptive to states because states have autonomy over their healthcare provision. *"The draft bill was presented to the Federal Council of Health and they were told that they can't make laws for states and local governments and so had to water this part down. They presented it to the National Assembly and were told again to be less instructive to the states… The National Assembly wanted to own the act – this means they liked it and wanted credit for it, but also meant it now became a 'National Assembly Act'*" (05).

A change in administration (2007-2011) resulted in a shift in national health priorities and turnover in National Assembly members. HERFON and others (including PATHS2) continued advocating and negotiating, but progress slowed and disputes over financial elements of the Bill occurred. However, despite blockage by some stakeholders the Bill passed again through the Senate, this time went successfully through the House of Representatives, but then failed to receive presidential assent in 2011. Diverse interests that were still dissatisfied and critically, the Ministry of Finance was not behind the financial commitments of the Bill. Finally, the Bill was passed in early 2013 and at the end of 2014 President Jonathon was persuaded, through a combination of high-level international and domestic political pressure to sign the Act in the last days of his administration.

Figure 3: Chronology of the passing of the National Health Act



The process of developing and passing the Act demonstrated the importance of long-term and expert support to achieve legislative change and policy implementation. DFID, through HERFON and PATHS, supported a cadre of health reform advocates. Stakeholders did not accurately predict the course of the reform from the start. Reform advocates assumed that the Bill would be not be controversial and, indeed, would be easy to implement once passed, yet they have had to respond to unexpected opposition and continually advocate for the Bill and then the Act.

3.2 Kick-starting the Act

One objective of this case study is to assess why the 2014 Act has not yet been implemented. We observed widespread criticism in the media, among activists, professional associations and technocrats that in 2017, the Act had still not been implemented. The Act, as illustrated in Box 1 (above), has multiple components and box 2 (below) shows it has many roles for different actors across the health system. But, to assess why implementation has been delayed and uneven, it is important to first understand what implementation would mean, given there is not consensus on this.

The rest of this section looks at the other features in more detail.

BOX 2: WHO SHOULD BE DOING WHAT?

Summary roles and key responsibilities are set out in the Act as follows:

A. *The **Federal Ministry of Health** will develop national health policy, prepare HR plans, provide technical assistance to States for policy, coordinate establishment of national and sub-national health information systems, information planning M&E and health information systems.*

B. ***Federal Ministry of Finance** will include an annual grant in the national budget to finance the Basic Health Care Provision Fund (more details below).*

C. *The **Federal Minister of Health** shall supervise the departments and parastatals (including the NHIS and NHPCDA) to facilitate the functions of the Act; classify health establishments and technologies; establish the several committees stipulated in Act; regulate HR to ensure adequate resourcing for training; set up a national Consultative Health Forum which allows establishment of further advisory and technical committees to achieve the objectives of Act.*

D. ***The National Council** – shall become the highest policy making body in Nigeria relating to health and be advised by a Technical Committee. The National Council shall determine time frames, guidelines, and format for national and State health plans, human resources policy and ensure adequate planning for manpower development.*

E. *The **Technical Committee of the National Council** shall advise the National Council on its function and on the implementation of health plans developed by the FMoH.*

F. *The **National Tertiary Health Institutions Standards Committee** shall advise on establishment of tertiary hospitals, planning and setting minimum standards of quality, undertake accreditation of facilities, setting criteria for fund allocation, operational guidelines etc. It will publish annual information in relation to tertiary healthcare services.*

G. ***National Health Research Committee** shall promote research on national priority problems.*

H. *The **Research Ethics Committee** shall determine guidelines (norms, standards etc.) for health research.*

I. ***Area Councils** (and private providers) will establish and maintain health information systems.*

J. ***Houses of Assembly** of any State will continue to make laws for the regulation and inspection of facilities and health information systems*

Good initial progress was demonstrated on paper

After the Act was passed, the Federal Ministry of Health made progress by establishing a Steering Committee, a Technical Review Committee and a Technical Working Group (TWG) to kick-start the Act's stipulations. The role of the TWG was to support the implementation of the Act,[44] to arrange implementation guidelines and an M&E and performance framework, and for a media and advocacy plan for the act. The TWG succeeded in producing a costed implementation plan; drafted a Basic Healthcare Package (needed to plan the path to UHC); and arranged state advocacy and orientation workshops for operationalization of the Act. Policies to support the implementation of the act were also put in place: the revised 2016 National Health Policy, the National Strategic Health Development Plan and a National Health Financing Policy and Implementation Strategy.[45] Five implementation sub-committees were created under the TWG to drive forward implementation. However, since

[44] *Members of the TWG as released to the media are: NHIS; NPHCDA; NBTS; WHO; World Bank; HSRC; USAID; NAFDAC; NIPRD; NIMR; Central Bank of Nigeria; Bank of Industry; Gates Foundation; Chairman Health Regulatory Group; Chairman of Chief Medical Directors; Budget Office of Nigeria; Federal Ministry of Finance; National Planning Commission; HERFON; KPMG; NMA, NANNAM; PSN; National Association of Medical Laboratory Scientists of Nigeria; Save the Children; James Daniel Consulting; Medical Ethics and Law; Health Ethics and Law Consulting; News Agency of Nigeria; Nigeria Television Authority; Federal Radio Corporation of Nigeria.*

[45] *Federal Ministry of Health, 2015. One Year Anniversary of the National Health Act, 2014. Press Statement of the Permanent Secretary, Federal Ministry of Health. http://www.health.gov.ng/index.php/news-media/press-releases/9-uncategorised/228-one-year-anniversary-of-the-national-health-act-2014*

the Act was passed, donor resources for advocacy for implementation has waned and this coincided with the moment when the TWG sub-committees needed bolstering.

A chequered record of implementation sub-committees

The five sub-committees initially set up were 'Healthcare Financing'; 'Research and Knowledge Management'; 'Healthcare Quality'; 'Advocacy, Publicity and Communication'; and, 'Equity and Investment Performance'. The sub-committees were responsible for establishing implementation guidelines for their respective part of the Act. One year after the establishment of the committees, there appeared to have been few tangible outcomes beyond production of work plans and the committees were dissolved by the Minister of Health. The dissolution of these sub-committees is the first formal indication that implementation was not going according to plan. The dissolution of the committees is likely to further delay implementation of various parts of the Act.

The main reason stated for the failure of the sub-committees was that the Ministry did not allocate funds to them to cover the costs of bringing the members together. Several respondents felt that financial contribution from development partners to the sub-committees would have helped circumvent this problem. Others felt that if the Ministry was supportive of the Act, then it would have made more effort to identify a budget for the work. A second proposed reason for the dissolution of the sub-committees was that the Minister of Health may have wanted to exert his authority over a process that he felt was ineffective, by setting up a new process for implementation. At time of writing there was no indication that new sub-committees will be established, and the workplans produced by the previous sub-committees have been set aside. This indicates a clear change in course by the FMoH, and a shift of political interest in how the Act progresses. The statutory committees stipulated by the Act (Box 2 – Who should be doing what?) have however been established and some progress has been made on financing matters, as described in the following section.

Tussles and mistrust over financing

The main financial component of the Act is the establishment of the Basic Health Care Provision Fund. The Fund will be disbursed through three 'gateways' for the following purposes: i) a basic healthcare package, ii) operational costs of primary health care centres and iii) emergency treatment (see Box 3 Financing summary). The Fund was considered, by most respondents, as the major source of difficulty in the implementation of the Act. Clause 11 of the Act states that the NPHCDA shall develop guidelines for the administration, disbursement and monitoring of the BHCP Fund, through the finance sub-committee and with the approval of the Minister. However, this sub-committee was associated with difficulties and controversies over how the finances would be controlled, exemplified by two respondents who referred to it as the "*financing jamboree*" (03,05). Respondents described, passionately at times, how there were disagreements, lack of trust and poor communication between the FMoH, the NHIS, the NPHCDA, and members of the (now defunct) financing sub-committee about how the Fund should be managed and through which channels: "*The lack of integrity in the process of writing the guidelines undermined trust*" (02); "*There were too many interests, it is all about power"* (03); "*The Agencies [NHIS/NPHCDA] believe the money is theirs*" (09).

The discussions relating to the content of the financial guidelines took months. The MoF argued that without the guidelines, the BHCP Fund could not be included in the National Budget. This seems to be why the Minister of Health requested a World Bank consultant to develop an additional set of financial guidelines. The counter argument, however, is that the Minister wanted to intervene to ensure that the Ministry of Health had greater control over how the BHCP fund would be managed. As a result, during 2016, two sets of financial guidelines were developed; one from the sub-committee, the second from the World Bank.

The involvement of the World Bank was apparently strongly resented by key members of the NHIS and NPHCDA and harshly criticised by some interview respondents. One argued strongly, "*If I was the government, I would investigate the role of the World Bank, it is a commercial bank, not a World Bank, it has a different agenda, which is about trying to get Nigeria to take loans*"(02). Another said, "*The World Bank wanted them [the guidelines] done quickly, but when you are dependent on them for aid through loans it is extremely dangerous to have World Bank interference in this sort of issue. Extremely dangerous interference*" (10).

Finally, in late 2016, the two sets of guidelines were harmonized into one document which puts in place the mechanism through which the Fund is managed. The responsibility for disbursing the fund now lies with a secretariat which includes the Minister of Health, the FMoH, NPHCDA, NHIS, each geopolitical zone in Nigeria, and CSOs. Box 3 provides an overview of the harmonised financial guidelines.[46]

[46] *Federal Ministry of Health; NHIS & NPHCDA, 2016. Harmonized Guidelines for the Administration, Disbursement, Monitoring and Fund Management of the Basic Healthcare Provision Fund*

BOX 3: FINANCING SUMMARY

The Basic Healthcare Provision Fund is the part of the Act which provides additional revenue to primary health services. The harmonised guidelines describe how the BHCP fund will be administered, disbursed, monitored and managed. The guidelines state that the fund will be managed by a secretariat led by a representative of the Minister of Health and with representatives from the FMoH, NPHCDA, NHIS, each geopolitical zone, and CSOs among others. The NCH approves or rejects the appointments of the Chairperson and Secretary of The Management Secretariat of The Health Care Fund (TMSOF). The Management Secretariat will have access to the fund which will be domiciled in a designated account in the Central Bank of Nigeria.

The BHCPF will be disbursed through three "Payment Gateways":

i. *50% of the Fund will be disbursed through the National Health Insurance Scheme (NHIS) and deployed towards the provision of the Basic Minimum Package of Health Services in eligible primary or secondary health care facilities;*

ii. *45% of the Fund will be disbursed through the National Primary Health Care Development Agency (NPHCDA) and deployed to strengthening Primary Healthcare Centres (PHCs) in eligible primary healthcare facilities (essential drugs, vaccines and consumables; provision and maintenance of facilities, equipment and transport; development of human resources); and*

iii. *5% of the Fund will be disbursed through a Committee appointed by the NCH and deployed towards emergency medical treatment.*

The guidelines state that "States (and the FCT) and Local Governments shall provide counterpart funding of 25% each of the sum being disbursed to obtain financing from the Fund". The conditions for accessing the funds arising from the NPHCDA gateway are as follows:

a. *Each State shall for a period of at least five (5) years starting immediately after the date of approval of these Guidelines, make annual budgetary provisions for operational expenses in Primary Healthcare Centres (PHC).*

b. *This budgetary provision shall be reflected in the annual SPHCDA budget as PHC overhead costs. As much as possible, the appropriation should be disaggregated in line with provisions of the National Health Act whereby 20% is earmarked for essential drugs, 15% for maintenance of facilities and 10% for human resources development.*

c. *Each SPHCDA shall receive 40% of the total possible sum per State in the first instance upon confirmation by the TMSOF that budget lines have been created for PHC operational expenses in the annually published budgets.*

d. *A second tranche of disbursement of not more than 15% of the funds shall be made in the following quarter as soon as the evidence of timely payment from the SPHCDAs to the PHCs has been verified.*

e. *A third tranche of disbursement of not more than 15% of the funds shall be made in the following quarter as soon as the evidence of timely payment from the SPHCDAs to the PHCs has been verified.*

f. *A final tranche of disbursement of 30% of the funds shall be made to the SPHCDAs upon release of their annual financial statements and audited accounts.*

g. *States who are unable to produce their annual financial statements and audited accounts four (4) months into a new fiscal year will be deemed to have forgone the final tranche of payments.*

The financial guidelines have been approved but several respondents still raised strong concerns that the funding mechanism would fail. They were concerned that financing of the National Health Act (through the NPHCDA gateway) would face similar difficulties to the Universal Basic Education (UBE) programme, which failed to persuade states to commit counterpart funding to the programme. One of the common reasons cited for the failure of UBE was insufficient ownership at the subnational level in the planning of the policy. The National Health Act has similarities to the UBE in its ambition for nationwide change and its requirement for state-level counterpart funding. The financial guidelines for the National Health Act do note the failures of the UBE and state that the counterpart funding requirements for the NHA are easier for the states to fulfil. However, as the guidelines and the PHCUOR stipulate, states need to establish State Primary Health Care Development Agencies (SPHCDA). Progress in establishing these agencies is limited. It may be that states are unwilling to establish SPHCDAs until the BHCP fund is in the national budget but this could become a sticking point whereby national funding is not made available until state governments are deemed ready to spend it.

The tussles surrounding financial control indicate why full implementation of the Act is a slow process: it requires a shift in control of financial resources. Commonly, in Nigeria it is reported that politicians at all levels are

motivated by control of financial resources rather than provision of public goods and services or other programmatic policy aims[47]. Political leaders' activities are therefore disproportionately skewed in that direction rather than ensuring that the full gamut of legal provisions in the Act are fulfilled. Having control over finance increases politicians' prestige and creates opportunities for leaders to reward their supporters and make investments which are visible to the public and so improve their popularity. Complying with the Health Act may result in better health outcomes but politicians do not appear to consider this to be an effective way of increasing their political profile and maintaining their position of power.

For now, the Fund has not been included in the national budget (2017), and it is uncertain when inclusion may occur. But, despite this and despite the dissolution of the sub-committees, the FMoH is working with donors to implement the BHCPF as a pilot in three states: Abia, Niger, and Osun that would follow the harmonised guidelines but using donor funds (Global Financing Facility). No guidelines exist from the other subcommittees to advise how other elements of the Act should be implemented. It will be important to see whether the pilots are successful enough to generate sufficient national and state-level political interest in the health reforms and so persuade national and state level leaders to invest domestic funds in implementing the financial parts of Act.

Little progress on establishing affordable health insurance systems

The NHA attempts to address Nigerians' high out-of-pocket expenditure on healthcare by allocating – through "Gateway 1" - 50% of the BHCP fund to support state government managed health insurance schemes. Initially this was supposed to be channelled through the NHIS but will now be held in the Ministry of Finance, and state governments will be able to apply to receive this funding. Few of the necessary health insurance schemes at state level have been established and this is due to several serious constraints. Firstly, the Federal health insurance scheme managed by the NHIS has lost public credibility and is widely considered to be a mechanism by which HMOs, national politicians and senior NHIS staff generate personal profit. For example, the Minister for Health suspended eight senior NHIS managers and the executive secretary following allegations of fraud.[48] There are calls for the NHIS to be scrapped and redesigned which means that state governments do not have a health insurance model to follow and, in the absence of technical expertise at the state level, there is a risk that HMOs are able to similarly capture the gains when state level health insurance schemes are established.

The poor reputation of the NHIS has also created public scepticism towards health insurance as a concept which may reduce political interest in establishing insurance schemes. While the BHCP fund promises financial support to states to offer affordable health insurance, this is expected to only cover a small proportion of the finance which states will need to invest in health insurance so that it is viable and widely accessible. Further funds from state budgets will need to be allocated to healthcare. Currently, the World Bank and possibly other development agencies are offering technical assistance to the federal and state level governments to design health insurance schemes. Until such schemes are in place, many Nigerians will still have to pay out-of-pocket to access healthcare which would undermine the planned improvements to the supply of healthcare services. Until health services are made affordable for Nigerians, whether through health insurance or another mechanism, UHC will not be achieved regardless of other areas of progress.

There is more to the Act than the financing arrangements.

For many, the National Health Act equates with one element: the release of Basic Health Care Provision Fund. We emphasise that implementation is more than the fulfilment of the financial provisions of the Act. While increased financing to the health system is necessary, the health sector needs to look beyond the funding arrangements, which are a means to an end, not an end in themselves. Other features of the Act, such as the definition of responsibilities and lines of accountability and the process for regulating the health establishments and technologies are important to ensure improved health outcomes. The Minister of Health has stated that other clauses are being implemented, yet few stakeholders across the health sector have shown interest in these features and, in the absence of any additional financing, there is little for politicians to gain from implementing these other provisions.

"*Ethics, research, quality, these are the issues that are not talked about, the only way to sell the act was through money, advocates also needed to hear the money story. The strategy to get the act moving forward was to talk about the money; the NPHCDA and HERFON knew that the states will not listen to the other provisions*" (11).

Generally speaking, the prospect of improving health outcomes is not sufficient to drive politicians – particularly in national government – to act in favour of health reform, and only those parts of the Act which relate to financing are capable of attracting interest. For health services to improve, attention to quality control, standards and regulatory mechanisms is needed but respondents criticised the lack of action to such provisions in the Act, "*the act covers it, but someone in the Ministry of Health needs to get moving on it and get it covered by the National Council of Health …at federal level, there is no effort beyond the financing issues*" (14). While it might

[47] *Joseph, R. (2013) 'Prebendalism and Dysfunctionality in Nigeria',* Africa Plus, *26th July 2013* https://africaplus.wordpress.com/2013/07/26/prebendalism-and-dysfunctionality-in-nigeria/#_edn31

[48] *Premium Times (2017) 'Health Minister intensifies NHIS sweep, suspends eight top staff', July 17th 2017, by Ayodamola Owoseye.* http://www.premiumtimesng.com/news/headlines/237189-health-minister-intensifies-nhis-sweep-suspends-eight-top-staff.html

be assumed that State politicians would be praised and gain political credit if they improved the health services in their jurisdiction, this does not appear to be a reality and health services rarely become political priorities with public attention.

Some of the stipulations are not complex, but progress stalled due to the ineffectiveness and then dissolution of the sub-committees, with no replacement mechanism to drive forward these processes. For example, the Act states that operating a health establishment without a Certificate of Standards 24 months after the Act has been passed will be punishable by a fine of 500,000 Naira or 2 years' imprisonment. Yet there is not yet a system for checking which establishments do or do not have the certificate of standards and so no-one has been held accountable. The lack of interest in monitoring and regulating health services indicates, in part, the low political interest in the topic, but, it may also indicate that enforcing health standards and regulations would challenge the power of existing providers. In a political system where leaders do not need to provide quality public services to stay in power, enforcing sanctions could damage a leader's relations with service providers (private and public sector workers) but not result in personal gains either. Underlying political problems such as these are likely to limit the extent to which the NHA is implemented effectively.

Civil Society Organisations (CSOs) driving the Act

We have noted the significant role of CSOs in contributing to the passing of the Act. The Nigerian civil society panorama is broad and active, including membership-based associations, 'professional CSOs', community-based organisations, (semi-governmental) traditional authorities as well as individuals who are well connected to government.[49] Mass media is vibrant and specialist media provide high-quality criticism and analysis of reform efforts. The DFID funded civil society strengthening programme (SAVI) documented how donor funding shaped 'professional civil society' and these groups were instrumental in pushing through the Act. Interest groups have played a major role in enabling and blocking health (and other) reforms, but are noted for generally acting singly, rather than in coalitions, and through personalised connections with political leaders.[50] There were two main criticisms about the way health CSOs operate: 1. they do not represent citizens sufficiently and, 2. their relationship with politicians and civil servants lacks diplomacy. HERFON is committed to promoting the Act through campaigning and awareness raising, and is considered by some respondents as crucial to its implementation, yet its previous leadership has diminished and the membership has become less active as core funding has reduced. The subtler political negotiations with relation to the Act have been performed by the Health Sector Reform Coalition, whose membership is changeable and has many overlaps with HERFON. Overall, there has been a loss of momentum from CSOs.

HERFON has typically taken a more overt campaigning role while the Health Sector Reform Coalition involves well-connected individuals less conspicuously lobbying colleagues and acquaintances in government. It is important to note that many of the individuals who drove the development of the Act were working within government at the time. Now, some of the advocates are retired or work outside of government and so their influence and access to government has shifted. Respondents commonly cited reduced funding for HERFON as a reason for the weaker momentum but it seems likely that the turnover within government and within the CSOs has also weakened the campaign as knowledge and connections changed.

There was some divergence of opinion between respondents on what they felt the role of citizens should be in driving reform. One stated "*In our political situation, in such poverty, the masses cannot make any change. They are able to collect money from politicians seeking votes. It is cheap for politicians to buy votes. This also affects the National Health Act, the governors know how to stay in power regardless of the health of the population*" (13). Whereas another felt that "*universal health coverage agenda can be driven by citizens' demand*" (10).

3.3 Political salience

Lack of high-level political support

The slow rate of progress in implementing the Act was most frequently blamed on the lack of leadership from the FMoH and disinterest of the President. It is recognized that in Nigeria significant decisions which are meant to transform nationwide policy are often taken personally by the President either because the President is personally concerned by the issue or has been actively lobbied from individuals and interest groups.[51] The health sector has not received this high-level concern in recent years and, as mentioned, high turn-over in government offices (political and technical agencies) means maintaining leaders' awareness and interest in the Act requires constant effort. Some respondents argued that in recent years Health Ministers have come from a clinical background and it has been harder to interest them in the kind of health reform that deals with the systemic issues covered by the National Health Act.

[49] SAVI, op cit.
[50] Utomi, op cit.
[51] Ibid.

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There is an obvious lack of high level leadership in promoting and enforcing the Act. "*I don't think there are even 10 people in the Ministry of Health who have read the Bill*" (06), "*The Ministry of Budget and Planning could be taken to court, they have not done what they should. There is a whole series of activities, of processes, which have not even started*" (21). In theory, federal government is contravening its legal obligation to implement the Act but it is unclear who, if anyone, would attempt to hold government accountable on this or enforce sanctions for inaction, or indeed whether this would be a constructive approach.

Tension and mistrust between government ministries and agencies

Political allegiances and the system of political appointments have undermined relationships and created friction between leaders in the Ministries of Finance, the Ministry of Health and its parastatals. The provisions of the Act do not resolve these issues and so the Act is caught in these inter-ministerial tensions. The Federal Minister of Health has a crucial role in ensuring the implementation of the Act, but is in a difficult position. The Minister needs to work closely with the heads of the NHIS and NPHCDA. However, these two are responsible to the Office of the President rather than the Federal Minister of Health and so are able to challenge the Minister of Health. Both the NHIS and NPHCDA have been accused of undermining the authority of the Minister and the MoH has also been accused of only taking an interest in the Act now that there may be funding attached. "*The Ministry have come in heavy at a late stage and pushed the two key agencies aside now that the act is in law*" (12).

It was claimed that because the FMoH does not clearly benefit from the Act – in terms of finance or power – health ministers have been disinterested in supporting the Act. The importance of this contention is that it has exacerbated underlying resentment and suspicion between the key stakeholders for implementing the Act, which delayed the development of guidelines and has worsened the MoF's confidence in the agencies' ability to manage the BHCP fund. "*If we had the Ministries of Finance and Budget and Planning involved from the start it would have made passing the Bill difficult, but implementation easy. It was not intentional. We talked to ourselves and forgot about the other sectors." (21)*

There are also tensions (as described with relation to the finance guidelines) between the MoH, NHIS and NPHCDA about control over the BHCP fund. "*In Nigeria we have institutional hostility, every innovation challenges the institutional environment, and the Act is one such innovation. Technically it is absolutely feasible, but the institutional relationships do not support it*" (05). The 2016 revelation of the misuse of GAVI funds has worsened trust in the health sector and there is a need to broker collaboration and improve the synergy and working relationships between the Federal Ministries and key parastatals. Without this, the MoF and the MoBP are unlikely to include the BHCP fund in the budget and so States are unlikely to take an interest.

Given the disagreements between the MoH, MoF, MoBP, the NHIS and the NPHCDA over the funding of the Act, it may be necessary for the President or Vice-President to use their authority to drive forward budget allocations

for the BHCP fund. But, neither the current President nor the Vice-President appear to be seriously interested in the Act or in achieving UHC and do not seem to be responding to advocacy on this issue. This was worsened by the state of political paralysis and uncertainty in Nigeria due to the ill-health and prolonged absence of President Buhari and this is likely to cross-over into the next election cycle.

Technical capacity in the public health sector undermined by political interests

The implementation of the Act requires competent and motivated administrative and technical personnel in health sector at the federal, state and local government level. However, political interests which shape how appointments are made and how staff are managed and motivated and this can limit the effectiveness of public health sector workers. Respondents identified three problem areas in particular:

Firstly, when federal ministers are appointed, nominees are questioned by senators to establish their competence. But these questions are general because nominees are selected before they are appointed to a specific ministry office. As a result ministers may be assigned to an office where they have little technical expertise or experience.

Secondly, in Nigeria, in order for all 36 States to have a representative in a leadership position in one of the 19 federal government ministries, federal ministries are often led by two politicians: a federal Minister and a 'Minister of State'. Their respective roles are not clearly distinguished in the Constitution. The relationship between the junior and senior minister is crucial to the smooth running of Ministries but this is determined largely by the individuals' personalities than structural incentives. Indeed, during the passage of the Health Bill, the difficult relationship between the Minister and Minister of State for Health created a palpable crisis limiting progress on the Bill. A shift to a more robust process of ministerial appointment and clearer allocation of responsibility between Minister and Minister of State may improve political collaboration and coordination at the federal level.

Thirdly, at State and local government level, there is considerable responsibility for practically operationalising the Act but basic capacity is limited. Low political interest in ensuring an efficient health sector means that there are few incentives and little investment in the sector to motivate and enable health professionals to perform well. Across the public sector, political leaders create jobs and appoint individuals in order to increase their own popularity regardless of whether there is a function to be fulfilled. As a result, a large proportion of public health funding has to be spent on staff wages but staff are not properly managed or trained and there is little remaining funding to pay for other resources. The subsequent poor quality of public healthcare creates demand for private sector provision instead. The decreasing public demand for publicly provided care and the limited demand or support from leaders for the public health sector to improve underlies the apparent apathy and persistently poor quality of frontline public healthcare services. In this context, the NHA is unlikely to be implemented effectively unless state as well as federal level political leaders prioritise improving the performance management of the public health sector until better health outcomes are achieved.

What is needed for 'full implementation' at Federal level?

These political circumstances, give rise to the question of how likely is it that the Act will be implemented at all, and what is needed in order for that to occur? The dissolution of the implementation sub-committees has been an important hindrance to progress for implementation in all areas except finance. With regard financing provisions, much now rests on the success of the pilot of the BHCP fund in three states. If we conclude that the biggest sticking point of the Act is in the pre-occupation over financing, then the capacity of those three states to demonstrate that they can set up the arrangements to manage the funds they are allocated, and commit the required counterpart funding will be crucial. Demonstrating this, will mean the MoF will have little excuse to continue to exclude the funds from the national budget. As has been noted, beyond the MoF, the President is the only individual who could ensure the allocation takes place. Efforts so far at getting the President behind the broader issue of UHC, or the specific issue of the Act have not borne fruit.

The functions of the implementation sub-committees that were dissolved in 2017, now need to be re-instituted. This is the mandate of the Minister of Health, who should be held to account on this issue. The sub-committee structure was in-effective, but the real reasons for this ineffectiveness (inter-ministerial conflict and/or low resourcing) are not entirely clear. Renewed advocacy efforts are needed to work with the Minister to set up a structure that supports those themes.

4. Progress on the NHA at State level

Once the conditions, described above, to enable implementation of the National Health Act are set up at central level, the actual daily implementation of the provisions of the Act will occur at sub-National level across each of Nigeria's 36 states. Secondary and primary healthcare is under the control of states and local governments. Each state will need to translate the Act into state legislation passed by each State House of Assembly and then implemented. The system of federalism in Nigeria means that the federal government has very limited power to persuade states to take up national policies such as this Act. States have considerable autonomy, are typically resistant to instruction from the Federal Government, and are reluctant to be held accountable for the substantial federal funds they receive. In the health sector, like other policy areas, we heard that State Governors, Commissioners of Health and Chairmen of Local Government Councils often follow their own agendas rather than health sector strategic direction set by the FMoH. Consequently, the implementation of the Act greatly depends on its uptake in every state. Advocacy for reform at the state level is therefore critical. "If the states do not take health act seriously, nothing will work, they are critical and advocacy at this level is necessary. The governor is everything. We have to craft our efforts to show that there is return on investment in health." (06)

To date, however, most of the debate and advocacy has focused on the national level despite similar political processes needing to occur in each of the 36 states. This challenge is explored in this section.***How to promote state level health system governance reforms***

Our case study research included a visit to Jigawa State to obtain an impression of what domestication of the Act may entail at sub-national level, and to observe the extent to which state actors are so far engaging with the Act. Understanding Jigawa's health sector reforms over the last 15 years, in particular the creation of a decentralised healthcare system (Gunduma), is useful for considering how health reform proposed by the Act could be supported in other states. Those involved in supporting state domestication of the Act and PHCUOR should benefit from lessons learnt from Jigawa's experience, to avoid similar pitfalls and emulate some of its achievements. A considerable investment of money (from donors) and time (from local stakeholders and donors) was put into Jigawa health sector reforms since 2001. The reforms are summarised in box 4.

A separate PERL case study was commissioned to further investigate our preliminary findings in Jigawa[52]. It concluded that the following critical factors influenced the success of Jigawa's reforms:

1. **Personalised policy-making:** Governors' personal interests, working styles and resources have influenced how Jigawa reforms were initiated and funded. Governor Turaki (ANPP, 1999-2007) allowed the reforms to start and his successor Governor Lamido (PDP, 2007-2015) showed a particular political commitment to improved healthcare as a source of political legitimacy, doubling the health budget and ensuring high budget execution rates. Access to Governors by politicians or senior officials, through formal or informal means, has also ensured support for reform or the resolution of institutional disagreements.
2. **The influence of development partners**: Jigawa is very aid-dependent. DFID has been highly influential as a source for change in Jigawa's health sector, in particular through a series of large and comprehensive programmes since 2001, with dedicated and trusted advisers based in the State (including PATHS1 and 2).
3. **Creating allies through evidence and incentives**: DFID programmes supported a cohort of committed civil servants who effectively used evidence, coalition-building and proactive advocacy to design and implement change.
4. **Managing resistance effectively**: Jigawa's drugs supply system was able to adapt and grow overtime. It remained within the remit of the Ministry which prevented tensions over direct control and accountability. In contrast, as a semi-autonomous agency, Gunduma took over responsibilities and access to resources from the State Ministry of Health which did not adjust to a policy and oversight role. Gunduma also faced resistance from some medical professionals, but seems to have overcome local government opposition.
5. **Technical feasibility**: Public financial management reforms, or a logistics supply chain, are relatively narrow reforms, whereas human resource management, information management systems and decentralisation are more complex and expensive. Gunduma entailed both geographical and

[52] *Piron and Ogunbayo, op cit*

functional restructuring. It attempted to improve performance and efficiency, expecting more of front-line staff.

BOX 4. JIIGAWA'S HEALTH SECTOR GOVERNANCE REFORMS (2001-2017)

Over the least 15 years, Jigawa, a poor and rural North-West Nigerian State, has undertaken a suite of far reaching health sector governance reforms to respond to persistent local problems in the health system identified in 2002 as including: low management capacity for planning and policy making; inadequate numbers of professional health staff; health staff indiscipline and absenteeism; inadequate funds for running health facilities; low availability of essential drugs and medical supplies; inadequate basic equipment; and poor communication between health staff and health facilities users.

These reforms comprised: (1) improvements in planning, budgeting, human resources and information management, (2) the Gunduma decentralisation that reorganised primary and secondary health care service delivery into district level units, and (3) reforms to drugs supply and management with the creation of a Drugs Revolving Fund and Jigawa Medicare Supply Organisation. During this period, Jigawa has benefited from a continuous and large DFID-funded effort at health system strengthening, including PATHS and other programmes.

The success of Jigawa's reforms in terms of improving the health system has been mixed. There have been significant improvements in the quality of financial management marked by a major increase in the health budget and good performance in budget execution, until recently. Challenges remain in terms of human resources management and information systems.

The most significant reform was the integration of primary and secondary care under a single line of authority and accountability in 2008: the Gunduma Health System Board and its nine Gunduma (district-level) Governing Councils. The system was based on WHO recommendations and modelled on Ghana. Its introduction was promoted and supported by DFID health programmes. A new structure was created in order to prevent LGAs or the SMOH from being dominant and or giving primacy to either primary or secondary healthcare. The SMOH was to be responsible for policy-making and oversight, but health system management, including financial and human resources, was devolved to Gunduma. Gunduma successfully integrated some key functions such as planning, budgeting, human resources management, operational primary health care delivery and accountability. Discipline was reported to be high, programmes well-funded and offices equipped.

However, Gunduma was abolished following the change in political leadership in the State in the 2015 elections and replaced by a Primary Health Care Agency in 2016, with PHC managers in each of Jigawa's 27 LGAs (rather than in the nine Gunduma District Councils). The SMOH has regained direct control over secondary care. Gunduma had adapted Ghana's model to suit Jigawa's perceived needs at the time, in particular to improve the system's efficiency by integrating primary and secondary healthcare management at an intermediary (district) level and overcome the lack of trained professionals. These were at the same time fundamental design flaws as they went against some powerful interests Gunduma could not manage.

Jigawa has seen improvements in health service delivery and outcomes over the period of these reforms, although from a very low base and not always exceeding the region. it is difficult to separate the effects of Gunduma from the other health sector reforms and the influx of DFID assistance to the State.

Source: Piron, L.-H. and Ogunbayo, D. (2017) Jigawa health sector governance reform case study, PERL LEAP

Some of Gunduma's institutional arrangements have been transferred into the PHCUOR system. A similar power struggle between SPHCDAs and the SMoH could be anticipated in Jigawa and elsewhere in Nigeria if SPHCDA are given a great deal of power and autonomy. As we heard about Gunduma: *"the [State] Ministry lost control, it didn't go down well" (20)*. This '*interference*' with existing control arrangements appeared to be an important source of the criticism of the reform process from some respondents in Jigawa, and probably led to the reversal of Gunduma in 2016.

How to support domestication of the Act

The Federal Government and development partners need to consider how they engage with states to support domestication of the National Health Act. This goes to the core problem of the Act being a reform process that was developed without state level involvement.

Technical assistance will be needed – in some states more than others – to domesticate the Act whilst a) limiting tension within the state and local government structures, and b) engaging with the cultures and incentives (not formal structures alone) shaping public sector performance. It will require thoughtful advocacy efforts *"It is a lot of work to make state governments understand that the federal bill is meaningful and relevant to them. We*

need to support the Federal Government to find ways to do that." (22) How this is achieved will be different in every state, and will require sensitivity to the specific individuals who are likely to be supportive of change. Sub-national stakeholders had suggestions, for example:

> *"Strong political allies of the Governor are the ones who push change. How do we get to the political allies? We need to feed the political allies what to push. We need to identify the soft spots of the people in power so the development partners and CSOs can lean on them. Development partners will be vital to slide CSOs into action, and the CSOs need to be trained to identify soft-spots. Those involved in advocacy need to be trained to talk to those in power. What you say matters a lot, but how you say it is more important. Advocates need not to be labelled as activists." (20)*

> *"the Commissioner's voice is the loudest, so we need to get him on our side by explaining the political capital of saving lives…but the Commissioner's appointment is entirely political, unless there is a radical governor they don't tend to inject technocrats."*

The pilots of the BHCP Fund in Abia, Niger, and Osun States will be vital opportunities to test approaches for supporting domestication. A draft operational manual is now in place; costing of the Basic Package of Care was being finalised in 2017. It is critical that they succeed if the other major lever for state level action is to be used: that the Ministry of Finance approves a budget for BHCP fund.

Promotion of the Act

This case study has also sought to assess the level of progress states are making towards implementing the Act. We were interested to know what measures had been taken so far, what the level of awareness of the Act was, and the importance different stakeholders gave to health outcomes, or health reform overall. At state level, as at national level, there is limited political salience of health reform.[53] This was plainly stated by several respondents who described how State Governors have little to lose and not much to gain from improving healthcare during their tenure. For example, "*Governors can't be bought, they are already rich, but they do want greater visibility, political credit and publicity. They know they can win elections by buying votes, not on health improvements therefore health is not usually their priority, other issues are more salient and visible than healthcare…elections are not won by merit but by rugged and raw power. Vested interest, opacity and non-accountability is what is stopping implementation. Governors do know and they are not fools*." (13)

HERFON recognises the need to advocate for health reform at state level across the country. It has engaged with State Governors on how to implement the Act, produced advice for State Commissioners of Health, and offered support on how states should adapt the legislation to fit their needs. It has also used scorecards to 'name and shame' SPHCDA systems which perform badly on health outcomes. Some respondents suggested the scorecard approach could go further by auditing which parts of the Act are being implemented and praising state governments according to their performance. So far, progress on the implementation of the Act at the state level is mainly seen in the creation of primary health governance structured. At the time of writing 28 states had passed the PHCUOR bill into law, and 33 states have a PHC board, which is a prerequisite for receiving the BHCP fund. This is further indication that states are motivated to act through financial incentives.

Awareness of the Act

In Jigawa, the development of the Gunduma system was undertaken with the draft 2004 National Health Act in mind, both supported by PATHS. The DFID-funded programme invested a great deal of efforts in influencing national policy development towards PHCUOR in 2011 and sharing Jigawa's lessons with other States.[54] (However, no other States adopted Jigawa's model). At the time of our research, we saw concrete signs of progress in relation to the 2014 Act in Jigawa. For example, a draft Bill to domesticate the NHA is on the State House of Assembly agenda. But, while we did not observe explicit resistance to the Act, there was an overall lack of enthusiasm preventing faster progress. Mirroring the Federal level, we observed that the interest in the Act mostly centred on the potential for extra finance. For example, in Jigawa, one of the reasons given for abolishing the Gunduma system and setting up a SPHCDA was the requirement for such an agency to be set up before the state can be eligible for BPHC funding. However, the 2015 PHCUOR Scorecard (which rated Jigawa as the best performing state in the country) explicitly recognised Gunduma as its PHCDA equivalent so other factors were at play.[55]

Public officials in Jigawa were aware of many features of the Act but there was confusion and conflicting knowledge about some elements, in particular regarding how states must contribute counterpart funding for the

[53] *There are exceptions, as noted above with regard Ondo State.*

[54] *Piron and Ogunbayo, op cit.*

[55] *National Primary Healthcare Development Agency (2015) Primary Healthcare Under One Roof Implementation Scorecard III pages 63-64 cited in Piron and Ogunbayo, op cit.*

BHCP fund. This is unsurprising given that the FMoF had not approved the federal contribution in the national budget at the time of this study and the harmonised financial guidelines had only recently been approved.

Distribution of power at State and LGA levels

Similar to tensions over resource allocation between SPHCDAs and the SMoH, the distribution of resources and authority between federal, state and local government is sensitive and may hinder implementation of the Act. State Governors have considerable power and tend to exercise authority over all major policy and financing issues, including over healthcare. As a result, the financial guidelines for the BHCP fund may be seen as an attempt by federal government to control resource allocation. For example, the financial guidelines set out how resources are channelled and managed through the SPHCDA and to healthcare facilities. But, the constitutional autonomy of states and LGAs means that the Act has to be locally negotiated and accepted. This is likely to be problematic in some states if issues of ownership between the State House of Assembly and SMoH rise to the surface, as ministries have political and technical priorities that may be at odds with the priorities of the House. There was concern from respondents in Jigawa that forthcoming reform as the Act is domesticated would create new resentment as power and resources in the state are redistributed (as noted with the Gunduma reforms).

Beyond Jigawa, we heard concerns about the limited state technical capacity for some features of domesticating the Act too. Each state will need locally relevant approaches, for example to design a state health insurance scheme which is not vulnerable to capture by the HMOs; or stipulations about how the roles and responsibilities of seemingly parallel structures (such as the SPHCDA and SMoH) will be distinguished. A case in point is, to whom are senior staff in the SPHCDA accountable? It is not clear whether it should be to boards, direct to the Commissioner, direct to the Governor, or to organisations at the federal government level. Jigawa's Gunduma experience shows the benefits and risks of semi-autonomous healthcare agencies, which may streamline allocation of funds but in doing so reduce the power of other existing actors in the health system. Such issues will need to be considered in each state to ensure smooth running of the new system but, there is no existing guidance in the Act that suggests that states should consider how new structures are incentivised to collaborate with existing state government bodies. Specific state level regulations and laws will make it easier for Governors to insist that the domesticated Act is adhered to, but as yet, technical assistance has not been provided. There are possible sources for support, for example the Nigeria Governors' Forum can encourage Governors to pay attention to these issues, and development partners and CSO could play a role.

Linking domestication of the Act to broader health systems issues.

The structural reforms at state level described here are only the start. Domestication of the Act alone cannot ensure improvement in the functional parts of the health system that result in good health outcomes, rather it lays the foundations for those changes. Many states in Nigeria have chronic health service provision problems; the health policy is honest about failures of the system it describes as "weak," "underperforming," and "largely unresponsive" to the needs of patients.[56] Human resources management and distribution, budgeting and planning and quality of care are major reasons for poor health outcomes. As advocacy to domesticate the Act takes place it could usefully be linked to addressing underlying failures of the system, given the proposition that success does not stem from good institutions, but success builds good institutions.[57] Therefore, the Act needs to be placed within a strategy for nurturing successful outcomes rather than anticipating that the Act's implementation will be the success. There is a danger that States will domesticate the Act to create the appearance of change (new SPHCDA structures) without addressing more fundamental issues (the functions the SPHCDA should play in order to deliver improved health outcomes). Reforms which change structures but do not also change service delivery incentives or cultures are unlikely to achieve improved service delivery outcomes.

Timing is also critical, by end of 2017 Governors will be looking towards campaigning for 2019 elections, so, as at the national level, advocacy and technical support needs to transcend election cycles. This would need the identification of eminent people in each state, who recognise the local political economy, understand who has power and resources and who can find a way to those in powerful positions. Just as was the case for passing the Bill into law, election campaigning distracts attention from policy reform processes and so sustained engagement will be necessary.

[56] *Downie,* op cit.
[57] *Andrews,* op cit.

5. Lessons for reform

The purpose of this study is to identify the reasons why the National Health Act has not yet been fully implemented, and to draw on existing theory and evidence to suggest ways in which implementation could be supported. In turn, the study aims to use this example of health reform to contribute to wider knowledge about the nature of public sector reform for service-level outcomes and how it may be supported effectively in Nigeria.

5.1 Principles for supporting public sector reform in Nigeria

The implementation of the NHA is progressing very slowly. Analysis of interview data has revealed a number of bottlenecks limiting the implementation of the Act. These were described in the previous section and are summarised in box 5 in order of severity, beginning with the most intractable.

BOX 5. BOTTLENECKS TO IMPLEMENTATION

***Low political salience of health reform, and especially of non-financial provisions**: political leaders in the federal ministries and state governments have shown little enthusiasm for the Act or health reform more generally, as evidenced by the repeated advocacy needed from CSOs to pass the Act and the failure of the MoF to include the BHCP fund in the budget. Among those in federal and state governments who have shown interest in the Act, their attention is focused on the financial elements of the Act while other important operational aspects are ignored. Low political interest in better healthcare regulation and information management mean that there has been little action or communication around these provisions which do not offer clear political gain.*

***Lack of institutional memory:** High turnover in political positions in the health sector and in the National Assembly mean that the advocacy process has to be repeated and sustained to ensure the continued support for health reform. Newly appointed and elected political leaders are often unaware of the health reforms which were in process before they entered into power and so need to be briefed and then persuaded to support a reform Bill or Act which was not their own idea.*

***Lack of trust**: a poor record on health budget management and the recent misuse of GAVI funds has worsened the trust of the FMoF and FMoBP in the ability of the health sector to administrate, disburse and spend the BHCP fund effectively. This has contributed to the delay in including the BHCP fund in the national budget.*

***Lack of collaboration:** the disagreement over the control of the BHCP fund between the Ministry of Health, the NHIS and the NPHCDA has delayed the development of guidelines for the use of the funds which has prevented the fund from being included in the national budget. Furthermore, the NHA presents a framework for national public healthcare across all states and at all levels but the Federal government has very little direct power to push states to implement the Act.*

***Controversy surrounding the NHIS:** a critical element of the Act is to use BHCP funds to support State governments to establish affordable health insurance systems. The credibility of public health insurance is currently undermined by controversy surrounding the NHIS which is viewed by many as dysfunctional and a source of profit for politicians, wealthy individuals and HMOs. Consequently, state governments lack a credible public health insurance model to adopt and there is public scepticism that health insurance can be functional and affordable.*

***Confusion over match-funding:** The harmonised guidelines for the administration, disbursement and monitoring of the BHCP fund were approved in 2017 but there is confusion among key stakeholders regarding what forms of funding will be accepted as state and local government match funding. Until these specificities are clear and communicated to state and local leaders, the BHCP fund cannot be operationalised*

Unlocking bottlenecks in public sector reform is notoriously difficult and several decades of international development experience supporting reform programmes have found that sustained progress is rarely achieved.[58] Explanations for why reforms usually fail suggest that programmes often focus too heavily on technical and financial support and overlook the complex and political process needed to change the working culture of a public sector.[59] This is echoed in the 2017 World Development Report on Governance and Law which argues that even when decision-makers have the right (pro-poor) policies, implementation can fail because enacting the policy would challenge the existing balance of power and distribution of benefits.[60]

[58] *IEG. 2011. IEG Annual Report 2011 Results and Performance of the World Bank Group. Washington, DC: World Bank. http://ieg.worldbank.org/content/ieg/en/home/reports/rap2011.html*

[59] *Blum et al. op cit. and Cummings C (2015) Fostering Innovation and Entrepreneurialism in Public Sector Reform. Public Administration and Development Vol 35, Issue 4, pp315-328, October 2015 http://onlinelibrary.wiley.com/doi/10.1002/pad.1735/abstract*

[60] *World Bank, 2017, op cit.*

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Drawing on this body of work, there are several principles for how donors and governments can effectively approach public sector reform. This section expands upon the concepts mentioned in the introduction and describes how they relate to the challenges of health reform in Nigeria. The following section (5.2) then uses this analysis to suggest how, if desirable, the implementation of the NHA may be advanced.

1. **Understand the problem and focus on function not form**: A common problem with public sector reform is that programmes encourage governments to adopt new organisational forms, without addressing the changes in incentives needed for these forms to function. For example, the Gunduma reforms were praised for achieving structural change but our respondents reported that the new structures have not reformed ways of working and so improvements in health outcomes have been limited. This problem is described by Pritchett et al. (2010) as 'isomorphic mimicry' whereby reforms focus on achieving a structural solution rather than starting with understanding the underlying problems preventing better services and finding ways to solve them.

   In Nigeria, a number of systemic problems underlie the poor provision of healthcare, as described in section two. Do the changes prescribed in the National Health Act address some of these underlying problems? The NHA is only a framework to guide health sector management and has little power at the state level. So, for the Act to result in improved health outcomes, the way it is implemented will need to focus on challenging the existing governance norms undermining effective service provision. This could mean that champions of health sector reform need to work closely with state leaders to identify root causes of health sector problems, agree on specific issues to focus upon, work out which health outcomes are priorities for that state (and leader). They can then work backwards, attempting different ways of using the BHCP fund and other provisions in the Act to achieve the desired health outcomes.[61][62]

   Simply establishing SPHCDA will not be enough. When it was designed, Gunduma adapted Ghana's model to suit Jigawa's perceived needs at the time, in particular to improve the system's efficiency by integrating primary and secondary healthcare management at an intermediary (district) level and overcome the lack of trained professionals. These were at the same time fundamental design flaws as they went against some powerful interests Gunduma could not manage in a sustainable way.

2. **Facilitate locally-led change:** Analysis of successful public sector reform initiatives have concluded that change processes need to be led by individuals who are embedded in the local context and who are personally motivated to achieve the reform.[63] It is not a question of the nationality of the reform advocates but rather that donors do not direct how a problem should be solved or use aid money to

[61] *E.g. from the 'SPARC' public sector reform programme: it tried to encourage the Lagos State government to consolidate its various bank accounts. It discovered that such a reform would upset many banks supporting the State government and benefiting from the current arrangement. Instead, a solution was found in which the State treasury could view its accounts through one access point by creating a 'Nigerian Inter-Bank Settlement Platform'. This achieved the desired function through a politically feasible form.*
[62] *Chambers, V., Cummings, C., Nixon, H., 2015. Case study: State Partnership for Accountability, Responsiveness and Capability.* https://www.odi.org/publications/9289-sparc-nigeria-public-sector-reform
[63] *Booth D, Unsworth S (2014) Politically smart, locally led development. ODI Discussion Paper* https://www.odi.org/sites/odi.org.uk/files/odi-assets/publications-opinion-files/9204.pdf

motivate the process (ibid). The development and passing of the NHA appears to have been a relatively locally-led process. DFID (the donor most engaged with the reform) supported individuals who were already personally committed to health sector reform to use their networks and ideas to instigate and maintain the reform process.

However, since the Act was passed, donor support to the advocates has waned and critically at the moment when the first implementation sub-committees needed support. If donors believe the Act is still valuable legislation, it may therefore be necessary for a) continued donor support to sustain the work and commitment of existing reform advocates to ensure the Act is implemented, and b) focus future attention on facilitating locally-led reform at the state level: supporting reform champions to use their connections and lobbying skills for the implementation of the Act within each state. The configuration of power in each state is likely to vary and this needs to be understood by the reform champions. Identifying the relative power of the State Governor and different State Ministers (for health, budget and planning, finance) and their relationships with each other and with other influential actors (such as the medical profession versus non-medically trained health workers[64], healthcare providers, other State Governors or political heavyweights, donors and NGOs, federal politicians etc.) is important for understanding prevailing political priorities and who shapes the local agenda.

3. **Form long-term and flexible partnerships**: Development involves political change which is unavoidably "largely endogenous and cumulative [...] and not dictated by any universal sequences".[65] This means that change can neither be predicted nor prescribed and so numerous theorists recommend an entrepreneurial and a long-term approach to public sector reform,[66] an example of which is the 'FOSTER' programme in Nigeria.[67][68]

   The process of developing and passing the NHA has demonstrated the importance of long-term support to achieve legislative change and policy implementation. Donors supporting the healthcare reform process therefore need to be flexible to allow reform champions to address unforeseen challenges. Support also needs to be long-term, acknowledging that political change is usually slow and that the high turnover in political positions means advocacy efforts have to be concerted and repeated.

4. **Think about power asymmetries and strengthen political incentives:** Where political interest in an area of public sector reform is weak, reform champions need to work politically and strategically to generate greater political support[69] (see box 6). To do this, advocates could consider three aspects of political will, as conceptualised by Andrews et al. (2017)[70]: 1. 'Authority' - which actors in power are needed to action the reform and do they support it? 2. 'Acceptance' – who will be affected by the reform and is their support necessary for reform to go ahead? 3. 'Ability' – do the actors who need to implement the reform have the necessary competence and resources? Considering these three questions could guide how reform champions try to increase political interest in the desired change.

   The experience of passing the Act demonstrates the importance of clarity and coordination among senior and junior federal and state level political leaders in the health sector and in the Ministries of Finance and Budget and Planning. For there to be continued progress on implementing the Act, reform supporters will need to consider how political leaders can be incentivised to take an interest beyond the financial provisions. For example, how some reform outcomes may be publicly visible and what opportunities there are for quick improvements to sustain leaders' interest. Reform advocates also need to consider how to maintain support across election cycles and how to use elections to generate political salience around healthcare reform. For example, when public sector reform benefits the whole population, not just particular social groups, it is likely to become more politically salient. Likewise, when a state has gained a reputation for good healthcare, future leaders may be expected to at least maintain existing standards.

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[64] *This was one of the essential tensions in the implementation of Gunduma – see. Piron and Ogunbayo, op cit*
[65] *Booth and Unsworth, 2014:3, op cit*

[66] *E.g. Andrews 2013 op cit.; Booth and Unsworth, op cit; Pritchett L, Woolcock M, Andrews M (2010) Capability Traps? The Mechanisms of Persistent Implementation Failure. Center for Global Development Working Paper 234. Washington, D.C.: Center for Global Development. http://www.ksg.harvard.edu/fs/lpritch/Governance/capability_traps(june2010).pdf; Faustino J, Fabella R V (2011) Chapter 10 in Built on Dreams, Grounded in Reality: Economic Policy Reform in the Philippines. The Asia Foundation. https://asiafoundation.org/resources/pdfs/FRONT.pdf*
[67] *E.g. from the 'FOSTER' programme, (promoting transparency and accountability in the Nigerian oil sector) which influenced key legislation and contributed to recouping a significant amount of public money. It takes an inconspicuous role in practically supporting local actors to champion for reforms and negotiate as opportunities arise. It invests in long-term partnerships with government, a deep understanding of the political economy of the problem it addresses, and can change who it works with as the context changes.*
[68] *Booth, D., 2016. Politically smart support to economic development: DFID experiences. Overseas Development Institute, London. https://www.odi.org/publications/10357-politically-smart-economic-development-nigeria-nepal*
[69] *E.g. Andrews, 2013 op cit. and Booth and Unsworth, op cit*
[70] *Andrews et al. op cit*

BOX 6: "POLITICALLY SMART" APPROACH

Working in a "politically smart way" is a concept which has gained enthusiasm recently in the international development literature. The idea has been defined and discussed in various ways. See, for example, communities of practice on 'Doing Development Differently', 'Problem-Driven Iterative Adaptation', and 'Thinking and Working Politically'. Generally, advocates of taking a politically smart approach to development discuss the following principles:

1. *Political economy analysis of the problem and operational context is important when designing an intervention but this needs to draw on the practical and informal knowledge of those doing the intervention, not academic literature alone.*
2. *Practitioners need to have time to reflect regularly on political constraints and possible opportunities for political support as the intervention progresses, and to adapt their strategy accordingly.*
3. *Practitioners should be personally well-connected to influential actors and, together, the staff team should have contacts across a range of key stakeholders relevant to the problem in question.*
4. *Practitioners may need to work at arm's length from the funder so that they can informally facilitate the formation of alliances, negotiate and find compromises with stakeholders in order to increase support or reduce opposition to the desired change.*
5. *Programme structure and design needs to be flexible to allow individuals to explore a range of tactics and develop relationships capable of generating political support for the change or outcome being pursued.*

Sources: Andrews et al. 2013[71]; Booth and Unsworth, 2014[72]; Faustino and Booth, 2014[73]; Valters et al. 2016.[74]

5.2 Unblocking the bottlenecks

By reflecting on how public sector reform evidence and theory relates to the experience of health sector reform in Nigeria, this section suggests a number of activities that could be tried in order to unblock the bottlenecks preventing the full implementation of the National Health Act.

Bottleneck: Low political salience of non-financial provisions

This may be an opportune time to encourage the implementation of those parts of the Act and intended outcomes the can be achieved through relatively low-cost state level changes which are not dependent upon release of the BHCP fund. Once the fund becomes available, the other provisions in the Act may receive even less attention as state leaders are drawn to the potential for new funding. Reform supporters could constructively work on advocating for the domestication of the Act, in particular on the implementation of provisions such as: establishing state-level primary health care development authorities, health information management authorities and local government health authorities; ensuring health information and data is being used in line with the Act's provisions; and that all providers have the necessary Certificate of Standards. There may, however, be opposition to these changes if some organisation or individuals feel that they stand to lose resources or authority. Analysis of how reforms may redistribute power would be helpful to anticipate whether even the non-financial provisions could be resisted.

Reform advocates could focus on how to create potential for political gain from implementing these changes and disseminate material to facilitate these activities. There is a need to discover innovative ways to engage the State Governors and these will need to be sustained across election cycles. The NGF could be an influential platform for drawing public and political attention to those states which are making progress on health reform. This could involve the media and scorecards to document improvements and create competition between states, revealing those which are slow to change and praising those which are progressing. Scorecards could be used to confront states on poor performance and create a point of discussion and collaboration between health reform advocates, service users and state leaders to understand the problems in their health provision.

[71] *Andrews, M., Pritchett, L., Woolcock, M. (2013) 'Escaping Capability Traps Through Problem Driven Iterative Adaptation (PDIA)', World Development 51: 234-244.*
[72] *Booth, D. and Unsworth, S. (2014) 'Politically smart, locally led development'. ODI discussion paper. London: Overseas Development Institute.*
[73] *Faustino, J. and Booth, D. (2014) 'Development Entrepreneurship: How Donors And Leaders Can Foster Institutional Change'. London: Overseas Development Institute.*
[74] *Valters, C., Cummings, C. and Nixon, H. 2016. 'Putting learning at the centre, Adaptive development programming in practice'. ODI report. London: Overseas Development Institute.*

Bottleneck: Confusion over match-funding

Learning from the slow and controversial process of developing the financial guidelines, it will be important that the agreement over how state and local governments can access the BHCP fund is agreed in a transparent and inclusive manner. Current confusion over the criteria for match-funding needs attention so that the key government stakeholders at federal, state and local level have a clear understanding of the agreement. Here, donors could support the implementation of sub-committees and respond to requests for support from the NGF and civil society organisations to hold discussion sessions on how the BPHC fund will be managed. Civil society at the state level may be important for advocacy for the implementation of the Act and so donor support at the state level could facilitate events to communicate the key elements of the Act and support existing health advocates to network and lobby relevant power holders.

Bottlenecks: Lack of collaboration and trust

The perceived delays to the implementation of the Act are not due to direct opposition to the reform overall but primarily about disagreement over how the additional resources (BPHC fund) would be controlled. At the federal level, donors working on health sector issues, such as DFID and the World Bank could coordinate their support and facilitate communication between federal ministry leaders who otherwise are unlikely to collaborate. Relationships between the FMoH, FMoF, FMoBP need to be improved. Special attention is needed to improve the working relationship and trust between key members of the FMoH, the NHIS, the NPHCDA and the World Bank. The donor agencies may, as external powers, be well placed to mediate discussion among these actors, identify shared interests and clarify misunderstandings. The current pilot projects which have World Bank support could be also be an opportunity for donors to encourage cross-agency working and support. The pilot projects are a way for the health sector agencies to demonstrate to the FMoF and FMoBP that the BHCP can be administered effectively and so should be included in the next federal budget. It could be useful to independently research and analyse how each of the pilots perform in order to learn more about the factors enabling and inhibiting the implementation of the Act at state level. Findings from this research could be shared across all states to inform and hopefully improve further attempts to implement the Act at state level.

Attention also needs to be paid to collaboration and trust between federal, state and local government levels over the implementation of the Act. State governments had little involvement in the development of the Act, and yet are instrumental in its successful implementation. The NGF could play a critical role in enabling State leaders' involvement in the domestication of the Act, communicating potential benefits of implementing it and enabling knowledge sharing on how states are progressing. Donors could support civil society and NGO reform supporters to lobby for sub-national implementation. This can take a variety of forms: offering technical assistance; translating the Act into formats which are accessible to the State level actors who have a role to play in its implementation; engaging with the media to disseminate the Act.

Bottleneck: Controversy surrounding the NHIS

The crisis of credibility in the NHIS requires urgent attention and donors are currently involved in providing technical advice to Federal government on this. However, regardless of the NHIS, support is also urgently needed to enable state governments to develop their own health insurance schemes. When BHCP funds become available for this, there is a risk that HMOs will be able to take advantage in a similar manner to the arrangement currently undermining the effectiveness of the NHIS. To avoid this, there is an important role for donors to offer independent technical assistance, for the NGF to provide knowledge sharing and good practice across states, and for healthcare champions, such as the former Governor and former Commissioner for Health for Ondo State to advocate the importance of affordable healthcare schemes.

Who is well placed to help drive implementation?

We have seen that beyond those who are directly responsible for implementing the Act, there are a range of actors who could have a role in advancing its implementation. What is important is understanding their respective strengths and how their influence could be leveraged. CSOs at state level need to be stronger and more able to react to local needs rather than donor driven initiatives. Professional groups, such as medical doctors and community health workers, will be important allies or opponents, as well as traditional rulers, as the Jigawa case study shows[75]. Among the non-government organisations, HERFON be a critical actor for anchoring public health campaigns, and a reference point for other smaller health organisations while being able to work at federal level as well as across different states. Smaller civil society organisations and individual activists can play a less visible role, using personal networks to lobby key position holders on particular elements of the Act. The NGF is likely to be a very important actor in enabling the domestication of the Act, but health is just one of several priority areas. The NGF can work in a few different ways: communicating the content of the Act to state leaders; enabling knowledge sharing across states on how to implement health reform effectively; and provoking competition between states over their health reform record.

[75] *See Piron and Ogunbayo, op cit*

Donors can also play a role but it may need to be at arm's length to ensure there is local ownership of the process and that aid money does not become a distracting motivation for reform. Donors can therefore facilitate the work of civil society organisations but should not direct their activities. Donors may also play a useful role in mediating relationships between high-level political office holders, use the international stage to praise leaders making progress on health outcomes, and offering impartial technical advice to federal and state governments on challenges such as models for public health insurance. Finally, donors could consider supporting the work of the National Council on Health to develop the missing implementation guidelines. But to avoid artificially incentivising government action on the guidelines, donors could explore funding modalities linked to the implementation of the guidelines, not their creation alone.

Moving from policy reform to health outcomes

The danger remains that the full implementation of the Health Act will not result in better health outcomes. The Act is, and can only be, a framework for managing healthcare provision and there are still deeply entrenched problems in the governance of the health sector which need to be overcome. These critical issues, described briefly in section two, includes the creation of health sector jobs which serve to increase political popularity but which do not have specific roles or responsibilities. The Act, as a piece of national legislation, cannot specify the responsibilities and accountabilities of state and local Government staff within the new system, or how they will be incentivised to perform well, so these are questions which need to be addressed during implementation at the state level. However, even with the guiding provisions for the certification of health providers, the rights and obligations of patients and health care personnel and a system for regulation and information sharing, political and technocratic leadership is necessary for these to be enforced.

The political economy context described in section two currently undermines effective public service delivery in most states. Political leaders usually stand to gain more from allowing over-employment in the public sector to continue than from reducing staffing, introducing specific responsibilities, enforcing performance monitoring and investing funds in basic healthcare. Jigawa's reforms, supported by a number of Governors over time, seem the exception rather than the rule. Attention to this difficult problem of political interest is necessary for policy reform to result in behavioural change in the public sector. It is beyond the scope of this report to recommend how to address this intractable problem other than to suggest (in line with the principles in 5.1) that reform advocates and donors must be aware of the deeper political challenges undermining progress in health outcomes, be able to work politically and strategically to influence political incentives, and focus ultimately on health outcomes as a measure of success, rather than the structural changes alone.

6. Conclusion

The case study suggests that implementation of the National Health Act is progressing slowly rather than failing entirely. We observed explicit political challenges to the uptake of the Act, including low political salience of healthcare, private sector capture of demand and payment for services, and political rent seeking undermining the effective use of public funds. Despite this, the national provisions are gradually falling into place and, opening the way for state domestication, which is where the real opportunities for change lie and where support will be needed.

Experience of NHA echoes lessons from public sector reform in Nigeria and other developing countries where commitment to new structures does not necessarily address underlying systemic problems preventing better service delivery outcomes. Likewise, it demonstrates that there can be agreement on the need for reform but it is agreement over how resources are controlled which is critical for reform to be implemented. How far a policy change can result in service provision outcomes also depends on leadership commitment to new ways of working, and will need to be accompanied by clear political wins if changes to public sector behaviour and norms in ways of working are to be sustained. There is not strong opposition to health reform, rather a lack of enthusiasm to act. In the absence of political drive for reform that is ideological or based on the personal beliefs of a leader, advocates are necessary to lobby and persuade leaders to take action on the basis of political or personal benefits which reform could generate for them.

The experience of the National Health Act reflects recent and established theory that public sector reform processes, in Nigeria and elsewhere, require political negotiation, sustained engagement, should avoid externally designed structures and must be locally led.

ANNEX

Annex 1

The following people discussed their views and experience of the National Health Act process with us.

National Level

Respondent	Affiliation
Ebere Anyachukwu	Health Adviser, Human Development Team. DFID Nigeria
Obinna Onwujekwe	University of Nigeria, Enugu
Tunde Segun	Director, Evidence for Action, Member of Health Sector Reform Coalition.
Felix Abrahams Obi	Former Deputy Programme Manager at HERFON
Shehu Sule	Former Permanent Secretary FMoH. HERFON board and NHA Implementation Consultative Forurm
Emmanuel ABANIDA	Executive Secretary. Health Reform Foundation of Nigeria (HERFON)
Tarry Asoka	Independent consultant, Nigeria health policy expert
Akin Oyemakinde	Director, Dept. of Health Planning, Research and Statistics
Ngozi R.C. Azodoh	Director. Dept of Special Projects (Previousl DPRS)
Chima A Onoka	Technical Advisor to the Executive Director. National Primary Health Care Development Agency
Emmanuel Sokpo	HERFON / national steering committee PHCUOR.
Muhammed M. Lecky	Former Executive Secretary/CEO of the Health Reform Foundation of Nigeria (HERFON).
Ben Anyene	NPHD, Former Director of HERFON.
Banji Filani	Advisor Health Financing and Fund Mobilization, Federal Ministry of Health
Chikwe Ihekweazu	CEO Nigeria Center for Disease Control
Okpani Arnold Ikedichi	NPHCDA
Olusegun Mimiko	Former Governor, Ondo State
Olumide Okunola	Senior Health Specialist. IFC / World Bank / MIGA / Health in Africa Initiative
Sampson Ebimaro	Social Development. Ministry of Budget and Planning
Muntaqa Umar	World Bank
Ejemai Eboreime	NPHCDA

Sub-national level (Jigawa, unless stated otherwise)

Rasheed Adebesin	PERL-ARC
Abubakar Sadiq Dalha	PERL-ARC

Abubakar M. Tahir	PERL-ARC
Isa Surajo	PERL-ARC
Jummai Joseph	PERL-ARC
Mohammed Badaru Abubakar	State Governor
Abba Zakari	State Commissioner for Health
Muhammad Kainuwa	Permanent Secretary Jigawa Ministry of Health
Kabir Ibrahim Aliyu	Excecutive Secretary, State Primary Health Care Development Agency
Bala Muhammed Gusau	State Coordinator. National Health Insurance Scheme.
Dr Habeeb Abubakar	Deputy Medical Director. Rasheed Shekoni Specialist Hospital
Magaji Mahmood	Deputy Chairman Medical Advisory Committee. Previous Director of Hospital Services. Rasheed Shekoni Specialist Hospital
Saratu Musa	Jigawa Radio
Baffa Abdulhamid Aujara	Jigawa Radio
Mallam Lawal Abdu Kanya	Jigawa Radio
Abdulrahman Idris	MNCH2
Muhammed Ahmed Garba and various	House of Assembly Deputy Speaker and Health Committee Members
Adamu Mohammed Garungabas	Permanent Secretary Budget and Planning
Zahraddeen Lawan	Freedom Radio
Baffa Ilayaya	HEEPA
Bashir Hassan	KAHDEV Ringim
Yusuf Lawan	KAHDEV Ringim
Fatima Sule	MNCH2 - AP
Abudullah H. Usman	MNCH2-AP/ JIMAF
Yusuf Dayyabu	MNCH2 (Kano)
Dayo	(Former) Commissioner for Health (Ondo State)

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