



Organization and Management of Health Services in Nigeria: 1960-2004

(A Case Study of the Federal Ministry of Health, Abuja, Nigeria).

By,

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**BEING DISSERTATION SUBMITTED IN PARTIAL FULFILMENT OF THE
REQUIREMENTS FOR THE AWARD OF THE DEGREE OF DOCTOR OF
PHILOSOPHY IN HEALTH SYSTEMS MANAGEMENT**

Of the

St. Clements University,

SEPTEMBER, 2004.

DECLARATION

I, Daniel Rikichi KAJANG, of the St. Clements University, Turks and Caicos Islands, British West Indies, hereby declare that this dissertation entitled: “ Organization and Management of Health Services in Nigeria : 1960-2004: A Case Study of the Federal Ministry of Health, Abuja, Nigeria” has been written by me and that it is a record of my own research work. It has not been presented in any form for another degree or diploma in any other institution. All questions and sources of information have been duly acknowledged in the reference section.

Signature.....

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APPROVAL (CERTIFICATION)

This is to certify that, this dissertation in entitled “ Organization and Management of Health Services in Nigeria: 1960-2004 : A Case Study of the Federal Ministry of Health, Abuja Nigeria” by Daniel Rikichi KAJANG was carried out under our strict supervision and has been approved for submission to the Postgraduate Department in partial fulfilment of the requirements for award of the degree of Doctor of Philosophy in Health Systems Management of the St. Clements University.

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DEDICATION

This work is dedicated to my family in acknowledgements of the providence of God
in our lives:

My parents- Rev'd and Mrs Rikichi Kajang,

My family: Mrs. Juliana D.R. Kajang (wife),

My children: Duniya Yagoro; Nehemiah Adam; Hadassah Katiyong
and Filibus Suhu,

And all my relations and friends.

TO GOD BE THE GLORY, AMEM !

Preface

This study was not intended to be unduly critical of the governments of the federation of Nigeria, nor their public functionaries, nor even the Nigerian citizenry, in an irresponsible way. After all, there is now a deep sense of frustration and general realization in the country about the abysmal performance of the health sector in recent years. A critical examination of previous policies and omissions which have brought about the present situation is obviously a necessary step in this direction.

As this work is a culmination of many years interest in the organization and management of health services in Nigeria.

ACKNOWLEDGEMENTS

During the course of this research I benefited from the assistance of many persons and organisations to whom I owe a lot of gratitude. I am indebted to Pro. David Iornem my desertion supervisor, for his invaluable assistance, constructive criticisms and guidance throughout the period of this research. My gratitude also goes to Dr. Y. K. Gandu my fellow colleague, whose intellectual stimulation guided me throughout the duration of the study. His criticism of some of my taken-for-granted assumptions have been of immense help in shaping the focus of this study into its final form. I have also benefited from the comments and constructive suggestions of Mr. Segilola Areoyo of the Federal Ministry of Health, Abuja. Mrs Halima Tajo of the Primary Health Care Development Agency, Abuja, to them I owe a debt of gratitude. I also wish to thank Mall Salisu Usman who assisted in the administration and retrieval of questionnaires. I benefited from the assistance of many people during the field-work. I am particularly indebted to the public servants in the Federal Ministry of Health Headquarters, Abuja from whom I had the privilege of learning more than I could have read from books. Their tolerance when filling in the questionnaires, granting interviews, and participating in group discussion, which occasionally chipped off some valuable time from their office work is acknowledged with gratitude. I also thank Dr. Y. Vatsa of the Health Department of Federal Capital Territory (FCT) for assisting me with the administration of some of the questionnaires.

I also wish to thank Chief Bayo Awosemosi and Mrs. Anne Okigbo-Fisher of the World Bank Country Office, Abuja whose encouragement and concern gave me the

courage and the incentive to push on and to be what I am today. I also extend my sincere thanks to my wife for her support throughout this study; to my office staff:

Mr.Ishaya Dawha, Mr. Tobias John, Mrs. O Abegunde, Mr Sam Archibong, Tine Jizhi and Dr. Ibrahim Atta for their various assistance at the various stages of my study.

I am particularly grateful to Professor Babatunde Oshotimehin and the entire management of the World Bank Assisted HIV/AIDS Project National Project Team and the National Action Committee on Aids (NACA) for supporting this study.

Daniel Rikichi Kajang

27/09/2004

ABSTRACT

This study sets out to document the evolution of the “Organization and Management of Health Services in Nigeria since Independence in 1960”. The study investigated the strategies devised by the various successive Nigeria governments in the organization and management of health services since Nigeria gained independence in 1960 to date. After independence, the colonial Masters transferred to the Nigeria indigenous authorities the responsibility of securing the health of citizens and attaining health goals. The purpose of the study was to explore the question, whether outcome of health services in Nigeria are management bound or not. The study was conducted at the Federal Ministry of Health, Abuja, Nigeria. The Federal Ministry of Health is the highest organ charged with the responsibility of coordinating and regulating health matters in Nigeria. A quota sample of 60 respondents from the Federal Ministry of Health Headquarters and its parastatals in Abuja responded to a questionnaire on the organization and management of health services and the performance of the health sector. Content analysis of official reports and related literature, questionnaire, individual interviews and group discussions were employed to complement the survey data. Frequency distribution was used for data analysis. The main assumption or hypothesis of the study is that ‘ Management services if effectively institutionalised in the health sector will enhance optimal performance and capable of producing the desired health outcomes of the country. In order words, Efficient management services is capable of bringing about the achievement of national health goals’. It is established that the introduction of management services in the health sector is an achievable goal and will bring about the desired health outcomes. The findings revealed that after gaining of Independence by Nigeria in

1960, the organization of health services became the responsibility of the Nigeria government with the Federal Ministry of Health at the helm of affairs. To meet its mandate, government resorted to producing health plans in various forms in order to meet the health needs of the country. The aggregate of the findings show that management services is a major determinant of health outcomes in Nigeria proving the hypothesis and the Mix Management Theory (MMT), being the Theoretical Framework set forth and advocated in the research. Therefore, based on the findings, it is the position of this study that, the capitalist nature of the of the Nigerian economy is reflected in the weak management structure of health services which is commonplace in the various public sector health institutions in Nigeria which has serious implications for health service delivery and currently poses a major challenge to the health sector and the government of Nigeria. It is the outcome of this study, that the issue of the impact of management services in the health sector is under researched. It is therefore recommended that one major problem that must be immediately tackled for rejuvenating the health sector in Nigeria is the evolution of a robust management regime in the health sector. Doing that will require government embarking on massive health management reforms with respect to enactment of an 'Health Act' to replace the current obsolescence health policy. The act should as much as possible address issues of health reforms, operations research and training of health managers and the establishment of a sustainable 'health manager cadre' in the quest for the provision of comprehensive health services to the Nigerian citizenry.

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LIST OF ABBREVIATIONS

ABUTH – Ahmadu Bello University Teaching Hospital

DFID – Department for International Development

USAID – United States of America International Development

UNICEF – United Nations Children’s Funds

UNESCO – United Nations Educational Scientific Organization

WB – World Bank

WHO – World Health Organization

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CHAPTER ONE: INTRODUCTION

1.1 Introductory Background:

Over the years, health and healthy well-being of humans has been conceptualized in diverse ways. Health or healthy well-being of humans does not merely connote the absence of ailments and disease. Its sum total also encompasses the proper physical, mental and social functioning of humans. Health is also influenced by socio-economic, cultural, environmental as well as hereditary factors (Wilson: 1970, WHO: 1978, Deliege: 1983). The attainment of healthy well-being by individuals, and the community at large, is therefore, a social concern because a society can function properly only when majority of its members are healthy enough to perform the tasks that sustains human society. In all historical epochs, human societies have evolved institutions, which provide health and medical services, prevent diseases, treat diseases whenever sickness occurs and promote over all health well being of citizens (Calhoun: 1978). The philosophy and organizational structure that govern health care delivery systems and institutions vary from historical epoch to the other and from one society to another. While several factors may be responsible for the variation, but one factor can easily be identified. The whole process depends on the individual or group's definition of what constitutes a disease and the cause(s) of illness. In most societies of the world, the definition of what constitutes a disease, the perception of the

cause(s) of illness, the course of treatment and preventive measures required, all influence the allocation and management of resources to solve health related problems.

The conception of the causes of disease can be categorised into two broad views. While the first category can refer to as the naturalist view, the second is simply the supernatural conception. The naturalistic view of disease causation emphasizes objective identifiable causal agents. The dominant explanation of this view is the germ theory of disease causation. It attributes sickness to pathogenic micro organisms of which diagnosis largely, consists of identifying the disease agent or the abnormal organ, surgical remedy and, or a combination of both. (Field: 1960, Twumasi: 1978). The supernatural view regards diseases as being caused by agents and factors such as gods, spirits, retribution for sins and taboos, witchcraft and sorcery by fellow human beings.

While the foregoing two broad views, are not mutually exclusive to any given socio-cultural setting, the naturalistic perspective appears to be the most dominant in the modern globalize world. In the quest for effective global health system management, the naturalistic perspective has given rise to bio-engineering medicine. This approach continues to permeate the world's peoples and cultures in varying degrees (Turner: 1987). Nigeria is not an exception. The foregoing notwithstanding, there are variations among nations with respect to nature of government public health

policies, structural organization and the management of institutions responsible for the health care delivery. The variations are a function of the level of economic, social and political development of nations. Existing variations can be grouped into two main perspectives thus: the egalitarian and the utilitarian perspectives.

The egalitarian perspective holds that every person or citizen of a country is entitled to fundamental human rights. These rights include equal access to adequate health care. The egalitarian philosophy of health dictates that government takes responsibility for providing health for all citizens regardless of social class and other forms of differentiations. Contra-wise, societies or governments operating the utilitarian or instrumentalist perspective do not believe that citizens have inalienable rights to health care. A market view on health care delivery system, it is context on how health care services can contribute to economic growth. For this utilitarian perspective, equal access to health care and equal health status of all citizens is not a priority objective (Roberts, Hsiao, Berman, Rich, 2001).

Apart from the foregoing perspectives, Terris (1980) came up with a typology of health policies based on ideological framework as follows: (a) National Health Service; (b) Health Insurance; and (c) Public Assistance. Terris however indicated that, these three medical care systems are neither fixed nor immutable but are a continuing process of

revision, replacement and change. Therefore, more than one type of the three medical systems could co-exist within a country. The foregoing notwithstanding, the dominant typology existing in most countries is the system by which the majority of the population have relative ease of access to health care. Roemer (1980), in a rejoinder supported Terris's views but suggested that each of Terris's three types of medical care system could be reclassified into two or more categories because of the diversities in national ideology and health care policies. Roemer (1980) further opined that Terris's classification has one major weakness. It paid little attention to self-care and traditional health care systems. In Africa as in Asia, a large segment of the population patronizes self-care and traditional health care systems. These criticisms notwithstanding, it is worthwhile to describe Terris's three systems of medical care as follows:

Public Health Care Delivery System:

Within the National Health Service, each national government takes responsibility for the health care needs of all her citizens. Under this system, medical treatment is provided free of charge to every citizen at point of delivery. In this system, services are financed by taxation and payroll taxes on employees. Salaried physicians and other health personnel in government hospitals and health centres provide both curative and preventive services. This practice was and is still common

amongst socialist countries in Europe and Asia such as Sweden, China, North Korea Cuba, and the former USSR (Terris: 1980).

Health Insurance Policy:

In the Health Insurance Policy, medical care is pre-paid by the health consumers or rendered on fee for service basis, through a mix of governmental and non-governmental insurance. The failure of most national health insurance to cover the full cost of care is a major deficiency of fee-for-service programmes. This practice is found in Israel, Canada, Japan, USA and most countries of Western Europe (Terris, 1980)

Public Assistance:

With respect to Public Assistance, governments subsidize medical services for citizens in various degrees. In effect, private health care providers and voluntary agencies are allowed to provide health services to augment government's efforts. The Public Assistance policy is mostly implemented in developing countries of Africa, Latin America and Asia. In this system, medical care is provided in public or government hospitals and health centres and is financed by general taxation. It has been argued that in this system, facilities are generally under funded, overcrowded with insufficient medical and health personnel due to poor staff remuneration (Terris, 1980).

Terris (1980:78-86) further stated that under the three policies or systems, government plays significant role in the standardization and regulation of public health and medical practice. He however interjected by stating that the adoption of any one of the three health systems by different countries, accounts for variations in the provision of medical services at the level of coverage, relative ease of access by citizens, and quality of services available to health consumers. Therefore citizens of the various nations of the world are subjected to differential degree of accessibility to medical care depending on the health care delivery model in operations in each case (Widger: 1980, Hellandendu: 1991: 4-6).

According to Shapiro (1997), the issue of differential access to health care services is particularly worrisome under the private health insurance model. This is because it operates for only those who have the ability to pay for the insurance premium. Those who are unable to pay are excluded and are denied medical care.

1.2. **Comparative Perspectives in Health Systems.**

As a follow-up to the Terris's classifications, this subsection further interrogates the major different schools of thought that have emerged over the years on the theme of organizing and management of modern health services globally. In an attempt to classify health-care system, Roemer (1977) draws a valuable distinction between free enterprise systems, welfare- state forms of health care, the health system of the

underdeveloped societies, the health systems of transitional society and finally socialist systems of health care. To simplify the discussion we can argue that health care systems vary along a continuum from private to public provision. But the practice of health care system in most countries is mixed, which combine both private and public forms of delivery. Basically private provision is characteristic of capitalist societies, while public delivery is usually associated with state subsidies.

It is pertinent to also acknowledge that there exist different factors that influence and influence health system in any country. These include the economic base for the support of health care, the organization of manpower resources, health care facilities available, the system by which medical care is delivered to users, the system of preventive services, the political regulation of health care, and finally the various methods for the plan and plan administration of health systems. We can also within each health care system consider the various levels of medical delivery. We can for example distinguish between primary, secondary and tertiary health care. Primary care includes the ordinary forms of outpatient care which is provided on the basis of a clinic by professional practitioners who represent, as it were, the first point of call. While secondary level health care include various specialized services; tertiary care encompasses a more complex systems of specialized hospital treatment such as open-heart surgery (Mechanic, 1968).

A number of important theoretical reasons have been advanced for the emergence of mixed health care delivery system in most countries. One of such reasons has been associated with the pressure to ration health care delivery (Mechanic, 1976, 1977). In principle the demand for medical care appears to be unlimited for at least two reasons. First, in contemporary societies as a consequence of various democratic movements, the demand for health is part of a system of rising expectation with respect to the state's role and responsibility in society. Secondly, the notion of illness is essentially infinite and the circumstances, phenomena and behaviour which can fall into such a category are highly elastic. Therefore, every health-care delivery system requires some principle of rationing in order to contain the exponential growth of medical care. Mechanic identifies three forms of rationing, namely rationing by a system of fee-for-service, implicit rationing and explicit rationing. Under a system of rationing by the fee, the physician appears as an entrepreneur in the market place where the use of medical service is clearly limited by the financial ability of the patient to pay for the service. He argues further that a fee-for-service system tends to collapse over time. It therefore needs to be regulated by governmental agencies due to several reasons. These include the ever expansion of medical technology leading inevitably to higher costs, the growth of insurance schemes which allow a wider use of medical services, the

adoption of expensive diagnostic techniques by the physician, and a greater commitment to a technological imperative in the medical system (Wolf and Berle, 1981). For various reasons, therefore this set of arrangements tend to lead to an over consumption of services. The problem with such a system is not only the growing costs of medical care, but the inequalities which it brings about through the inability of certain sectors of the community to pay for the service.

Implicit rationing takes place through the means of a centralized system of budgetary controls as in the UK or through the limited financial provision of charity institutions or sickness associations. Under these conditions, the professional physician is still left relatively free to determine the price of services and the specific use of medical facilities. Implicit rationing depends primarily upon the existence of the queue, limited medical resources, and restrictions on the availability of manpower. While medical provision may be relatively free under such a system, the length of the queue for surgery and other services may drive wealthier people into the private market for medical provision. Implicit rationing does not therefore overcome the problem of inequalities of provision and use.

Due to problems associated with the fee-for-service system and implicit rationing, there is a tendency for governments to intervene. State intervention is always geared towards bringing an explicit system of

rationing with the aim of controlling total expenditure and stabilizing a more rational and egalitarian system of medical provision. From these arguments, we can develop the thesis that states as follows: the defects of private medicine will be adjusted by the use of public regulation and the problems of public delivery will be regulated by privatization. This oscillation between the private and public can be illustrated by the French health-care system (Cullis and West, 1985). In France, the health system has been predominantly a private market form of medicine in which physicians are principally in private practice under the system of 'La M'edecine Liberale' (Webb: 1982). The clients are free to select their own doctors and the physician is free to determine the price of the service. Although the French constitution provides each citizen with protection of health, as a result of the market-dominated form of health care there have been major inequalities within the French system. For example, in Paris there are twice as many doctors per capita as in 'Piardy'.

Although the system is largely private, the French government has brought about a number of changes in recent years to regulate the system. For an example, fees are now established as the outcome of a set of negotiations between the social security funds and the medical profession. The government has also attempted to control significant geographical inequalities resulting from a private medical system regulated by

professional norms. Following Mechanic, Cullis and West argue that health-care systems tend to evolve from fee-for-service systems to implicit rationing, and finally to state regulation of the market in order to control medical costs and to bring about some redistribution of services in the interests of an egalitarian principle. From the foregoing, an alternative trajectory for health systems have been developed, whereby the enormous cost of explicit rationing will be occasionally regulated by a period of privatization and cut-backs.

The underlying problem in the organization of health care is the apparent contradiction between efficiency and equality (Daniels, 1985). It is typically argued that a free market system produces greater efficiency. On the contrary, a public system of health attempts to guarantee equality. It is normally assumed that it is impossible to achieve both a radically egalitarian system of health and an effective service. In order to understand this apparent contradiction, we need to look more closely at the economics arguments which are utilized to justify a free market system. Behind the economic argument for the market system, there are the usual assumptions of demand and supply side and consumer choice. It is assumed that each consumer has perfect knowledge of the market, that there is a perfect supply by competitive means and finally that there is consumer sovereignty in the choice of goods and services. The argument

suggests that this system in the health market would produce an efficient cost-effective supply of medical services (Le Grand and Robinson, 1976). The disadvantages and advantages of economic models for the analysis of social welfare functions have been cogently outlined in a variety of directions by Arrow (1951, 1983). Arrow has been specifically concerned with the problem of applying utility models from economic theory to the system of medical care in mixed economies (Arrow, 1963). In Arrow's critique, the particular character of medical information as commodity departs significantly from the classical assumptions of economics. In medicine the product and the activity of production are often identical and furthermore the consumer cannot test the medical product before consumption. Unlike motor cars, we cannot try out surgery before purchase. In addition, the decision to seek medical services is, as seen in the conventional sick role is a complex social process. Often the client does not know what their wants or needs are before they visit the doctor. It is in this situation that trust in the physician is an essential feature of the medical service. Within a Parsonian analysis, trust is an important component of professional values and norms. Associated with these conditions of ignorance, there is the problem of the uncertainty of the medical product itself. Due to ignorance, the patient is not always in a position to judge the effectiveness of the service vis-à-vis other forms of treatment. Given the uncertainty which underlines the notion of the docile

patient role in relation to the doctor's intervention, uncertainty is becomes an essential component of patient compliance within the sick role. The patient has relatively little control over the norms of treatment in terms of the length, form and outcome of the service.

There are various reasons why this uncertainty in the medical context and the professional norms of the physician should have the consequence of increasing the cost of medical services. According to Mechanic, there is a professional norm to treat the patient without regard to the patient's ability to pay. Physicians therefore take actions in the interests of their clients without significant consideration for the cost or long-term economic consequences of medical treatment. Another feature of professionalism is the absence of price competition and advertising of professional service. Because of the existence of professional control, there is little specific advertising of medical services; and as a result, medical prices are not significantly responsive to changing consumer demand. Professionalism also restricts entry into the medical market place which is controlled by professional medicine attempts to regulate the market and to prevent the introduction of alternative systems of care. These controls on entry bring about limitations on competition which means that there is a strong pressure for the maintenance of medical costs. In short, there is little public regulation of prices and the supply of services because of the existence of medical dominance.

It is not clear that medical institutions or health behaviour can be understood appropriately in terms of economic model of efficiency. On the other hand, there will always be an element of rationing for the reasons noted earlier. It is not clear how the supply of medical services relates to the general health of the people. It is difficult to evaluate the specific contribution of professional medicine to the general status of a community.

Despite the theoretical arguments of classical economics, it appears that most western societies possess health systems which are neither efficient nor egalitarian. In free market circumstances and in states dominated by a welfare system, there has been an important continuity of class inequalities in terms of morbidity and mortality rate. During the period of post-war reconstruction, there was a general improvement in the health of populations generally as measured by longevity and infant mortality rates. However, the differences between the social classes have remained relatively constant. For example, the Black Report of 1980 in the UK found that during most of the 1960s and 1970s there was no significant improvement in the health experience of the unskilled and semiskilled manual classes. While the infant mortality rate of the lowest classes had declined, the gap between the upper and lower classed increased (Townsend and Davidson, 1982). Because of inequalities and

inefficiencies in both free market and welfare systems, a number of writers have argued that by comparison, socialist health –care systems are egalitarian and relatively effective. The argument in favour of socialist health-care systems has to assume that a comparative sociology of health care is possible and feasible.

From the foregoing it is essential to note that in most countries the system for delivering health services is complex. Within the health system, there are different types of health care facilities, different levels, different type of providers, and different type of services being provided and different ways through which services are provided. However what is common in all health care systems is the fact that there are people who are in need of health services, people who provide health services and people who manage or supervise the provision of health services. It thus also implies that as a matter of fact, some health practices or services if not properly managed could be more dangerous to the health system than total neglect. The foregoing explains why the model of the health service adopted by a country, with respect to the organizational development and management of the health sector, has a critical direct impact on the effectiveness and efficiency of the health system. The aspect of the organizational development being referred to here is the operational structures put in place by models of health care systems. While the operational structures and models of health care systems in terms of the relationships among the

various groups and units in the health sector may be vertical in some cases, in others they come in horizontal pattern. The vertical relationship relates to power and authority while the horizontal reflects functional distinctiveness. According to Akinwale (1996), it is the principal functions of management to organize the structural elements of an organization in such a way that it clearly defines how tasks would effectively be performed and how resources could adequately be put in good use to accomplish organizational goals and objectives.

1.3 The Nigerian Health Sector:

The health sector in Nigeria is one of the biggest social sectors in the country. This makes it expedient to try to understand how the organizational framework and management dynamics of the Nigerian health sector impacts on the execution of its mandate. Such an understanding will provide us with valuable information on how to reposition the Nigerian health sector so that it can properly execute its expected mandate in the country.

The Nigerian health care delivery system has undergone tremendous policy changes over the years. In the immediate post-colonial Nigeria, the health sector like other sectors of the economy was heavily subsidized. With the introduction of the Structural Adjustment Program (SAP), which witnessed the massive withdrawal of state subsidies from the health sector in 1986, health care delivery became privatised. This policy

continued into the 1990s and 2000s. We can therefore locate contemporary health care delivery system in Nigeria within a market or capitalist ideological framework. Although the major source of health care financing is derived from a free market economic system through the private sector, external funding from the World Bank, the International Monetary Fund (IMF) and many other multi-lateral donor agencies, there are other sources such as government (public sector) and voluntary organizations. This mode of health care financing in Nigeria differs significantly from health care financing in socialist and welfare countries where their governments take sole responsibility for health care delivery. The Nigerian free market model creates disparity in the provision of medical services to the various socio-economic groups in the country. The Nigeria health sector operates in the three tiers of government thus: Federal, State and Local. This is responsible for disparities in status, service delivery and resource availability and the attainment of ideal state of health. For the purpose of this study 'Health' is seen as the attainment by a person or persons of a state of general physical, biological and social wellbeing substantial enough to learn, work, achieve potentials and enjoy life' (WHO 1978, Kajang 1999.). This definition is a departure from the conventional medical model, which conceptualises health in terms of cure, pharmaceutical supplies, or complete absence of disease. Within the context of what is generally regarded as the 'health services approach,

this study understand “health” to mean the physical (including environmental medicine), mental and social wellbeing of the individual. An extension of this definition encompasses the organization and the management of the health systems. The emphasis in this study is that an adequate analysis of the broad components of health care delivery has to look at the effective and efficiency in the management of health care resources particularly funds, manpower and material resources that are available to the health sector at any point in time.

‘Health Sector’ in this study means the formal institutions and or agencies created both by government and non-governmental organizations to provide one form of health services or another. As noted earlier, health care delivery systems and its institutions are created and run by the Nigerian Federal, States and Local government authorities. Non-Governmental Organizations also participate in the implementation of various health programmes in the Country. This study investigates how the government component of health services are organized and managed for the optimal development of the health sector in Nigeria, focussing on the federal ministry of health. The Federal Ministry of Health as part of its functions is vested with the responsibility to develop policies, strategies and plans that provide direction for the national health care delivery system in Nigeria. It is also the main provider of tertiary health

services and preventive health interventions programmes for protecting the health of all the citizens of Nigeria.

1.4 The Research Problem:

Since political independence in 1960, successive governments in attempts to secure her citizens opportunity to attain their health goals, Nigeria adopted and implemented a mixture of public health policies, private sector driven health insurance schemes, and bilateral funding and credit facilities by international creditors. The declaration in the Nigeria National Health Policy of 1988 revised 1998, affirmed thus:

“The Federal, State, and Local Government of Nigeria hereby commit themselves and all the people to intensive action to obtain the goal of health for all citizens by the year 2000 and beyond, that is, a level of health that will permit them to lead, socially and economically productive lives at the highest possible level” (National Health Policy and Strategy to Achieve health for all Nigerians 1988/1998.)

The Nigeria Government also further affirmed in the same policy document to review its resource allocation to the health sector and explore avenues for financing her health care system by introducing health insurance schemes. The overall goal of the Nigeria health policy is to provide a formal framework for the direction of effective management of health services in the country. Despite this great declaration, the Nigeria health sector continue to experience persistently low funding below the World Health Organization (WHO) stipulated

levels. There has also been a slow pace in developing health insurance schemes and other viable options for health care financing in Nigeria.

This scenario is a matter of concern because Nigeria is reported to be the sixth largest oil producing country in the world with high oil revenue accruing into her foreign reserve account (Olukoshi, 1991). Nigeria was in oil boom in the 1970s and of recent in the last five years May 1999 to date. Nigeria is also the most populous country in Africa, with a projected population figure of about 122 million people in 1998 (UNFPA: 1998). Yet social indicators particularly health indicators in Nigeria are reported to be very low when compared with other poor and non-oil producing developing countries. Low financial allocation to the health sector has been a problem since independence in 1960. Since 1960, expenditure on social services has expanded rapidly and especially during the oil boom in the 1970's. Yet health indicators have never reached acceptable international standards. Unfortunately still, public financing of the social sector to which the health sector belongs continued to decline during the economic predicaments of the 1980's and 1990s. These factors partly account for further deterioration of health services in Nigeria. Health facilities are mostly ill maintained; personnel are insufficient or inappropriately trained and poorly paid. To make a bad situation worst, shortages of clinical materials and medical equipment is wide-spread. There was no time that Nigeria witnessed budgetary constraints and cost

recovery schemes in funding the health sector than during the Structural Adjustment Programme (SAP) in 1986 (Olukoshi 1991, Kajang 1999)..

Worst still, is the fact that despite inflow of donor funds into the sector from various development partners to up scale the Nigeria health sector, her health system has continued to deteriorate remarkably. The announcement in 1988 and 1998 in the National Health policy and the declaration of the slogan that there will be health for all Nigerians by the year 2000 and beyond has not changed the gloomy situation of the Nigerian health sector. Among the one hundred and ninety one (191) member states of the United Nations (UN), whose overall health systems performance was assessed by the World Health Organization (WHO: 2000), the targeted year of the declaration of health for all by the year 2000, ranked Nigeria in the One Eighty Seven (187th) position, coming ahead of only Democratic Republic of Congo, Central Africa Republic, Myanmar and Sierra Leone. It is pertinent to also observe that these countries with whom Nigeria ranked last have been pre-occupied with civil wars and political instability for close to three decades. Nigeria on the contrary has had relative stability within the same period.

Total health expenditure of Nigeria as percentage of the gross domestic product, public health expenditure as a percentage of total public expenditure per capita for Nigeria are below the average for Sub-Saharan Africa, and far below the recommends as well as the acceptable minimum

levels by WHO. The report also revealed that Nigeria health status indicators with respects to maternal mortality rate 948/100,000, infant mortality rate 115/1000 and child (under five) mortality rate 205/1000 are worse than the average for Sub-Saharan Africa (WHO, 2000; FMOH 2001).

The report further revealed that Nigeria's health sector instead of becoming better is worsening despites evidences of interventions in form of funding from external donors. In particular it has been reported that since 1985 the government of Nigeria has been collaborating with the World Bank, to secure financing for the health sector. As at 1998, the World Bank has funded five health projects in Nigeria, namely Sokoto Health Project; Imo Health and Population Project; the National Essential Project; The National Population Project; and the Health System Fund Project. Between 1998 and 2003 two more World Bank Projects came on stream. These are the HIV/AIDS Programme Development Project and the Health System Development Project II (Cole, F.G.A., 1998)

Apart form the World Bank there are other donor agencies and International Non-Governmental Organizations (INGOs) that showed interest and provided funds for the health sector. Some of these include, WHO, African Development Bank (ADB), United Agency for International Development (USAID); Department for International

Development (DFID), United Nations Development Programme (UNDP) etc.

Despite the resource support from these bodies towards reforming the health sector and the introduction of cost recovery schemes within the government systems have not provided the desired impact on health system organization to meet the WHO recommended minimum standard. The general thrust of opinion shows that Nigerians are dissatisfied with the performance of the health sector considering the resources invested in the health sector. As to be expected donor's funds should have provided better opportunities to sustain the health sector so that its performance would meet the WHO acceptable levels. But unfortunately health indicators are still below the approved averages reported by the WHO's 2000 report, thereby defeating the purpose of increase funding in the health sector by government and the external donors. It is therefore worthwhile to investigate this state of affairs that hinder the attainment of organizational objectives in the health sector.

From the preceding sections it is seen that despite the increase resources acquisition both internally and externally for the health sector, there is still a general belief that the Nigeria's health sector organization and performance is poor because statistics still shows that quality of health care delivery is declining in terms of absolute levels of health status and poor service indicators. Current public health programmes like

HIV/AIDS, TB and Malaria control, reproductive health etc are currently being implemented within a weak health system with limited impact. For instance, routine immunization coverage rate of over 80% in the early 90s has dropped to less than 25% in the 2000s. Public expenditure on health is less than \$5 per capita compared to the \$34 recommended internationally. Also private expenditures are estimated to be over 70% of total health expenditure with most of it coming from out-of-pocket expenses. This is happening in spite of the endemic nature of poverty in Nigeria. Partnership between the public and private sector is almost non-existent and if it exists, it is ineffective. This deficiency is also noticed in the coordination of development partners and external donors (FMOH, 2004).

The path to resolving the persistent poor performance of the health sector despite massive resource allocation is an important problem which has sufficient practical value to educators, students and parents and Government and requires investigation to determine the relationship between management of health care resources and performance of the health sector. This will answer the main question on the impact of management services on utilization of health care resources in the health sector in Nigeria. It will also provide clarifications on whether the huge investments made in the health sector in the past four decades have yielded the required dividends. This is in view of the general notion that

despite the investments made in the health sector since independence, the Nigerian health system is still weak. Such a notion has implication for managing health care services. From the foregoing it has to be stressed that the issue of management and organization of the health sector is crucial because in many cases resources are either unavailable or deficient. Therefore the level of resource allocation, management and structural organization of health system services is expected to have a resulting impact on health policy and determine both the satisfaction of health needs and objectives of the health sector. The major challenge in this type of scenario relates to the identification of management and organizational model that can provide the required result in the health sector which provides the theoretical rationale for the problem under investigation.

In response to this growing concern about the decline and the unsatisfactory performance of the health sector, this study investigates the management and structural-organizational mechanism of health services in Nigeria since independence. The study sets to answer the following research questions-:

- (i) What factors in the management strategies and structural organization of the Nigeria health delivery system impedes the realization of the national objectives of the health sector?

- (ii) What are the reforms required to improve the performance of the health sector?
- (iii) What are the specific proposals required to strengthen the organization and management of the health sector to guarantee optimal provision of health care services in the country?.

1.5 Objectives of the Study:

This study examines the effects of organizational structures and management trends in the health sector in Nigeria since independence with the view of re-engineering the health sector for optimal performance. The specific objectives of the study include;

- a. To identify the state of the health sector in Nigeria by exploring the issues involved in the provision of health services, with respect to the organizational and managerial challenges facing the health sector by linking theory to practice.
- b. To identify the extent to which management strategies could help in the re-engineering of the Nigerian health sector.
- c. To assess specifically the impact of external donors on health care delivery in Nigeria.

1.6 Rationale for the Study:

The management of health care organizations has potent effects on the normal and proper functioning of the health sector and consequently the health status of the citizenry. In Nigeria, adequate research attention has

not been accorded studies on the impact of the management of the health sector. Conducting a study on this aspect of the Nigerian health problem is compelling because:

- a. Since independence in 1960 the health sector in Nigeria has benefited substantial public budgetary allocations. It is therefore necessary to document the extent to which resources have been managed over the years to meet national health objectives. Questions have been raised as to whether health care institutions and organizations have effectively and efficiently managed resources availed to them. It is necessary to investigate and determine what has been achieved by the health sector vis-à-vis resources allocated or donated over the years.
- b. The lessons learned in the study will contribute to the expansion of sound baseline knowledge on the effects of the management component on the health sector and the institutionalisation of realistic management strategies for health care delivery in Nigeria.
- c. This study provides a general framework for health managers to improve on the skills of health administration for effective and efficient organization of the health system.

1.7 Significance of the Study:

The study is significant to the extent that it has documented both discrete and relative issues on the management of the health sector. It has also come up with findings, which would help government and private health care providers to develop better management capacity for running the health sector. The study has therefore made significant contributions to the knowledge of the impact of management services on the health sector in Nigeria and elsewhere.

1.8 Scope and Limitation of the Study:

This study is restricted to the extent to which structural organization and management strategies of health care delivery system contribute in the realization of national health care objectives, with a case study of the Federal Ministry of Health in Nigeria. The study limits itself to a period from independence in 1960-to- 2004. The reasons for these limitations include the following:

- a. From the historical perspective the issue of management of federal health care system and local ownership of the health sector became a critical issue when Nigeria gained independence in 1960 and the establishment of a Federal Ministry of Health

- b. Within this period, from 1960 to date, Nigeria as an independent nation intensified self-effort to manage and sustain the health sector in the post-colonial era.
- c. From 1960 to date Nigeria put in place different phases of economic adjustment and restructuring in governance which directly affected resource allocation to the health sector.
- d. Between 1960 and the 1980s, Nigeria developed a national health policy, which was eventually launched in 1988 and 1998 respectively. By 2004 the Federal Ministry of Health is reported to have embarked on health reforms.
- e. Dearth of data and study reports and research on the impacts of management on health services is one of the limitations and challenges faced by this study. Time and resources constraints made it very difficult for the study to be conducted in the entire health sector in Nigeria, hence the limitation of the study to the Federal Ministry of Health Headquarters.
- f. It was not possible to investigate 100 per cent of the components of the entire population/ participants of the subject of the research due to limitations imposed by: costs, time and the sheer amount of work involved which was not practically possible to be accomplished in a single research.

Chapter Two:

LITERATURE REVIEW ON GLOBAL HEALTH AND HEALTH CARE DELIVERY IN NIGERIA.

2.1 Introduction:

This chapter reviews literature on broad areas on the global concept and management of health services in Nigeria and elsewhere. The chapter undertakes an overview of the global concept of health and emergence of health systems bureaucracies and management of health services, (ii) reviews the historical evolution and development of health care delivery system in Africa from the 10th Century and in from pre-colonial, colonial and post-colonial Nigeria from 1960, (iii) interrogates the evolution of health care system in Nigeria from 1960 to 2004 and (iv) provides a theoretical discourse on the political economy of health care management in Nigeria.

The literature has been adequately surveyed and pertinent materials presented in the review is not just fillers; but previous findings and studies have been critically evaluated and has pointed out deficiencies and have provided alternative explanations on the issues reviewed. The literature has revealed gaps in our knowledge of the issue investigated and therefore supported the need for the study of the problem. The review also provided a theoretical for the research problem.

This chapter rests its debate on the argument that the absence of an adequate and effective management regime in the Nigeria health care

delivery system contributes to the weakness in health management capacities at all levels of public and private health institutions. Such a weakness creates a high propensity of error in the implementation of health care policies. Also that, the quality of health management is further compromised by the limited attention paid to the underlying determinants of health, which is outside the traditional or conventional purview of medical practice leads to inefficient management of resources and weak health sector which is now almost in-capable of meeting its constitutional mandate. What is required are management reforms in the health sector to take care of these lapses so as to improve health care delivery and service capacities in the Nigeria health sector.

2.2. EMERGENCE OF GLOBAL HEALTH SYSTEMS

(a) What is health?

It is auspicious that any discourse about health should begin with an elaborate exploration of the concept of ‘health’ as the entry point. For anyone involved in designing, promoting or participating in a health care system, the way in which the concept of health is understood dictates the boundaries. Over the years many different concepts of health have been proposed and practiced, and perhaps the one statement that all participants in the debate would accept is that:

“...health itself is not a precise or simple concept...” (Royal Commission on the National Health Service, 1979.)

The burgeoning of 'what is health? Controversy has been nurtured by many different interests, including managers of health services, radical observers of the health scene and sociologists of health and illness. However, the participation of those actively involved in the provision of health care has emphasised one dimension of the debate, namely the implications of the practical application of any concept. They are concerned with the use concepts to construct models that can be used for the provision of health. Much of this essentially practical, rather than theoretical interest is generated by the apparent inability to affect significantly the health of particular groups of clients, primarily the chronic sick, the handicapped and the terminally ill.

For these professional workers seeking explanations for apparent failure and alternative programmes and policies, the adoption of new concepts of health around which to re-organise health care can seem very attractive. It is important that the goals as well as the techniques and strategies of health care are open to continuous examination and evaluation. For the purpose of this study, we proposes simply two opposing paradigms: a negative and a positive model of health.

The negative model sees health as the absence of the constraint of illness. That is to say, you are healthy if you are not ill. For this model health and wellness are synonymous. The positive model sees health as the active management of life in a particular way. A specific pattern of living is

equated with good health. These two models may be seen as two successive stages. That is, the removal of the constraint of illness is necessary to make 'healthy' pattern of life possible. But more usually, and more radically, it is claimed that the presence of a particular life pattern constitutes health despite the presence of disease or incapacity. This idea is particularly attractive to those who work, for instance, with the handicapped as it enables them to set health as the goal or achievable target despite the presence of an incurable handicapping condition.

Both these models have severe problems if one attempts to operationalise them in Nigeria today. We will look first at the negative model. It was widely assumed in 1948 when the National Health Service was established by the United Nations that 'health' was the opposite of illness, and illness was assumed to be synonymous with the presence of disease. The renewal of health in a diseased individual was the result of the removal of the disease. It can be expressed as the simple equation: disease A + medical treatment A = health. The problems involved were, therefore, firstly the correct diagnoses of disease A, and secondly the discovery of development of treatment A. These were difficult problems, certainly, but capable of solution by the 'holy' alliance of doctors and scientists. The major problem and the major area of controversy were considered to be achieving equal access to treatment, and this was a financial and logistical problem.

Murcott (1979), reminds us that this was not the only available model around with which to construct the National Health Service. It was inevitable, however, that such a model could be used, not only because the medical profession is based on such a model, but also because it fits the whole character of the welfare state, which is not a revolutionary institution but rather a bureaucratic rationalization of existing individualized services. The essential fabric of society is therefore assumed to be satisfactory provided and that, protection could be extended to individuals against particular catastrophes. Thus sickness, like poverty or unemployment, is viewed as a potential transient individual phenomena and the scientific administration of services would conquer sickness as it would conquer poverty. This view owed much to the advances in medical science during the 19th and 20th centuries. The achievements in surgical technique and antibiotic therapy showed that such an approach could have spectacular recognition. To the effect that preventive personal and environmental services which had also produced very significant results received relatively little emphasis. Thus the 'health' services of nations then were primarily designed to cope with those who were ill.

Before mentioning the problems inherent in this model it is worth emphasizing that for very many individuals this approach had been an unmitigated blessing: for the many people with cancers were healed by

surgery; those with cataracts were removed and sight restored; those with broken bones were set and deformity avoided. All these and many more successes provides a vigorous and justifiable defence of the negative model, which suggests that the relationship between illness and disease is a complex one. Because people generally have to feel 'ill' before they refer themselves to a doctor, many cases of disease are not seen by doctors, at least in the early stages, and consequently do not receive medical treatment, although they may be treated in other ways by other people. Similarly, many people feel 'ill' but the doctor may be unable to define their problem in terms of the disease state that he understands, and may therefore either offer no help or prescribe a placebo or treatments related to separate symptoms.

Because of their increasing sophistication, scientific aids for diagnostics have rapidly reached the status of determinants of diagnosis rather than aids. Treatments are directed towards the scientifically defined symptom rather than towards the person as a whole. Thus, one is presented with the macabre spectacle of patients being discharged as 'cured' because for an example their haemoglobin or blood pressure is now within 'normal' limits, despite the fact that they still complain of the feelings of illness that first took them to the doctor. Because of the mechanistic nature of this model of illness and because related expectations of cure have increased dramatically doctors find it hard to sustain interest in patients

for whom a cure will not be possible. *Either they refuse to admit the possibility of failure and turn to increasingly bizarre remedies, or they attempt to pass the patient out of the system.*

However, care as well as cure is a legitimate response to illness and can equally rest on the knowledge base of a 'sickness'-oriented training. Where care is required other than in relation to sickness, for instance for the mentally handicapped, the health service has traditionally provided assistance in the absence of any other source.

Thus, although the specific medical emphasis on the definition of disease and on cure at all costs has distorted the current use of the illness/wellness model, nations cannot abandon their responsibility of treating illness in order to help those whom the National Health Service currently neglects such as those with chronic illness, degeneration disorders and terminal illnesses. While emphasis on prevention of illness is not incompatible with this model, financial competition sometimes seem to encourage the propagation of this view.

Advocates of the prevention model are divided into two camps: those concentrating on personal responsibilities and those concerned with wider environmental problems. The former school has been eagerly embraced by government policy makers (HMSO: 1976) seeking relief from demands on the National Health Service in the transference of the consumer's role from victim to agent of his own misfortune. Although

this argument has a certain libertarian attraction it ignores the obvious fact that man lives inside a closely regulated framework and is not free agents. As humans, our choices are largely circumscribed by the economic necessities of society. In any case we must note that such individualized measures are largely based on preventing illness. This is a negative approach and not a giant step for mankind. This can be context within the general contention that humans must give up smoking to avoid cancer; butter to avoid coronaries; variety in sexual partners to avoid venereal disease and HIV/AIDS.

Some of the environmentalists can be equally diseases oriented. Lead pollution causes accidents; and this is the sole reason for their avoidance. Thus the link with sickness remains. However this relationship between disease and the environment has been developed into a more radical critique of the relationship between illness and modern industrial, and more specifically modern capitalist societies. Such a critique is not concerned merely with the connections between specific environmental factors and specific disease but with the relevance to capitalism of a disease-free labour force, the supremacy of profit over health, and the relationship between health care and the private suppliers of health services, pharmaceuticals, etc.

This critique is a telling and relevant one. But it points not to minor changes in orientation of the health care system, nor indeed to a major

revision of the system, but to a reconstruction of society. Doyal (1979) concludes: 'any preventive medicine which was to be substantially effective would need to interfere with the organisation of the process itself.' From the foregoing, health care workers seeking new orientations to practise their profession would be confronted with more. An examination of other radical alternatives to the illness/wellness continuum shows that it rejects any equation of health with the absence of disease and thus belongs to our opposing paradigms: positive health. Probably the most widely known of such models is that of the World Health Organisation (1948), which defines health, as: a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

The basic assumption of the diverse collection of propagandists within this model is that: to be healthy simply means something more or something different from just not being ill. A healthy individual assumed to be one who is to some undefined extent fulfilled; enjoys life to its full; and experiences wellbeing. Wilson. (1975) equates the foregoing definitions of healthy wellbeing to mean the same thing as self fulfilment the natural biological and on spiritual values of humans. This approach runs parallel to that of the World Health Organisation definition.

While we cannot deny self fulfilment to any individual, the self fulfilment definitions only avoid the real problems of conflict between individual

goals and community goals and of considering the nature of the contributions health services can offer. It may be inevitable that such definitions are expansive and ill-defined because their purpose is not to provide a working definition on which to base practice, but to define an area of life as 'belonging to' a professional group. Clearly one purpose of defining an area of life is to lay claim to it, to propose that one has special knowledge of its problems and therefore special rights to offer solutions. One can see this process operating between different branches of the medical profession and between the medical profession, health managers and other related occupational groups. For instance, the attempts to define childbirth as either a *medical problem* or a *natural process* can be seen as a dispute between rival claimants for power over a client group (Donnison: 1977).

It should however be pointed out that the expansion of health care practice into areas of life that were not previously defined as containing specifically health problems, seem not to be the doctors, the traditional targets of criticism on this score, but rather the nurse and other paramedical workers. Perhaps they have found that it is easier to expand into lay areas of expertise rather than challenge the doctors in the medical sphere. The health visitors' self-defined sphere of influence, for instance, seem to be rapidly expanding to encompass all of life; if health visitor have an interest in health and nothing falls outside the boundaries of

health as they define it, then literally 'by definition' their work can be all encompassing.

Advocates of the positive view of health tend to concentrate on an environmentalist approach. The environmentalist approach relates closely to the radical critique of health in relation to modern society. It emphasises that aspects of society that produces sickness can easily be associated with large-scale production. Advocates of this view envisage that all industrialized or technological advanced societies are generally detrimental to the health well-being of the human society. From this analogy, it is then given that every advanced industrial society is 'sick'. Obviously there are degrees of radicalism within this viewpoint and certainly the rejection of any nuclear technology seems to be a growing trend. However, the logical consequence of this view involves a reversion to a pre-industrial society and the rejection of high technology.

In another definition of health, (Cape, 1979) holds that health is a fundamental state of well-being that is periodically felt experience during the dynamic process of environmental interaction and personal development. By implication, Capel equates health with happiness. The implications of belonging to a profession dedicated to promoting happiness for all need further close examination before such a definition is taken up more widely.

One of the major problems would seem to be how 'happiness' or 'fullness of life' is to be defined and by whom? Michael Wilson defines the health goals as 'what a people believes to be fullness of life' (Wilson, 1975). However, in Nigeria today, we are not 'a people', we are divided in many ways: by class, by culture and by ethnic group, and we probably have nearly as many concepts of fullness of life as there are individuals. One man's fulfilling life-style is not necessarily another's and indeed the state already intervenes to prevent the adoption of certain routes to fulfilment, for instance a drug enhanced route is considered illegal by the community of civilized countries of the world.

A more profound problem, however, lies in the framework for individual activity laid down by the structure of capitalist society. If our current way of life demands that many people suffer unnecessary disease through accidents and stress, then the message of a health worker advocating a healthy lifestyle becomes either irrelevant or insulting. Indeed it could be argued that by urging the individual to adopt to prevailing conditions the health worker is reducing the likelihood of change in the level of disease-inducing factors in the environment. Thus the emphasis on 'positive' health will increase the necessity for 'negative' health care interventions.

In presenting the positive model, Travis (1977) present a Wellness Inventory that contain a self-administered questionnaire which readers can use to assess their wellness, and identifies the activities of life he

equates with high level wellness. Many of the elements of the questionnaire relate to obvious ways of avoiding disease. One section, for example, relates to physical activity and you score points for agreeing that 'I climb stairs rather than ride elevators.' Both Harrison and the World Bank (1993, 1987, 1994) present three key elements associated with concept of health. These include: the positive model, the ecological model of health and the model of health inequalities.

Under the positive model, health is seen as a positive concept, not merely the absence of disease. The positive model of health is rooted in the World Health Organization (WHO) definition of health as 'a state of complete, physical, mental and social well-being and not merely the absence of disease or infirmity' (WHO, 1946). This means that any ideal assessment of health, be it on an individual or collective basis, cannot be premised upon or restricted to measurement of mortality and morbidity. This is particularly so because measures of morbidity are very difficult to come by. It is also difficult because health itself is not a precise concept (Royal Commission on the National Health Service 1979) as noted earlier by Doyal in same year (1979).

One of the challenges this seems to pose is the difficulty to persuade all to accept the fact that there is more to health than death and disease. Medical staff and hospitals are not necessarily the major determinants of health status. Interestingly though, when people are asked to talk about

what being healthy means to them and what makes for a healthy community, they do not talk about the absence of disease nor about medical service they talk about well being, feeding, shelter, clean water, good roads, peace, sense of esteem, income etc (Harrison Paul and World Bank 1993 and 1987). This suggests that the problem is not so much one of educating the public, but encouraging them to trust their own initiative in defining and promoting health. This follows that, the health of any community should be assessed in terms of their physical, mental and social well-being or fitness as much as not more than, their mortality and morbidity rates.

The second model of health as listed by Davies and the World Bank is the 'ecological model of health.' This model recognize the fact that the determinants of health are multi-factorial, incorporating both physical and social environmental factors from the individual level, culture and global ecosystem. The model considers the determinants of health to be more than simply the provision of hospitals and medical services. Rather, health is determined by a broad range of public policies (including those aspects of private corporate practices that have public impact), where government is expected to continue to play the traditional role of enhancing health and well-being. Under the socio-ecological model of health, each local government or community ought to develop a systematic salutogenic epidemiology with respect to causation of good

health and assessment of the different determinants of health. The term 'Salutogenesis' is taken from Antonorsky (1984), who was searching for the understanding of why some individuals survive or remain relatively well in situations where others do not. He was interested in what he called salutogenesis as the opposite of pathogenesis. The most fundamental salutogens are of course basic needs such as food, shelter, clean water, a safe environment and peace. Beyond these basic human needs other salutogenic factors include social-net works, sense of self esteem, power and control over events and conditions of one's life, income, sustainable ecosystem etc (Davies and Kelly, 1993).

The third model as conveyed by Davies and the World Bank is that of 'inequalities in health' which are rooted in inequalities in access to basic prerequisites for health. Dealing with inequalities in health presents a number of problems for government. The first is whether data exist to document inequalities in health. The second and more important is whether government has capacity to implement measures that address inequality in access to basic determinants of health. Governments often have powers to confront some of the symptoms of these inequities, but they frequently lack the power to deal with the fundamental economic and social determinants underlying such problems as unemployment, inferior health care acquisition and inferior education associated with poverty (poor income). The larger determinants of inequity usually lie

with the private sector for which government may have little or no involvement. That notwithstanding, in equalities in health and inequalities in access to health can be documented and monitored and comparisons can be made between different government health plans, management of the plans and formulation of policies. The next subsection therefore will focus on reviewing the concept of management and its relevance and relationship with health service delivery.

(b) Emergence of Management of health services

i. What is Management?

According to Nwachukwu (1996), management is defined as “getting things done through others” It can also be more scientifically defined as the co-ordination of all the resources of an organization through the process of planning, organizing, directing, and controlling in order to attain optimum organizational objectives, goals meeting results (Nwachukwu 1996: 46). Therefore the main role of a manager is to plan, organize, direct, and control human and material resources (Rao and Naraweze, 1982)

What the foregoing definitions seem to suggest is that management enables the manager to evaluate the physical, human, environmental and psychological aspects of any job. The manager does this by linking and integrating the whole work processes. An example of a system is the

motor car. The parts are assembled in a manner to produce a unified whole. Every system is made up of sub-systems. For the system to function effectively, the subsystems must function effectively. In a general sense, the human being is a complex system made up of sub-systems, such as the circulatory system, the auditory system, the locomotive system and so on. These sub-systems are inter-dependent. When any of them fails to function effectively, the entire system experiences a severe setback. Therefore, the functions of the manager could be perceived as managing the system. A manager is to create and define the objectives of each sub-system and integrate the sub-systems. Failure to recognize this fact could make each system pull in the opposite direction and a common objective would not be attained.

ii. Management of health services.

This sub-section is an attempt to provide an overview on the concept of management of health services. This will be done by first getting to the root of the origin of the 'hospital' which is the prelude to evolution of medical bureaucracies and subsequently health management services in modern society:

(a) The 'hospital' in history as the Forerunner of Health Management.

Turner (1987), reports that the origins of the hospital lies in religious culture and religious needs. For example, many early hospitals were

places of rest and protection for pilgrims travelling to holy shrines. The growth and development of the modern hospital provide a significant illustration of the secularization of religious cultures under the impact of urban industrial capitalism. The history of hospital may be divided into three major periods. Religious foundations between 335-BC and 1550 AD, provided the basis for most hospitals in the early history of European societies. This period of religious foundations begins with the decrees of Constantine to close pagan temple and erect Christian hospitals and it closes with the collapse of monastic hospitals in the sixteenth century. The second period of hospital development was denoted by the evolution of charity hospital beginning with the foundation of the first charity hospitals in London in 1719 and closing with the National Insurance Act of 1913. Finally, the period of major expansion in the modern bureaucratic hospital was between 1913 and 1948 when in the UK the National Health Act came into operation.

Turner further stated that, the word 'hospital' derives from the Latin adjective 'hospitals' which relates to 'hospites' or guests. Other terms for the hospital include hospice and spital. This original meaning of the term is preserved in the notion of hospitality. The early hospitals were therefore general refuges or way-stations for those people who fell ill during religious pilgrimages. Hospital grew very quickly after the Northern Conquest in Britain when there was an increase in the volume

of pilgrims crossing the English Channel. These early hospitals were completely unspecialized and operated as open houses for the sick, the old, the poor and the infirm. A wide range of institutions in this period provided services for the poor and the sick. In addition to the hospitals for pilgrims there were alms houses, bed houses or Maisons Diue. Most monasteries had a hospitium at the abbey gate for travellers. Those institutions which tended to concentrate on services for the sick were called spitals or spittle houses. Between 1066 and 1550, approximately 700 such spitals were established in Britain; most of these were very small institutions catering for a limited number of patients.

The earliest form of hospital specialization was the development of the spital devoted to the service of those suffering from leprosy, known as lazar-houses. In 1078 a leprosarium was founded at Rochester and in 1084 Archbishop Lanfranc built a spital for lepers at Harbledown near Canterbury for the care of 100 patients. From these early beginnings, lazar houses developed rapidly in the twelfth and thirteenth centuries. As leprosy increased dramatically, many old almshouses were converted for the use of lepers. There was an increase in the number of statutes controlling lepers and these regulations included measures to prevent lepers from entering city gates. Leprosy began to decline after 1315 when there was severe famine, but the real termination of leprosy as a

significant disease coincided with the Black Death (1346-1350). There was therefore no new leprosy legislation after 1348.

Other forms of specialization related to the provision of accommodation for lunatics. St Mary of Bethlehem in London was founded in 1247 and became famous for its accommodation of the insane. Another highly organized form of hospital specialization was the development of the lying-in hospital for pregnant women. A statute which dates from 1414 acknowledged the reception of lying-in women as an appropriate aspect of hospital charity. Two great medieval hospitals in London (St. Mary-without-Bishopgate and St Bartholomew's) provided obstetrics and provided charitable support for children whose mothers had died during childbirth. In the nineteenth century the notion that a period of rest was required after labour became specific to middle-class women receiving the specialized attention of male doctors.

There is therefore a certain amount of evidence of hospital specialization around leprosy, lunacy and pregnancy, but these institutional developments were not extensive or based upon systematic knowledge. In general pre-modern hospitals were places of last resort where the inmates had a wide variety of illness which were not treated on a specialized basis. The aim was to provide care for patients rather than a cure and there was little professional development of nursing as a specialized occupation. These medieval institutions depended a great deal on

patronage and ecclesiastical support, since there was obviously no state provision for hospital care. Hospitals also raised money through such mechanisms as an annual affair or by charging admission fees. In some cases hospitals had the power to raise money or taxes from the local population.

Many of these religious institutions were dissolved during the Reformation by which time many of these religious hospitals had become corrupted by the abuse of patronage. In England many of these hospitals disappeared between 1536 and 1547 as a consequence of royal intervention in order to raise additional revenues for the monarchy. However the establishment of charity hospitals which developed in the seventeenth century were created for some what different reasons and by a different class of people. They arose from middles-class philanthropy rather than from a significant religious zeal for social reform. The new hospitals were patronized by a new class of renters rather than by rich merchants and capitalists. They were typically not supported by the church the state or by tax payers, but maintained their independence through the benefactions of individuals and they were often served by unpaid hospital accommodation. By 1798 nearly every country and large town had acquired an infirmary characteristically maintained by a private benefactor. For example, in 1719 Westminster hospital was founded by a group of London merchants. This hospital was quickly followed by Guy's

(1725), the London Infirmary (1734), the Middlesex Hospital (1746) and Bath Hospital (1737). Between 1743) and (12787) twelve major hospitals had been created in the English provinces.

These hospitals were primarily concerned with providing shelter to the homeless, the sick orphans and unemployed vagrants. Many of these hospitals were poorly ventilated, cold, unclean and overcrowded. Morbidity and mortality rates in these institutions were consequently very high, especially for young people and children. For example the London Foundling Hospital in its first few years of existence provided accommodation for approximately 15,000 children of whom only 4500 survived hospitalization. These charity hospitals were therefore not places where middle-class people sought cure or rest. They were largely dumping grounds for those who were unable to support themselves.

But interestingly formal specialization of hospitals began to be a significant feature of Nineteen century medicine when a number of hospitals began to specialize in the treatment of specific illnesses. For example, Moor field's Eye Hospital was opened in 1808, the Hospital for Diseases of the chest began in 1814, the Royal Ear Hospital was developed in 1816 and St. Mark's hospital for Cancer was established in 1835. These were followed in 1848 by the Victoria Park Hospital for Diseases of the chest, the London smallpox Hospital in 1850 and the Hospital for Diseases of the Throat in 1863.

Although there was a significant increase in the number of charity hospitals, it became evident that these institutions were unable to cope with the needs of a society undergoing rapid urbanization and considerable population increase. Furthermore, they were unable to cope with the numbers of dislocated, unemployed poor in the middle of the nineteenth century. The voluntary hospital system was also inadequate as a system provision in the context of large, mass warfare. Medical provision, training and knowledge were revolutionized by the Crimean war (1854-1918), the Boer war (1899-1902) and the First World War (1914-1918). Mass warfare demonstrated the fact that the male population of Britain suffering from a variety of disabling diseases, and disorders such as tuberculosis, poor eyesight, respiratory diseases, diabetes and mental illness. In addition, these wars demonstrated that the medical provision for modern armies was totally underdeveloped and ineffective. For example, during the Crimean war more men died (Donnelly, 1930).

(iv) Hospital Bureaucracies: As Prelude to Modern Health Management:

From the foregoing it is evident that the hospital is not only a crucial institution within modern systems of health care, but it is also symbolic of the social power of the medical profession. It also represents the institutionalization of specialized medical knowledge. The bureaucratic, centralized hospital system has a significant part to play in the training of

doctors and other health personnel. As an institution it controls the organized power of medical professions. It is the locus of contemporary political conflicts which are not simply economic, but ideological and cultural. The very existence of hospital is a significant statement about the structures of modern societies. In many respects, the hospital is a crucial illustration of Weber's analysis of rationalization and Foucault's concept of panopticism. The hospital as a professional arena of medical power illustrates many of the most fundamental processes of industrial societies: namely urbanization, secularization, the dominance of professional power, and the development of the service factor. (Larson: 1977).

As earlier seen, the hospital was an institution (the 'hospitium's), which emerged in medieval society, but there are a number of special features, which distinguish the modern hospital from its primitive origins as rest-stations for pilgrims. The development of the modern hospital and health management services is firstly associated with a major change in the character of disease in contemporary societies, particularly the shift from the prominence of acute to chronic illness. Secondly, the modern hospital has been transformed by the impact of medical technology on its structure and functions. Thirdly, the nature of hospital work has been trans-care. The consequence has been a sharp increase in the number of persons who are employed in such institutions. There is proliferation of new specialist

occupations within the hospital setting. The consequence of these structural and technology changes has been that the hospital increasingly resembles a collection of workshops (Strauss, 1985).

In addition, the fact that the hospital resembles a bureaucratic collection of work-shops, it has been criticized by a variety of writers. Some have suggested that the alienating environment of the hospital ward has a detrimental effect. Not only on the patient's capacity for recovery, but on their emotional well-being. While it is often difficult to provide an exact measurement of the quality of care within hospitals, there is considerable evidence of various forms of patient satisfaction with the formal and bureaucratic character of Medicare within hospital (Cartwright, 1983)

Following the bureaucratization of medical care, there has been a considerable discussion of whether hospitals conform to Weber's ideal type of rational bureaucracy. According to Weber (1979: 956), bureaucratic organizations consist of a number of structural dimensions. The structure of a bureaucratic organization consists of number of distinctive offices with specialized duties, which are formally defined. The authority structure of a bureaucracy requires that these duties should be performed in a stable and systematic manner. Officials within these offices are recruited according to general rules by competitive examinations and their employment is in terms of a system of salaries. The principle of office hierarchy is the basis for a line of command,

which is hierarchical. The official is expected to behave in a way which is universalistic, specific and neutral such that the bureaucrat does not question legitimate instructions descending from superiors. The public realm of rational conduct is completely separated from the private life of the official.

Weber also argued that modern system of management by bureaucratic offices presupposes the emergence of the modern state, a monetary economy and a universal education providing the basis for specialized training by competitive means. The modern bureaucracy also presupposes the development of a rational system of law which will provide a stable legal environment for the modern bureaucracy. Weber has often been misinterpreted. He has been criticised for arguing that the bureaucracy provides the most efficient means for the achievement of known organizational or societal goals and objectives. The essential part of his argument by contrast is that bureaucracy provides an enabling environment for stable management rather than efficient management. The bureaucracy form of organization guarantees that activities will be uniformly performed in a stable and reliable fashion (Parkin, 1982). Bureaucratic procedures are the opposites of ad-hoc decision-making by fiat.

Although the large complex bureaucratic hospitals have a number of features which conform to Weber's ideal type, it has been suggested by

many scholars that the modern hospital has a number of features which conform to Weber's type in a number of significant respects. Although the hospital has an administrative structure which is bureaucratic, the doctors retain considerable professional administrative power. The hospital therefore has a dual system of authority structure. While the first would consist of the governing body, the second is the professional group doctors (Goss. 1963). The hospital authority structure is obits around the difference between the rational bureaucratic system of administration and the professional autonomy of the medical doctors. Although the medical profession remains relatively autonomous, it still has space for the participation of auxiliary or Para-medical personnel and also regulated by non-medical institutions. In some circumstances, a private physician who may not be an employee of the hospital but a guest can be allowed access to utilize the facilities available within the hospital. Medical practitioners also enjoy considerable social status outside the hospital setting. In addition, their professional calling could in some circumstances outweigh to bureaucratic control and management (Georgopolous and Mann, 1972).

This dual system of authority can have problematic impact on some medical occupations such as nursing. This is because the nurse is subject to both bureaucratic and professional regulation. In fact, we could regard hospitals generally as structures involving various columns of

occupational prestige and authority versus the overall hospital administrative structure and control imposed by the board of governors. Given the competition between various professional groups within the hospital system, some scholars have suggested that the hospital system should be regarded as 'a negotiated order where professionals, administrators and patients are forced to seek compromise in order to maintain the day-to-day hospital duties and activities (Strauss et al., 1963).

The argument that Weber's ideal type of bureaucracy is an adequate framework for the analysis of hospitals has also been criticized on the grounds that hospitals, like other social institutions, generally develop an informal structure of authority and informal culture of inter-personal as well as group relations among both hospital administrators, medical doctors, nurses, other medical professionals and the patients. Blau (1963, 1974) argued that generally, social organizations are structured by both formal and informal patterns of authority structure and practice. The fact remains that the formal system of rules of an organization can never cover every eventuality. Over the years, the Sociology of Complex Organizations observed that a long period of interaction by social groups and individuals within a formal authority structure do lead to the emergence of informal systems. This may be functional for the continuity of some bureaucratic or formal organizations. Research on penal

institutions has however shown convincingly evidence that correctional agencies do develop informal structure of control to essentially maintain order. But such practices has ended up corrupting the bureaucratic authority structure of institutions like the police and prison (Sykes, 1956)

This approach to informal social structures was developed with great panache and success by Goffman (1963) in his study of hospital institutions. He noted that patients within hospital institutions develop an informal culture which functions as a survival strategy in an environment which is foreign and alienating. Studies of mental hospitals (Stanton and Schwartz. 1961) have shown that inmates wellbeing no matter what it takes from the informal mechanism it takes to enforce it, do lead to the stability of such institutions. These informal systems are not part of the bureaucratic character, but they are clearly significant in the therapeutic process, which is experienced by the patients. Finally, large hospitals have what Goffman refers to a backstage. By that he means that there are various areas, units and departments in the hospital that are not highly visible, but are organized by norms and customs falling outside the line of command required by the official bureaucratic structure. For example, the kitchen areas of hospitals constitute a backstage where the norms of the hospital may not be entirely appropriate or effective (Peterson 1981). Back -stages are places where “dirty work” has to be accomplished by low-status staff.

There are as a consequence various ways in which Weber's bureaucratic model is not entirely appropriate as a perspective or framework for the study of the model hospital. Research has shown that these institutions have multiple systems of authority and divisions of professional power which rule out the operation of a single line of command. The result is that hospitals are scenes of inter-occupational conflict and resemble negotiated orders rather than smoothly functioning machines. Para-medical professions and occupations in particular are subject to cross-cutting lines of authority which render their performance of tasks complex and frustrating.

The foregoing history of the development of the modern hospital in Western societies (Collins, 1986), shows that the hospital has been more or less a social vehicle that led to the rationalization of medical practice, specialization of medical knowledge and the division of health –care systems into specialized units. The reform of the hospital system throughout Europe was an important feature of late nineteenth century medicine and laid the bases for the evolution of modern medical science. The 1960s were years during which the majority of industrial societies extended hospital reform and reconstruction. By the late 1970s, the period of rapid development had come to an end and the contemporary period had begun.

From the foregoing we have seen that a variety of criticisms of the hospital as a health care institution point toward alternative systems. This explains why rationalization and reform has always proved very problematic even in advanced industrial societies. There is wide area of consensus that health care reform can and do achieve results. In reviewing the problems of health planning and management, Rodwin (1984) identified three primary explanations for the barriers to health care reform. In the first place, health care is not just a state of affairs which lends itself to rational technology and systematic planning of administrative structures. Health management in terms of hospital bed / population ratio is not like the concept of economic productivity; this is so because, health is not a unitary –phenomenon but a highly elastic socio-medical phenomenon. Because there is no genuine agreement as to which criteria would be appropriate in the politics of health, achieving rational objectives and applying contemporary management strategies have proved to be elusive.

Consequently, health reforms are often difficult to be achieved because of the clash of interests between physicians, administrators and consumers. In particular, the professional monopolies in the health sector have clear interest in maintaining their control over the hospital and health system, thereby blocking any attempt to achieve reform. This makes the institutionalization of professional and career ‘management services’ in

health sector very difficult and sometime impossible with attendance adverse consequences of poor performance in the health sector.

2.2.1. THE MANAGEMENT OF HEALTH CARE ORGANIZATIONS IN LESS- DEVELOPED COUNTRIES:

This subsection introduces the discourse on the state of management services focussing on less developed countries to which Nigeria belongs. For the purpose of this study the review will be limited to only two countries: New Zealand and Nigeria.

According to Muthumala (1989), many areas of management, organization and delivery of health care services in the developing world, has been the responsibility of under-trained generalists. In most developing countries, health care delivery systems are managed by physicians trained in settings that provide little support for or experience with management of resources or people. Whereas other sectors attract those with management training and interests, the health sector is often seen as the “private preserve” of the physician. One response must be, the development of management tools that incorporate good management science which are pragmatic for the management of health care resources in developing countries.

Senior leadership within the health sector includes insufficient numbers of individuals with experience in dealing with issues of finance, planning and large-scale resource management. As a result, many health service

delivery systems in developing countries have been characterized by major problems of inefficiency and inappropriate resource allocation. Since such problems occur in conjunction with inadequate and, for many countries, shrinking overall resource levels, they result in more limited access to care, poor and deteriorating general health conditions, and continued lost opportunities to contribute to improved social and economic development. The need for strengthening national management capabilities is increasingly being recognized by developing countries as a key requirement for improving these circumstances.

One solution to the problem of inadequate management has been the support of increased formal training opportunities in management and, in some countries, in health care management as a specialization. Some efforts in this direction are already evident. The potential benefits to be derived from improvement in the management of health resources are considerable. In almost every developing country, the inefficient management of existing resources serves to limit and constrain the ability to organize and manage the resources that are already in the system. Therefore, strengthening existing management services by the creation of appropriate system for managing health care resources is a major challenge to developing countries. The subsequent sections shall attempt to discuss this state of affairs in a more brother details, by drawing specific examples from New Zealand and Nigeria.

(a.) HEALTH CARE SYSTEM IN LESS- DEVELOPED ECONOMIES – THE CASE OF NEW ZEALAND AND NIGERIA

i. NEW ZEALAND

A report on the New Zealand's health system (1987) and Rosenthal (1990, 1997), posited that that, history shapes all systems and that the New Zealand's health care system is strongly rooted in the past. The independence of the early, mid-19th –century colonial settlers led to health services that were locally funded and man-aged. The elected hospital and more recent area health boards are vestiges of this historical approach. Government resisted funding those but provided certain residual services, such as lunatic asylums, maternity hospital, and public health measures. Many, though by means all, of values and mechanisms in the system derive from the United Kingdom.

There has always been a tension between the national and regional levels, over both funding and control. Proposed reforms calling for more centralization have been strenuously resisted. Members of the medical profession in private practice have tended to seek to retain professional independence and have resisted the several attempts to integrate general practitioner care with the public health service.

A number of epoch-marking events in the history of the New Zealand health service, is discussed below:-

PUBLIC HEALTH ACT, 1900 AND THE HEALTH ACT, 1920

These provided an adequate framework for public health for the central administration of New Zealand's health services.

SOCIAL SECURITY ACTS 1938

This legislation sets a basis, not only for welfare activities, but also for health. The act envisaged a publicly funded system of health care available to all at no direct charge to the patient. Clearly, this would be a costly system and the proposal was one that the medical profession found difficult to accept. What emerged in practice in the 1940s was a compromise, but still a work- renowned achievement.

Government and local government (cities, counties, boroughs) jointly funded the complete cost of hospital care. Subsidies were provided for private hospital care and primary care services. The latter, to the 1950s and 1960s, were sufficient so that price was not a barrier to anyone's receiving the service of a general practitioner or other primary care. The general practitioner's role was, and remains, important as a gatekeeper to other health services.

THE HOSPITAL ACTS, 1957.

This act introduced virtually 100 per cent funding from government to hospital boards. The local government share of hospital cost was eliminated. Tightened central controls were introduced at the same time.

CONTEXT OF THE HEALTH SYSTEM IN THE EARLY 1980s

In the early 1980s the health service could only be described as fragmented, ill managed, and lacking in real policy directions. This was due more to a lack of political resolve to address identified problem than to inefficiency. Inflation had eroded the relative value of key primary care subsidies. To politician, that funding difficulty as well as structural imbalances seemed impossible to remedy in a climate of inflation, reduced overseas earning, and the rising oil prices of the 1970s

Thus, at the start of the 1980s the Department of Health provided “ public health” and other services (environment, public health nursing and school dental services) through district health offices. Private and voluntary agencies, general practitioners, and others played a large role in providing a variety of services (from private hospital to community pediatric and family service). Many of those were, and some continue to be, government subsidized through a plethora of funding mechanism with little local coordination. Locally elected hospital boards provided hospital and some community and ambulatory service and were virtually 100 percent government funded, the Department of Health retained significant but often counterproductive controls over the activities of those boards. *In practice, political action by the boards usually had more of an influence on decision making than did the bureaucrats.* Special pleading was a significant way of doing hospital boards business and was effective at gathering resource.

This picture of fragmentation, poor linkages, and therefore, low accountability for efficient and effective result was for decades a major and unremedied fault of the health system in New Zealand.

To describe New Zealand's health system fairly is very difficult in a single dissertation. The problem mentioned above need to be balanced against the more positive aspects of the system. The public hospital and health services provided by the board offer comprehensive and very professional treatment services. No one in New Zealand needs to be concerned about receiving the best possible attention for emergency care or for major interventions such as cancer therapy or renal dialysis. And the services are provided free. Heart bypass and transplants, renal dialysis, and kidney transplants are provided but liver and heart/lung transplants are not available in New Zealand, and patients are referred overseas, mainly at their own cost. New Zealand has one lithotripter and has invested in MRI (magnetic resonance imaging), and adequate investments in CAT scanning have been made.

As hospital and specialist outpatient treatment is free, there is the inevitable corollary of waiting lists. In some areas and specialties they are too long, but the problem is being addressed in a variety of ways. Alternative delivery systems are being actively developed to provide cost effective care. Well developed community care programs are evolving to promote health, delay admission, and facilitate early discharge. As a

consequence, New Zealand's services are becoming innovative and, from a policy perspective, are being pushed in the "right" direction.

The private hospitals in New Zealand have a role to play in specialist surgical services. That surgical role is now almost totally unsubsidized by government, except for accident compensation payments. The sector is not large and is experiencing some financial difficulties. Long term care of the large and is experiencing some financial difficulties. Long term care of the elderly is the major role for private hospitals and that service attracts a safety net subsidy from government. New Zealander's long term "nursing home" and hospital care are both funded and reasonably managed. Geriatric assessment and rehabilitation units ensure that the elderly maximize their potential. When augmented with other services, such units are very effective in keeping the elderly in their own homes or ensuring placement in the most appropriate environment.

Mental health services, including those for the intellectually handicapped, are provided by areas health boards and a limited number of voluntary agencies. The delivery mechanism, philosophy, and approach regarding these services are all under current review. The major weakness to be upgraded is in the areas of forensic mental services and community support for those suffering from mental illness.

In general, the hospital sector has maintained more beds than are necessary for patients and significant improvement in efficiency are possible. The political and social frameworks, as well as the incentives, are now better ordered to make gain in this area.

Public health services are well developed but have taken the brunt of some fiscal pressure. Some areas of public health activity are under intensive review to reduce the number of agency involved and to pin down accountabilities. With the pressure to decrease funding and the lower public health risks due to past efforts, there is a risk that the ever-clamoring treatment services will force inappropriate cutbacks in funding and activity. The balance is tenuous, and the advocates for public health are politically less powerful than are the advocates for special interest groups pressing for increased treatment services. That has tended to occur in recent allocative decision and must be more carefully considered in future.

Primary health care services, though reasonably well provided, are subject to some geographic imbalance. The sector operates mainly on a fee for service basis, but considerable government subsidies are also provided. A significant voluntary sector is involved in primary care, as are some service provided and funded by government, for example, school dental nurses and district and public health nursing. The general practitioner is the key, or gatekeeper, to most of the health system. The

serious worry is that the patient co-payment is now an area of concern to the are health boards but they are unable to influence change readily because, responsible, and largely well regarded by its clients. The Government has tried to redress some of the access problem by increasing the subsidies to general practitioners for children, the elderly, and other beneficiaries.

Payments for pharmaceuticals that were once free are now subject to modest co-payments, and a form of safety net has been provided for the chronically ill and disadvantaged.

SIGNIFICANT REFORMS OF THE 1980s

The major reforms of the health service in the 1980s and 1990s in the New Zealand have been financial, structural, and philosophical

POPULATION BASED FUNDING

Hospital expenditures account for the largest proportion of government health expenditures, or nearly 70 per cent of total health expenditure. The local boards were able to mount political campaigns to receive funding additives. Typically, the new hospital syndrome, or “cathedral complex” was a way boards showed they were progressing and national –level politicians would also gain some glory as a result. Inevitably, the capital costs were high, and there were no constraints on local spending levels, as cost were met by the central government, not the board. In addition, the building usually had new or increased service that would lead to a case

for more operating funds. Having funded the building government could not leave it lying idle and so was forced to pay additional grant to increase local services as well.

Boards that were able to play the system did well- either because their case was well presented or their political pull was well directed. Other board did not do so well because their political acumen or the local political color was not appropriate – even though the priority may have been high. Financially prudent boards did not gain any reward for excellent result: the fruits went to boards that were resource hungry. The result was that, when measured by population any other objective proach, there were massive distortion between the grant that should nominally have been applied to particular board and their actual level of funding. So both service provision and financial resources were over provided, and other parts of the country were poorly served and under resourced.

The 1960s and 1970s had seen virtually all government hospitals (psychiatric and maternity) brought under hospital board control. There was an urgent need to apply a fairer system and one with better fiscal control. The objective was a more rational distribution of hospital funding and, therefore, of services than that which had resulted from the continuation of the previous pattern of irrational block funding.

After a detailed review of several system of hospital funding, one based on the RAWP (resource allocation working party) methodology of

England and Scotland was introduced in 1983. It was dictated on the principle that hospital funding should be related to the size and characteristics of the population served. The formula provides a theoretical funding level for each board, which leads each year to reductions for those whose actual level of funding (according to the formula" national level) is too high and to entitlements for funds for those that (according to the formula) are underfunded.

The system has led to a fairer distribution of fund among boards and to an objectivity that counters most special pleading. Boards are also required to produce service plans if they want additional funds. Although the plans are mixed quality, there is at least a frame work by which to consider service and their relationship with other sectors.

AREA HEALTH BOARDS ACT, 1983

After a decade of discussion, study, and self – examination, the then National Government passed legislation with the purpose of integrating public health and hospital service at the local level. The area health board was formed following the amalgamation of the hospital board and what had formerly been the district office of the Department of Health. This new area health board was to coordinate the provision and planning for the local health service. The idea behind this reorganization was that comprehensive health services could be provided for the same amount or less than before – the premise being that prior to the advent of the area

health board, services were duplicated, fragmented, and poorly coordinated. Therefore, gains in efficiency could be expected.

Ergo, a better balance between curative and preventive medicine and wiser choice through a health reorientation involving more self care Community based care and service coordination would achieve a better bang for the health buck. Coordination across the sector is to be achieved through service development groups, which involve the private and voluntary sectors in the planning of services. Public consultation is also vital to the planning system.

Persuasion is the only device provided to area health boards to work with the private and voluntary sectors. No other leverage is designated. Government commitment to the proposals was initially so muted that hospital board were under the legislation the initiators of any move to an area health board. And until 1989 no effective time target or pressure was applied to achieve a national network of area health boards.

Despite these difficulties, the concept of the legislation nevertheless has merits, and now that the full network of area health boards is established, it is expected that the legislation will be very effective

STATE SECTOR ACT, 1988

This act provided significant reforms in government department and the health service. Its objectives were to provide better management and

accountability throughout the system. Substantial changes were enacted that placed the state and health sectors much closer to private sector management and industrial practices. It removed many of the trappings of the old stultified public service and introduced fixed term contracts and performance assessments to improve accountability. *It also gave managers more power to run their business effectively.* Interference from separate control departments, appeal system, and so on was eliminated.

For hospital and area health boards the changes were significant. The triumvirate approach to management at all levels of their service (sometimes referred to as the wobbly stool) was removed and clear lines of accountability and authority were provided. *The act has a profound impact on boards and on the role of management within the health service.* Above all, it has signalled that government intends that the health service will be managed and has provided the tools for the purpose. New roles at the interface of board and management have had to be sorted out, not always with early success.

A PERIOD OF GRAPPLING AND DEBATE

As the Labour government moved quickly with its reforms of the economic sector and non –social service government activities, it became obvious that the social sector, too, would be the subject of reform. After the re-election of the government in 1987, this was

specifically signalled in various of its statement of policy and intent.

Several reports were commissioned:

- Health Benefits Review, 1986
- Hospital and Related Services Task Force, 1988
- Royal Commission on Social Policy, 1988

The backdrop to the report was the debate over the future economic and social policy of the country. Was it to adhere to the tents of the early Labour party (Social Security Act of 1938) and provide a universal system, largely publicly funded? Or were New Zealanders to become reliant on the government in social welfare and health and move toward less government spending and more targeted service (a safety net approach)?

Most New Zealanders and the health sector as well, feel that the last word is not yet in on this matter. As a result, an climate continues to exist. That unease is likely to remain either until the 1990 election are over and/ or until more coherent policies on the health content of the government's no fault legislation and on primary health care are put in place. Until that occurs, there will continue to be doubt as to whether government can afford its policies.

The unfortunate rub to the Government of New Zealand was how it, decisively tackled difficult and endemic problem in all sectors of the economy. For until the economy recovers, it is unlikely that the resource

needed to achieve the government's goals in the social sector will be available. Economic recovery for New Zealand is determined as much by external as by internal forces. The external brick in the necessary economic foundation is not totally in their hands a fact that the electorate may, or may not, recognize.

HELEN CLARK'S ADMINISTRATION, 1989

Helen Clark was appointed minister of health in early 1989. As already mentioned, a number of reports analyzing the health service, as well as comments on those reports were available to her. Each report contained recommendations and offered a similar diagnosis, but there was little consensus as to cure. In characteristic style, Helen Clark carefully considered options, sought separate opinions and advice, and prepared her own demanding but thoughtful agenda.

There was very quick action as far as major initiatives in the health portfolio were concerned. The list that follows it by no means exhaustive.

1. There was a review of board boundaries as to size and district composition. Legislation to give government, rather than boards the initiative in creating area health boards was passed. By the time of the October local elections (which included area health boards), a defined network of area health boards (fourteen in total) was in place. They were operative as of early December 1989.

2. The composition of the area health boards was amended by reducing the permitted number of elected members and allowing the minister of health to appoint up to five board members. The purpose of this strategy was to supplement the skills needed on a board, not to appoint party hacks.
3. Capital funding was devolved to area health boards effective July 1, 1989. This means boards are able to control their own destiny for capital purposes, without having to jump through central government hoops to get approvals.
4. The New Zealand Health Charter, Health Goals and Targets, A Contract for Area Health Boards- a package of Health Charter material –was released on December 15, 1989. Particular health goals and targets are clearly defined. The underpinning philosophy of the health sector is clearly set out, as are equity issues and protections for the respect and dignity of patients. The future direction of the service and its accountabilities are clearly specified.

Minister of Health Clark identified a number of important areas when the New Zealand Health Charter was issued, as follows.

For the first time, area health boards are operational nationwide.

[They] are charged with promoting, protecting, and conserving the public health, for providing health services, for ensuring effective

coordination balance in resource use between health protection, promotion, education, and treatment.

Through integrated management at the area health board level within a national policy framework, it is hoped that the health system can be more clearly focused {on our principal objective which must be to raise the overall health status of New Zealanders. We have a much better chance of achieving [that] objective if we have clear goals and targets. Without such goals and targets all we have are good intentions.

Given that health services are not managed at the level, not only do we have to set goals, we also have to be clear about the appropriate relationships within the system which will enable it to achieve the goals.

It will be the individual area health board's responsibility to manage and plan within its region. However, if the New Zealand health service is to achieve national goals and targets there must be both leadership and coordination within the system to ensure that we are all heading in the same direction. There needs to be more national leadership on what we are trying to achieve and local responsibility for determining how we should achieve it.

The main principles set out in the charter are:

- Respect for individual dignity, patient rights, and informed consent
- Equity of access

- Community involvement in the planning for provision of health services
- Earmarking a greater proportion of health resources to health promotion and disease prevention
- Resources that are used effectively

Each of the health goals included in the charter addresses an important cause of death, disease, or chronic disability. The major criteria used in selecting the health goals were that the target was amenable to measurable change through some known strategy and that the target addressed one of the current important causes of premature death, disease, or chronic disability.

Each of the board goals set out in the charter has defined targets that are both clear and measurable, these goals include reducing smoking; improving nutrition; reducing alcohol consumption; reducing the prevalence of high blood pressure; reducing preventable death and disability due to motor vehicle accidents; reducing hearing loss in children under five; reducing disability and death from asthma; reducing avoidable illness from coronary heart disease and stroke; reducing the incidence of invasive cervical cancer and the cervical cancer death rate; and reducing the incidence and death rates of melanoma. Obviously these goals do not constitute an exhaustive list of what the health system should

achieve over the next ten years. There are many other causes range of treatment service must be maintained.

Associated with New Zealand Health Charter and Goals and Targets is a pro forma area health board contract. The principal purpose of the contract is to improve the level of accountability of the area health board to the founder – that is, the government. The contract and charter together set out clearer relationships and provide a system of negotiation and review that will lead to increased equity and effectiveness. On the one hand, the Department of Health and the Minister of health are obliged to state what is expected of area health board in return for the funding provided. On the other hand they will require health boards to reorient to the charter and its related health goals and accept responsibility for working by themselves and with other agencies toward improving the health status of their communities.

The ambiguities that existed previously have been largely eliminated, and the planning and management activities of the boards will now be focused. In addition, a transparency for accountability reason is provided – both to central government and their communities. It is not an enforced compliance with central dictates that is mandated. Rather, room is left for carefully thought out local variations. The contractual relationship and the review of performance associated with it are both based on a concept of continual improvement, not one of audit. *The objectives has been to*

provide necessary room to move and to preserve management incentives within a frame of accountability and national planning.

THE CONTEXT FOR MANAGERS IN AREA HEALTH BOARDS IN NEW ZEALAND FROM THE 1990s.

As can be deduced, management was not particularly highly valued in the New Zealand health service prior to 1988. The management function was less necessary as the health system became accustomed to funds additives that made up any extra costs incurred. As wages and price increased, an automatic increase was made to area health board grants. Since productivity never had to be traded off in wage settlements, managers were protected in large measure from resource realities. With the expected fiscal savings, principally by service adjustments at the margin, by attempts to find efficiency gains, and often by a more intensive rationing of services.

As of 1988 the law required that general managers be appointed. They now have clear responsibility for managing all aspects of the board's service. That same year brought a new initially largely disbelieved approach to funding. Whereas earlier governments had severely constrained expenditure, they had also always provided virtually full funding for inflation. In 1988, inflation funding was not provided at full value, and about 2 per cent had be absorbed by boards.

The new general managers were truly in the front line as gains in efficiency were sought. The government indicated that it did not wish the reductions to be manifested in service cuts. Unions were faced with an entirely different negotiating stance from this group of managers. The managers therefore sought a low or nil settlement to wage claim made in 1988 – 89. Without that, they would have had to finance the settlement room service – and government was looking for efficiency gains. Managers were thus caught between a rock and a hard place and the need for low wage settlement and the attendant likely industrial action, on the one hand, or insuperable difficulties in quickly finding efficiency gains to fund the costs of wage increase from existing budgets, on the other.

In the end there ensued strikes of unprecedented scale but of short duration and a low settlement was reached – on average a little over 2 per cent as compared with 15 per cent in an earlier year (but that was a catch up following the wage freeze). The trade off to gain this result was an industrial protocol that required *General Managers* to consult with unions over future restructurings the first glimmerings of industrial democracy. It should be noted that almost 100 per cent of area health board staff were members of a union, even specialist medical staff, who were employed either full or part time. Those on part time salaries usually also work in the private practice.

Unexpectedly, the severest test of general managers has been to negotiate low wage settlement with workers (in New Zealand an annual or more regular event) because of government funding policies and, predictably, to deliver improved services from a budget that is not being adjusted for wage or price movements. Accountabilities within the system, including the application of various control measures, were also tightened during 1989. The minister of health made plain to boards what she and the Department of Health expected in financial budgets and reports. This was a quantum upgrade from the level of reporting and accountability previously required. It would however, be a good lead in to the new contract arrangement. Pressure was maintained to ensure that financial reductions in health service made in response to fiscal pressure were reasonably obtained from efficiency gains not just service cuts. No additional funding was provided to meet cost increases during the 1988.

There is little doubt that management was seen as a vital element by the then Government of New Zealand in the delivery of health service. Government turned to management principles to bring about a more efficient service. It seeks to introduce accountability and management excellence throughout the service. Coupled with this approach was a clear reorientation of health service toward health measures and coordinated, integrated planning and operations, concentrated on health status needs and priorities. One can therefore see how important the area health

boards' general managers were in a national health system that relies on boards for bulk of its health service delivery. The other vital link is national planning and effective system to lead the area health boards and other agencies long an appropriate course, *while holding them to account on grounds of both efficiency and effectiveness.*

However, the new general managers faced the following environmental pressures as they consolidated their jobs:

- The expanded operation involves both treatment and public health service (a total shift to health concepts, away from treatment imperatives only) and management responsibility for the whole of the board's operations.
- The managers were forced to be the major players in attaining bottom line objectives set by boards and monitored by the Department of Health that have a pincer effect: lower real funding coupled with a demand for improved, better ordered service at about the same overall level of services as previously.
- They were required to reshape their organization for the new purposes outlined above and to spread the principle of unity of command throughout their organizations.
- Improvements must be made in informed consent. Patient advocacy and individual dignity issues. Managed care is a clear

reality, and these development demanded good relationships with clinical staff.

- New Zealand, like most Western countries, was facing an increasingly aged population, with the increased burdens on the health service that it brings.
- Disciplines such as the National Health Charter and the accompanying documents required considerable effort and rethinking of priorities.
- There was uncertainty as to the fiscal resources that will be made available in future years. Boards did not know their actual budget level for a particular year except, when the government's budget is released. Boards could not make any firm nor forward planning, and by law they had little or no ability to raise any significant revenue themselves. An impending round of wage talk increases the level of uncertainty – and insecurity.

The expectations of general managers were high. They operated in a very volatile (not just a turbulent) environment. Although they faced considerable odds, they had several advantages in their favour:-

- *As the direct employer of the work force the general manager were therefore able to manage it effectively. General managers were able to offer incentives to key staff group and member (staff welfare).*

- The management role can be seized, and board and government encouraged to deliver adequate policy guidance. Most newly appointed board member saw and understood the need for this and were supportive at board level.
- Accountabilities issue were very clear.
- *Medical and other staff member had no independent direct access to the board so that a pure management model has emerged.*
- The contract between the minister and the area health board was a two edged sword. The national level was forced to be realistic about resources and deliverable.

Clearly, the managerial skill needed to cope with the demanding and volatile environment were considerable. Therefore, generalist health management trainings were established in New Zealand in order to develop the paragon of management virtue in the health sector. Examples of such included:-

UNIVERSITY COURSES IN HEALTH MANAGEMENT

DIPLOMA IN HEALTH ADMINISTRATION (MASSEY UNIVERSITY)

This is a distance learning (extramural) course offered at the postgraduate level. It provides a background in management issues for health professional and in health planning and health issues for managers/administrators.

DIPLOMA IN BUSINESS STUDIES HEALTH MANAGEMENT (MASSEY UNIVERSITY)

This program provides a business focus for health employees who are graduates from non-business disciplines. It offers option in various aspects of health management. It is provided on a distance learning basis.

DIPLOMA IN COMMUNITY MEDICINE (OTAGO MEDICAL SCHOOL)

This diploma is a multidisciplinary course but accepts mainly medical graduates. The course has residence requirements and supervised experiential work. The course has been successful in supplying a good work force of graduates in community medicine. Some management subjects and electives augment the usefulness of this course.

OTHER COURSES/TRAINING OPPORTUNITIES IN HEALTH MANAGEMENT IN THE NEW ZEALAND.

In addition to the management training programmes listed in the preceding sub-section, the recruitment of staff with broader management degrees from universities, industry, and government departments was also encouraged. Those individuals then learned the necessary health knowledge and skills through experience and training. Similarly, a number of health staff had to undertake courses in general management, finance and so on in order to broaden their skills base.

Job experience and supplemental courses were often provided for the staff of area health boards. In designing such courses, management-

training staff try to focus on gaps identified in work force education for management and health.

In 1987, the Department of Health again recognized the need for a more organized national approach to training and foresaw what was then identified as a gradual need to move boards away from the triumvirate management style toward general management, or the principle of unity of command. (That move came quicker than expected in the form of the State Sector Act, 1988) It was decided in 1987 to fund and establish a Health Service Management Development Unit to reorganize and coordinate existing approaches such as the then junior management training program and ad hoc courses run by the then existing training bodies. Its other major task was to establish a senior level course that would build relevant competencies in very senior managers.

Two staff experienced in overall approaches to both senior and other training program were recruited from overseas to undertake this task. The brief given was to provide an experience based training program for senior and potential managers to train them for a management role in the New Zealand Health Service.

The Health services Management Development Unit that emerged was desperately needed due to the shortage of available university courses in health management. Though the unit can handle only relatively

small numbers of candidates, it is nevertheless adding to the pool of trained staff and improving management networks.

NEW ZEALAND INSTITUTE OF HEALTH MANAGEMENT

The New Zealand Institute of Health Management is the major health management professional body. Its mission is to provide and promote quality health management. To achieve this end, one of their objectives is to “focus on and promote health management skills and education in health management issues.”

The institute which started operations at both a national and local level, had approximately over six hundred members throughout New Zealand in 1989 alone and with the aim of increasing this to thousands in subsequent years. *At the national level, a program was begun in 1989 to facilitate the continuing professional development of health managers, hence the course name Continuing professional Management Development (CPMD).* It was designed to involve members in a process of self – appraisal in their management positions by providing mentors and encouragement to develop further. An additional objective of CPMD is to have certified health managers. The certification indicates that the individual is involved in continuous managerial and professional development. It was hoped that the majority of institute members will soon be involved in this program.

The institute also compiled a directory detailing what was available for the professional management development of its members in terms of courses, further qualifications and other training opportunities. At the local level there were programs for members that included invited speakers, workshops, videos. All of these were designed to address topical or relevant issues in various areas of health management in the health sector.

In conclusion, this review has brought out some information on the health service of New Zealand on its strive to provide high –quality health service. New Zealanders being an innovative breed, took to the management challenge in the health sector with a gusto that augured well for them with substantial success. The New Zealand health service moved and shifted from ossification to action.

In analysing the progress of the health service of the New Zealand, the documentation shows a correlation and similarities between the development of the New Zealand’s health service with the Nigerian experience in the following respect:

This is with respect to the stages in the organization of health services and approaches to health management, health planning, budgeting, and programme implementation. Other similarities include the following:

Both New Zealand and Nigeria, gained independence at about the mid 19th century; they both had public health acts enacted by the colonial

governments in the 1920s and their first post-colonial health act and policy respectively in 1988. Both New Zealand and Nigeria attempted to institutionalise health management services and introduced specialised health planning and management training courses in the 1990s etc. The truth is that, most of the developing countries seem to have similar developmental experience which is made manifest in the development of the health system in New Zealand and Nigeria. They therefore need to be opportunistic enough by sharing the experiences towards creating a conducive environment in the organization and management of their health sectors for optimal performance. We shall look at Nigeria in more detail in the next sub-section in order further appreciate the issues under review.

(b) THE CHANGING MANAGERIAL ROLE OF PHYSICIAN EXECUTIVES IN NIGERIA AND MANAGEMENT TRAINING NEEDS OF DOCTOR AND ALLIED HEALTH PROFESSIONALS.

For a proper understanding and appreciation of the perspective in the management of the health sector in the developing world as seen in the case of New Zealand and as concluded in the last sub-section; this sub-section is on some of the salient areas on the Nigerian experience compared with the New Zealand experience. This is being done for emphasis sake and for better appreciation of the issues under review in this dissertation.

In doing that, it will be important to first seek to have a proper understanding of the changing managerial role of physician executives in Nigeria who are the surrogate managers of the health sector in Nigeria. In discussing that, it will also be logical to begin with a discussion on development of medicine in the Nigeria state.

MEDICINE AND THE STATE IN NIGERIA

According to Alubo (1995), the origins of Western (also known as allopathic or “orthodox”) biomedicine in Nigeria relates to European voyages of discovery during which malaria inflicted heavy scourge on the explorers. The introduction of medical Education in Nigeria began in 1930 with the establishment of Yaba (Lagos) Medical School. The school was modelled after a similar school in Dakar, Senegal (1918). The Yaba Medical School ran a three – Year programme to train doctor for the indigenous population. Its graduate received a licentiate in medicine and were regarded and treated as inferior and earned lower salaries than, those trained abroad. This discrimination was a major incentive for further training, which was only available, overseas. Consequently most Yaba graduates ended up in Medical Schools in Britain.

In addition to Yaba, which eventually became the University of London College Hospital was opened in the Western City of Ibadan in 1952. Unlike Yaba, this school ran a five year post “ A level course and

awarded a combined Bachelor of Medicine, Bachelor of Surgery, MBBS, of the University of London one of the then much priced overseas degree. There are now over 16 medical Schools in Nigeria all of them publicly owned. There are in addition to the basic medical school postgraduate specialist training available in Nigeria through the National postgraduate Medical College (NPMC) and West African Medical College (WAPMC). Most Nigeria doctors are perhaps until recently, mostly employed in the public service. Traditionally the public service is the dynamic arm of the state for the execution of its policies and the public workers its privileged “ service”: The doctors and on several occasions insisted on maintaining control over a whole range of issues from health policy to medical education and to government particularly in managing the health sector. The ultimate objective of doctors is to assert that no health policy would be implemented without their information and consent. As the perceived custodians of public health, Nigerian doctors have advocated, and sometime opposed legislation construed to affect health or their professional status and autonomy. Doctors do this knowing fully well that medicine is a powerful weapon. For example doctors ever demand to maintain an edge over the other salary earners, such as pharmacists, lab Scientists, nurses etc: because maintaining professional dominance in the health sector requires among other, higher salary for doctors, leverage on the policy making machinery

to the exclusion of other health professionals. This conception invests power of conferring health leadership on the physician and thereby ensures professional dominance and materialism which is now an aspect that is affecting the role and status of doctors in the overall national economy. Medical doctors are becoming more engaged with parallel activities other than medicine for the sake of materialism. Probably some of them are dissatisfied with their earnings from clinical practice.

With respect to the changing or emerging role of physician executive in Nigeria, the changes are more glaring in the unrestrained new managerial role now assumed by medical doctors in Nigeria. To the extent that there is yet a census or lack of consistent nomenclature regarding the designation of physician or medical doctors who have assumed administrative or managerial responsibilities. Sometime the term *Physician Executive* is used as a surrogate to designate the “*Physician Manager*” who is either full- time executive with no clinical responsibilities or the clinician executive who may be both full time administrator and full- time clinician. This new role assumed by the medical doctors in Nigeria and elsewhere is in contrast to previous believe that Physician executive have no role in general management and confined to clinical practice. In practice, medical doctors lived in state furnished houses segregated from the ordinary citizens and enjoyed high income in addition to other fringe benefits peculiar to them.

During colonialism, doctors enjoyed special privileges as, they were next in status, to the regional governors. They earned higher salaries than other categories of civil servants, an advantage they relatively maintained to date. *This and other historical privileges for the doctors have always made them to distinguish themselves from other workers and resisted being equated with other public or civil servants.* Their sympathisers are with the ruling class and the bourgeoisie; some of them in fact come from these backgrounds. To a very large extent medical doctors in Nigeria as an occupational group are a potential petite bourgeois.

This unique location of doctors as a category within the political economy in Nigeria is best understood in terms of their changing income and status perception in the public service. Doctors and or medical Executives in Nigeria, are the kingpins in the health care system. Whose power now extends to other areas. It is now accepted without question that to be employed or stand trial medical certification is often required, when these erstwhile function of other institutions are added to the medical, doctor's power is apparent.

Doctors/ Medical Executives are Senior Staff in the public service along with other Universities graduates in Science, Education, Engineering etc.

Whereas all are senior staff, the salary levels differ. The case of the medical doctors is a reflection of the major a normally of the inherited salary gabs between them and other occupational groups, although the

original gap have been slightly bridged over the years. This gradual relegation of doctors status in terms of salaries and position is one of the major attempt to bring doctors to level up with other professionals, *unlike in the colonial days, when the most senior doctor deputized for the governor. But to day, the highest paid doctor has no place in the protocol list in the political structure.* However; doctors through their strong association, have sought to influence policy legislation and always demand for political and administrative changes. They have voiced concerns and on several occasions insisted on maintaining controls over a whole range of issues from health policy to medical education and governance particularly in managing the health sector. The ultimate objective of doctors is to assert that no health policy would be implemented without their information and consent. As the perceived custodians of public health, Nigerian doctors have always advocated, and sometime opposed legislation construed to affect health or their professional status and autonomy.

But this trend is on the reverse, because materialism is now affecting the role and status of doctors in the context of the overall national economy. Medical doctors nowadays in Nigeria are becoming more engage with parallel activities other than medicine for the sake of materialism, this has in turn affected the elitist respect they have always enjoyed before now. The doctors now dabble into general management away from the primary

focus of concentrating on medicine and medical staff issues. This has brought increased attention to the emerging and exaggerated importance of physician executives in health care organization in Nigeria and elsewhere.

For an example, in the Nigerian teaching hospitals, the head doctors are called Chief Medical Directors, in some private clinics and hospital establishments they are called Managing Director, or Medical Director. If, as it seems, physicians executives are becoming increasingly important in the management function, it would be important and necessary to understand more clearly the nature of the administrative roles physician (medical doctors) are carrying out and how these roles are likely to remain or change in the future. A major issue that requires attention in this respect is the lack of consistent nomenclature regarding the designation of physicians who have administrative responsibilities in Nigeria, who at the moment are given different names. The second issue that will also require urgent resolution is to address the issue of management training for doctors or physicians so that they can effectively assume managerial roles when the need arises. The way to approach to this issue forms the focus of discussion in the subsequent sub-section.

MANAGEMENT TRAINING NEEDS OF MEDICAL DOCTORS

Management is important in organizational setting because of the cardinal objective to ensure that goals are attained. The idea of mission statement

can only be met through effective and efficient management (i.e. effective and efficient planning), with the view to achieve common purpose of setting up the organization. Ideally the corporate goal of an organization should take precedence over those of employer and employees. In that wise the health industry where medical doctors are employed should not be different either. If that is true, it means that the inadequate knowledge of methodologies of management by medical doctors that are occupying management positions in the health sector will have far reaching negative effects on the performance of health care organizations.

The health care sector is one of the few sectors that has in the last three decades in Nigeria had series of work and job designs in an effort to increase productivity in the industry. This is more evident in the 1988, 1995, and 1997 civil service reforms agenda. This is because when specific tasks are given to specific group of people, there is the tendency that certain degree of specialization is attained that would allow the task to be done more properly than when it is generalized. Thus the idea of productivity improvement and accomplishment of purpose in the management of Health care Organizations takes the trend of Specialization and professionalism.

The structure of work in the Health Care organizations also reflects the growing pattern of movement where medical doctors become more and more involve in management service. But the issues of adaptation of

medical doctors to the new dispensation of management roles also come to play. Some doctors are conservative and employ medical approach to management. This is not always effective for the management of health services as health care organizations need to respond to the dictates of the larger environment. The implication of this is that medical doctors will require management training in order to properly fit into their emerging managerial roles in the Nigeria health sector or industry.

The term management training will apply to educating medical doctors who are prospective managers, in the techniques of planning, organizing, staffing, directing and controlling the operations of their organizations. The training will also consist of basic information on major functional areas of an organization, namely, entrepreneurship, accounting, marketing, personnel management and administration. *The medical doctors require such training because management is not a precise science and is not restricted to a specific group, so there is nothing wrong in training medical doctors to become effective managers.* But unfortunately while the conventional medical Curriculum is oriented to personal relationship between doctors and patient, it does not contain much in the way of management of any sort. Therefore, it is obvious that medical doctors require management training.

In addition to the foregoing, the medical doctors need management training because of the following obvious reasons: -

1. Many issues originally considered as health concerns have evolved into development issues and as such doctors may need some training on how to deal with issues that have to do with management of human and material resources.
2. Medicine and management are not the same, therefore doctors will need management training even to understand basic medical planning and how to handle the resources available in their clinical practice.
3. Generally, all professionals at certain periods may find themselves in positions where they will have to manage resources; human material etc and will require training in order to be more effective.
4. Medicine is a highly technical and scientific skill, while the art of performing medicine requires management skills, especially for those vested with position of heading health institutions. Such doctors will need management training in order to enhance their performance.
5. Medical doctors need management training in order to facilitate job mobility as they grow in their career to become hospital administrators, Departmental Heads and Executive Directors etc and will need adequate management preparation for this management positions inside and outside of the health sector, especially now that more and more Nigerian medical doctors are

becoming more involved in political affairs; emerging as local government council officials, legislators, governors ministers, etc Even in the civil service some are now permanent secretaries a position that was hither to preserved only for professional administrators or the management specialists, commonly referred to as management generalists in Nigeria.

6. The hospital environment is a workplace, so for things to work properly doctors who are the most senior cadre in the hospital environment require management skills in order to enable them handle situational management problems at least for the fact of handling patients on a regular basis.
7. Medicine is an undergraduate training and at this first level of training no adequate management topic in the doctors training Curriculum, even the continuing education packages for doctors lacks management content. The technical skills of medicine are not sufficient for good management; the medical doctor will need to attend management appreciation courses even if they seem to be doing fine in the management positions assigned to them. There will still be great room of improvement if formal managerial training is given to them (Iornem, 2001).
8. Doctors become private practitioners, and will require management skills in order to effectively and efficiently run their

private outfits. These outfits are run on commercial basis and the doctors will need to generate enough earnings and profits in order to sustain the private outfits.

9. Some medical doctors end up not practicing clinical medicine and move to other professions and therefore will need management background in order to be flexible to adapt to changing work environment. There are medical doctors who have left clinical practice and are pursuing businesses like, consultancy, medical equipment suppliers, general contractors, politician etc. such doctors will need management background in order to fit in into human development fields and activities.
10. Most physician executives enter their management roles after having only a significant exposure to the health care system through clinical practice, so they will certainly need formal managerial training.
11. The management training needs of medical doctors cannot be over emphasized because a combination of clinical management and general management skills will produce major successful medical executive or physicians executives for the betterment of the health sector.

The above are some of the reasons why provisions should be made for strengthening the management capabilities of medical doctors which is

very critical towards improving the management of health care organizations where doctors are by the existing structures on ground are at the helm of affairs (Attah, 1995).

What the proceeding discussion has revealed is that, management education programmes need to be developed for clinicians (and also for non-clinicians as well) especially those who find themselves in the position of managing health services. The training module should include coverage of such topics as health policy and legislative relations, negotiations, the role of Health Care Organizations in the community, communication, public relation, practice of management. Knowledge and skills in these areas should be able to increase the effectiveness of the medical doctors in internal and external and environmental relationships as they assume the role of managers in the Health Care field and other sectors of the economy which are becoming more and more complex everyday.

SUMMARY /CONCLUSION

In summary, what this sub-section has established is the fact that, managing hospital and health care businesses have persistently continued to pose great challenges to both medical practitioners and employers of labour. *It is increasingly being realized that medical expertise alone does not guarantee sustainable hospital management and management of health care services.* Because managing such organizations involves full

fledge planning, effective business management skills, balancing of social responsibility with profitability and sound financial decision making which are the core of any good management system.

It is therefore the conclusion in this sub-section, that there is more similarity in the generic role of medical doctors and management than expected that less managerial tasks might discriminate against them.

Therefore the managerial skill they require should not be underemphasized: they too require management training like anyone else.

The training will empower them and will also avail them the opportunity to conduct their management functions effectively (Block, 1988). Nigeria just like the case of New Zealand has been committed to manpower development strategy, which saw the establishment of some management training institutions and bodies from which the health sector personnel (i.e. medical doctors and other health staff) have benefited. According to Onah (1984) and FMOH (2004), such institutions and bodies include the following:-

- i. The Nigeria Council for Management Education and Training (N.C.MET) established in 1972
- ii. The Center for Management Development (CMD) 1973. was established in 1973 as an operational arm of management education and training.
- iii. The Industrial Training Fund (ITF)

iv. The Administrative Staff Collage of Nigeria (ASCON) established in 1973 had similar mandate with that of CMD

Institutions of higher learning and management consulting organizations

V. The University of Nigeria,

Faculty of Business Administration – This faculty aims to pride students with fundamental training in important aspects of business and governmental organization and Administration control . See 1970-73 calender pp 2-31.

Vi. University of Lagos

Faculty of Business Administration -1973-1974
Calender ;p74

Vii. Ahmadu Bello University –ABU 1969 -70 Calender p105

The Institute of Administration ,Zaria founded in 1954 was incorporated into Ahmadu Bello University in 1962

Viii. The University of Ife –Unife calendar 1968-69 p140

Offers Post graduate diploma course in administration and in addition offering an

M. Phil in Public Administration and MBA

ix. Yaba College of Technology : Prospectus 1973-74 p.8

x. The Ibadan Polythecnic- 1973-74 p.1

Professional bodies and consulting firms

Xi. The Nigerian Institute of Management

Professional Associations(These organizations attempt to inject professionalism into management Education in Nigeria). The examples of such include:

Xii Institute of Chartered Accountants of Nigeria(ICAN)

Xiii Institute of Bankers

Xiv Institute of Personnel Management

Xv Nigerian Institute of Management (NIM)

Xvi Nigerian Institute of Public Relation(NPR)

Xv Nigerian Marketing Association(NIMARK)

xvi. Nigerian Institute of Management Consultant (NIMC)

xvii. Certificate in Health Planning and Management- Introduced in 1990
in the following Universities: Benin, Maiduguri and Ilorin in
in collaboration with the University of Hull, UK.

The Masters of Health Planning and Management programme also came
on board in 1993 at the Universities of Benin; Maiduguri and Ilorin
(Attah, 1993).

All of these have similarities with what was seen in the case of New
Zealand and help in establishing bases relevant to this research.

2.3. EVOLUTION OF MODERN HEALTH SERVICES IN AFRICA AND NIGERIA

This subsection is divided into two main parts: the first part will focus on
an overview on the emergence of health services in Africa from the 10th
century, while the second part will centre on Nigeria which is the focus of
this study.

2.3.1. OVERVIEW OF HISTORY OF HEALTH SERVICES IN AFRICA FROM THE 10 CENTURY.

How did modern health service emerge in Africa? To answer that we
need to look at how health services of any commenced, and this is most
be easily understood chronologically. This is reviewed as reported by
Shcram (1996).

The Period of Exploration from the 10th Century.

Arab and other Middle Eastern people traded, explored and crossed different geographical areas of Africa at an earlier period than Europeans. Islamic medical concept spread widely from the Red Sea to the Mediterranean and the Atlantic and through and around the Sahara. This occurred between the tenth and fifteenth centuries, and from then until European trade routes were established around and along the coasts, Islam spread deeper onto West Africa across the 'Soudan' around the Great lakes of East Africa and down the east coast to Zanzibar.

The dominance of the Omanis and the Ottoman Empire led eventually to the acceptance of Islam in vast areas. The depth of this acceptance was increased by a series of religious movements, and war for example: Sultan Bello' s Jihad in West Africa, the Madhist movement in the Sudan and the extension of the dominant of the Sultan of Zanzibar over a long coastal strip of Kenya and Tanzania. The slave trade across the Sahara, the Red Sea and the Indian Ocean played an important part as did the Trans Atlantic trade when Europeans joined – not only in the health of the slaves but also in the removal of fit, young people from providing health care themselves in their own lands.

Did this massive Muslim movement and new religion play a part in the health of the public? We must ask the same question of the impact of the captains of the Portuguese ship of King Henry the navigator and their

new religion. Roman Catholic Christianity. Although in general the answer is clearly yes in both cases, the total health impact on traditional ways of keeping health is not easy to assess.

After all, neither the Koran, nor the Bible nor some Jewish writings (which were already circulating in Ethiopia and North Africa) were read at this period by more than a few mallams, priests and senior officers on expeditions. Most people were not literate, neither were most sailors, bearers or camp – followers. Nevertheless, since Christianity had swept across North Africa from Israel during the first to sixth centuries, and from there up the Nile to Ethiopia, and since Islam had displaced Christianity every where in that region except for some Coptic Churches in Egypt and Ethiopia; fundamental changes of practice and attitude to health had taken place.

Personal cleanliness, the avoidance of infection through dietary and ritual abstentions, the care of livestock and the use of medical treatments all had a real effect. Early travellers from Europe immediately noted the improvement in personal hygiene and the cleanliness of clothing of the population who accepted Islam. Much later missionaries of Christianity noticed the same effect on people who accepted that faith. It was a great pity that this sometime meant the temporary loss of tradition styles and designs – but this is fast being recovered in the 20th century. It is obviously impossible to describe the change of lifestyle and health

practices brought about by these two major faiths in a few paragraphs but they must not be minimized and both taken seriously however, were very advantageous.

The early explorers – Portuguese, Spanish, Dutch, Danish, Syrian, Lebanese, Greek and Arab had some drugs to offer, but these were only of limited value. After the fall of Rome. During Europe's Dark Ages and the Golden Age of Islam, classical learning and early scientific knowledge, which had grown so splendidly in ancient Athens and Rome, was preserved in Arabia, Persia, Iraq and Egypt. Islamic medical ideas, which spread to India from Persia were known as the Unani system. Christian and Hebrew scholars fleeing from Europe were welcomed in Muslim lands, including African ones. After the Renaissance in Europe they returned to Italy, Spain and the Balkans together with Arabic professors, to the new universities of Padua, Cordova, Montpellier, Naples and Milan. *Thus the site of the earliest medical school, that of Alexandria in Egypt in the eighteenth century again became a centre for the reinvigoration of medical knowledge that was now on its way back to the continent of Africa.*

Although familiar with many herbal treatments and many complex prescriptions involving metals, salts and other chemicals both Christian and Muslim healers introduced a lot of superstition into Africa. Incantations, exorcism and many models of eliminating curses or ill –

fortune were little in advance of ancient Babylon; and many African people of animist background would have found little difference in these ideas from their own practices. Then again, while there were licensed medical practitioners on slave ships their technical expertise was at the level of encouraging bleeding, purging and overdosing with calomel and other dangerous drugs – *practices frequently more dangerous to health than total neglect*. Drinking a cup of washings of ink, which had been used to write prescription on wooden boards (the prescriptions being Koranic texts) was at least innocuous. *With the recovery of scientific freedom in the west it proved to be the development of western medical care that now became significant*. As the Portuguese ships undertook longer voyages, away from the coasts and from any chance of obtaining fresh food and drink, scurvy caused heavy loss of life among their crews. The assembling of crews by press – gangs in ports led to rapid spread of infection among the unwashed, drunken men, who had then to live in appalling conditions in which typhus frequently occurred.

To counter these evils, James Lind experimented successfully with improvement on boards royal naval ships on which he was a medical officer. He introduced *quarantine, washing uniforms, training exercise, deck washing the provision of hammocks* (his best known achievement) and a small, controlled trial of dietary additions to cure scurvy in which he proved that those given citrus fruits recovered. Although he rose to

become medical superintendent of the great naval hospital at Haslar, Portsmouth, he did not succeed in convincing the admiralty that the crews of British ships should be given oranges Lemons or limes routinely – a reform later established by Gilbert Blane.

Lind travelled in the coast of West Africa and recognized that fever was more likely in those sailors who slept ashore, but he did not realize that this was due to mosquitoes. His reforms were adopted by Captain James Cook, and consequently only one sailor was lost on Cook's many great exploring voyages in the Pacific, in sharp contrast to those of da Gama or Magellan,

When European explorers set out they were well aware they might not return. Apart from the risks en route to the cost, once they landed they faced yellow fever, malaria dysentery (as they of forest were non – immune) and possibly starvation, especially if they had to cross deserts or immense tracts of forest. There were wars and loss of supplies or bearers, who not infrequently left them if Slaveraider were close. Some lost confidence in their ability to return home. A few explorers of note were medical men perhaps the best know being Mungo Park on the Niger, sir John Kirk and David Living stone on the Zambebezi the Great Lakes, the Shire and the Lualaba. These three were Scotsmen. They contributed to the abolition of slavery and the slave trade by stirring up opinion in Europe with their report journals, books and letters and by addressing

public meetings and scientific societies when they were back in Europe, packing huge buildings such as the Albert Hall and Exeter Hall. *But only Living stone made any real contribution to medical progress.*

Thanks to the Explorers River system were identified and mapped and trade began in earnest. Soon, foreigners came not only to trade but also to settle in gradually increasing numbers some to exploit the great natural wealth of Africa in timber, tin, gold, diamonds, tungsten, copper,bauxite, sisal, coffee, tea, palmoil, cotton and cocoa, As the miseries of the slave trade died away, these new industries developed, and Africa's resources were exported to the Western powers in exchange for clothing consumer goods, firearms, machinery and for all too long a period – cheap strong spirits. Europe nations vied with each other to sell to these huge new markets, ushering in the colonial era.

In the early phase of their competition, Portugal, Denmark and Holland featured most prominently, though Africa in their eyes was but a series of forts and harbours en route to Indonesia, India and China. In the late nineteenth century the nations most involved were Britain, France, Germany and Belgium. *Arab and Indian influences declined and in 1884 these European power sat down at the Berlin Conference to draw the map dividing out their spheres of influence, regardless of the people involved.*

THE IMPACT OF MISSIONARIES ON THE DEVELOPMENT OF HEALTH SERVICES IN SUB-SAHARAN AFRICA.

Before turning to the effects of trade, foreign settlement and colonial government on health in Africa the missionary movement deserves closer attention. *Medical and nursing staff from missionary societies were willing to live in remote areas. They began training schemes for African staff earlier than anyone else.* They were particularly enthusiastic in their approach to schemes of rehabilitation for the chronic sick and disabled – notably those suffering from leprosy, polio and eye disease and in relief work amongst the orphaned.

Although, Dr David Living stone was the first to achieve international fame, Drs Brunton and Greig worked among the Susu in the border country between Sierra Leone and Guinea in 1798. Living stone was also preceded by African doctors – Dr John Macaulay Wilson of Freetown and Dr S.F. Magill of Liberia. Wilson qualified about 1795 in Edinburgh and Magill in New Hampshire, USA.

Two other Europeans preceded Living stone in South African. Dr Jean Prieurdu Plessis, a French and Huguenot a physician set up in practice around 1660. By 1799 a Dutch ex-army doctors, Johannes van der Kemp, came in later life to South African and gave simple medical care to a group of freed slaves at Graaf Reinet, helping both Hottentots and Zulus, despite much opposition from his own country men who were Boer

settlers and already infected with the apartheid philosophy. The London Missionary Society sent him at the time of the French Revolution; so he was disliked on two scores: being accused of being a revolutionary and of being pro – British! He died there after a life devoted to religious and medical effort, *eccentric possibly, but forward looking in his liberal attitudes.*

Drs Wilson and Adams, two Americans were in South Africa in 1834, and Dr Fliedner was in Egypt a few years later. In 1841, Dr Illott of the Church Missionary Society was in Sierra Leone, and Dr GK. Prince of the Baptist Mission in Fernando Po and the Cameron's. That year Dr John Abercrombie founded the Edinburgh Medical Missionary Society. Through its work and that of its medical students were given hostel accommodation under medical wardens who had long experience abroad in India, China or African, together with travel grants and support in their mission calling. Today these societies also help medical students who wish to do their electives ' abroad.

Living stone's best known achievements were geographical. He discovered several of the Great Lakes – Ngami, Malawi (then called Nyasa) and Bangweolu. He surveyed the course of the Zambezi in a grim, determined effort that dragged on for years in a state of ever weakening health to discover the source of the Nile. He did in fact trace Lake Tanganyika and the Lualaba tributary of the Zaire made three attempt to

get his boats up beyond the Kebrabassa rapids driving his faithful companion John Kirk nearly to despair.

His geographical exploits were momentous. He mapped accurately with relatively simple instrument and detailed notes of flora and fauna with exemplary patience. He walked or rode an ox over 29,000 miles in African. Opening up routes to the east and west coasts in Angola and Mozambique. He made it possible for other to undertake future missionary expeditions without having to walk up from the south. He got on well with almost all the people of the many tribes and nations that he met, although he had not much success in leading fellow Europeans. He inspired great devotion among his personal friends two of who carried his body back to the coast at Zanzibar, after his death at Chitambo's Kraal in Zambia.

He was also exceptional as a doctor. He was one of the firsts to make use of a clinical thermometer Describing malaria in man and sleeping sickness in animals accurately, he was able to quinine prophylactically long before any other Europeans with the exception of the Portuguese from whom subcutaneous injection becoming the first doctor ever to do so. He described tropical ulcers, onchocercal worm in the eye, scurvy, schistosomiasis (which he though was due to iron in the water) and maggot- fly boils and recognized that mosquito swarms and malaria fever went together, but did not establish the link (this awaited

the work of Major Ronald Ross in India). He was unusual as a missionary in that he got on well with herbalists and witch – doctors and exchanged ideas and drugs with them.

In complete contrast, Dr Robert Law perhaps Livingstone's most distinguished successor, settled in one country, Malawi. After a brief stay at Cape Maclear on Lake Nyasa (Malawi), he established a first – class group of institutions at the northern end of the lake – a printing press, a trade school, school a teacher training college, a clerical polytechnic and a hospital. He worked there from 1875 to 1934 and named the place Livingstonia. He introduced chloroform to medical practice in central African. His iron – hulled steamer, the *Ilala*, could be dismantled. Taking advantage of this he surmounted the cataracts and eventually got the steamer onto the lake and up the Zambezi and Shire River – something Livingstone could not achieve.

Another doctor James Stewart also created what might be termed a missionary college campus by the founding of Lovedale Institution in South Africa in 1867. The various Scottish missions, well described by Michael Gelfand (1964, 1984), attracted a wealth of unusually capable medical missionaries such as Kerr Cross, John Chisholm, Walter Elmslie, Mrs. Fraser, George Prentice of Bandawe, Mac Vicar of Blantyre, Henry Scott and Awilliam Afflect Scott, all rerouted in the period 1880 to 1905, by which time 13 hospital and 16 dispensaries had been build in Malawi.

The Universities Mission to Central African (now the United Society for the Propagation of the Gospel) was created in response to Living stone's appeal from Cambridge. The first party led by Bishop Mackenzie was wiped out by malaria. Mary Living stone returned to Africa and also died of malaria, and their only doctor Dickinson, died and was buried beside the Shire River. The mission returned to Africa later but this time based on Zanzibar Island, and eventually a Dr Robert. Howard opened Likoma hospital on the Island in Lake Malawi.

Although not medically qualified, a few other explorer – missionaries became important to the delivery of health care in that they opened the way for others: Dan Crawford and Fred Arnot of the Christian Brethren filled that role in Angola, Zaire and Zambia. Dan Crawford worked for 22 years in the bush without home leave. Francois Coillard, a Frenchman employed by the Paris Evangelical Missionary Society, was another. As a result of their work, hospitals such as Kalene in Zambia where Dr Walter Fisher and Dr Julyan Hoyte worked came into being.

Stanley's letter of 1875 to the Telegraph in London recounting the welcome missionaries would receive attracted another Church Missionary Society group led by Alexander Mackay. They walked from Mombasa in Kabaka's capital in Uganda where Mutesa I welcomed them. But Albert Cook only replaced their doctor John Smith, having succumbed to dysentery en route in 1897. He founded Mengo hospital and lived all his

working life in Uganda. When Cook arrived although there were three government medical officers, Ansorge, Moffatt and Macpherson, no hospital had been built. From the first in the primitive mud and thatch hospital he had built. *Cook wrote clinical notes of unusual detail on every in patient. These notes are still preserved in the library named after him at Makerere University Medical School (Foster, 1970 1979) and are still being used in research.*

Working together with the matron, Miss Katherine Timspon, whom he married, he saw in the next few years the growth of health centers and maternity home throughout Buganda. Twenty-one at the peak, these closed by 1974. The centers and homes were exceptional in they came into being so early in the twentieth century, employing midwives and nurses trained by Miss Milnes – Walker at the school at Wamulonge. The government later employed these girls, being the first in the country to be trained. In the subsequent demand for dressers in the First World War, secondary school boys from King's College, Budo, proved themselves so effective that in 1917, Cook his brother Jack and Dr Schofield began training medical assistants at Mengo.

Major Keane and Captain Tombling described the value of the Africa Native Medical Corps in the East African campaign in a book (Keane Tomblings, 1921). Cook's Mengo medical school' took such training further and this was merged into the government medical college based

upon Mulago Hospital in 1922. *Makerere University, founded in 1924, eventually took over this school and after a period of Special Relationship with London University and the University of East Africa, awarded its own medical degrees (accepting all those qualified from 1950 on wards).*

The Church Missionary Society also sent out Drs Pruen, Praeggar, Baxter, R.M. Gaskoin Wright and R.W. Felkin. Felkin published an atlas of disease distribution and was therefore an early medical geographer. It was not until 1975 that a similar work was published (Hall and langlands, 1975).

There were of course many more missionary societies other than those mentioned here the Sudan United Mission (SUM), the Sudan Interior Mission (SIM) and Nigerian Baptists were especially important in West African (Schram, 1971). West and Central African and the African Inland; and African Evangelical Fellowship in Central and South African. These beginnings illustrate the achievements of medical missions in the early decades of the twentieth century, following on pioneering efforts by a handful of women in the last twenty to thirty years of the nineteenth century. All put up dispensaries, a very few started health centers, many more erected maternity homes, and most commenced hospitals in mostly small district centers. One of their most useful attributes was that they trained nurses, midwives, dressers, assistants of all kinds and

occasionally, even something approaching health visitors (public health nurses), physiotherapists and radiographers.

At first, for many decades there was no government recognition. But in the 1970s when even major international health agencies such as the World Health Organization (WHO) and the United Nations International Children's Emergency Fund (UNICEF) recognized the need for training auxiliaries at a massive scale the pioneering role of missions began to be appreciated outside the church circle in the 1940s and 1950s government grants in aid for such training were becoming available in many countries, and later the entire cost of training schools was virtually met from this source.

Within the space of 30 years Christian groups of diverse faith had built up a rural health service in many countries in the southern parts of west African, in a broad belt stretching across the continent from Gambia and Angola to the Sudan and Ethiopia and also down the east coast to Kwazulu and Ciskei in South African. They had very little work in North Africa and almost nothing in the whole Sahara regions. Spanish Africa was almost devoid of medical missions and French Africa had some but they were fewer than in British areas.

Most Catholic work developed in Belgian, Portuguese and British areas. Some societies and their staff were small, unheard of and unfamiliar even to other Christian groups and certainly unknown to colonial governments.

Others such as Dr Albert Schweitzer of Lambarene on the river Ogowe in Gabon were world famous. Schweitzer came from Alsace, then Germany and was in addition a distinguished musician and exponent of Bach's organ music and a doctor of the theology. His work and writings attracted many visitors and inspired more than one generation. There are almost as many books about or by him as there are Living stone (Brabazon, 1976). It should be added that at the close of his long life (he was 90 at his death in 1965) he was subjected to some criticism for keeping conditions primitive in an age impatient for advance. *Strangely, the 1980s recognized the need for simple health care with a level of appropriate technology, which avoided excessive cost, as correct. Nevertheless the hospital at Lambarene was built and still continues his dedicated work.*

The first doctor with Presbyterian mission at Calabar in Nigeria was himself a descendant of slaves, the West Indian Dr Archibald Hewan, who worked for 11 years from 1855. The Church Missionary Society (CMS) also encouraged two Nigerians: William Broughton Davies, a Yorubaman, and James Africanus Beale – Horton an Iboman. They were educated at Freetown, and then studied medicine in Britain Davies and Beale – Horton had remarkably similar careers. Both gaining their MD in 1859 and entering the medical service of the British Army of the Gold Coast, where they rose to the rank of Lt. Colonel. Beale-Horton was the better Known as he several books, one of which concerned public health

precautions for expatriates in West African. He was a Leader in political thought at the time as well.

Clyde (1962) describes the career of Adrien Atiman, a Catholic West African who qualified in medical at Malta. He was encouraged by the white fathers Mission. Atiman joined the mission work on the shores of Lake Tanganyika, working there for 40 years. He was decorated successively by the Germans, the Belgians and the British. *Another Catholic, the French priest Jean Coquard, who had instruction for only one year as a medical student before entering the priesthood, built the first general hospital to open its doors to Nigerians, the Sacred heart Hospital in Abeokuta. (Lagos General Hospital was opened earlier, in 1887, but was then only a naval hospital for British sailors.)* Conquered arrived in 1890, built the hospital by 1895, and later added a leprosy hospital. He taught himself how to do major surgery and this was recognized in his obituary in the West African Medical Journal in 1933, where he was obviously regarded as close to the medical establishment.

The first hospital to open in East Africa was Mzizima on Mombasa Island, built by the CMS. *By 1905 there was a small Christian Dispensary in the home of Dr Walter Miler (another CMS pioneer) in a wholly Muslim city, Zaria in Nigeria (Miller, 1936). In 1927 when Dr Bullen and Max Warren (later general secretary of CMS) came, this was enlarged to a hospital in the suburb of Wusasa. After independence when*

the Pediatrician Dr Ishaya Audu, a graduate of University of Ibadan and Kings University, London, became Vice – Chancellor of Ahmadu Bello University, a close link between Wusasa and the medical College was developed.

Dr C.F. Harford, a colleague of Dr Miller who was invalided with black fever after three years in northern Nigeria, opened Livingstone Medical College in Britain with the assistance of Patrick Manson. This center helped to give training in simple tropical medical care to lay missionaries for more than 60 years. The Missionary School of Medicine, Great Ormond Street, continues to run courses in the 1990s.

Two remarkable women, both Catholics, illustrate the capacity of the voluntary sector to forward public health as a whole. Mother Kevin, from Eire arrived in Uganda in 1902. She was responsible for the opening of hospitals at Masaka (1903), Kisubi (1905) and Nsambya (1906). Angal, Naggalama, Tororo, Kitgum, Lacer, Aber and Iganga, she died in 1958. Little wonder that the affection with which she was held the Ugandan church to request that her body be re-buried in Iganga after having been flown out from Dublin.

Anne – Marie Javouhey, a nun on the Island of Goree, off Senegal left her convent in 1819 and began nursing on that Island and mainland, assisting in the reform of the hospitals at Bathurst and Freetown, 30 years before Florence Nightingale did the same at Scutari in the Crimean war.

HEALTH CARE IN AFRICA DURING THE ERA OF COLONIAL GOVERNMENTS (PRE-INDEPENDENCE).

As colonial governments began small group of officials set out for the shores of Africa to attempt to govern vast tract of land inhabited by many people of different backgrounds, cultures and religious beliefs: different not only from those of Europe but from each other. *Some colonial statesmen, such as Lord Lugard, evolved a means of peace – keeping and method of government working through traditional rulers – often those who had been at one time very powerful leaders of old empires, such as the Kabakas of Buganda, and chiefs and emirs in Nigeria (the Dual mandate).* Guided by district officers, they were recognized as local authorities within the British Empire under the sovereignty of Queen Victoria. Others like King Leopold II ruled through men who were totally autocratic and often also cruel. This was true of certain early trading companies. Later every where was taken over by more responsible metropolitan government. Each European regime had its good and bad point's genuine successes and gross mistakes. Many of the officials who stayed a lifetime learnt the customs and languages of their hosts and did a great deal of good that has not been forgotten even today. *Some regimes were military in character, particularly those from France and Germany and this was reflected in the character of the health services, and public health legislation. A first class military health service*

was evolved in French Equatorial African (Gabon, Chad, Congo Central African Republic and the Cameroon's), and another in French West Africa (Mauritania, Mali Guinea, Ivory, Coast, Upper Volta, Senegal and Niger) based upon the key centers at Ouagadougou, Bobo- Diolasso, Dakar and Bamako.

Large numbers of French doctors graduated in the military and navel academies of metropolitan France and served their whole lives in Africa, bringing clinical, surgical and public health skill of a high order to bear on the tasks before them. Under men like Colonel Eugene Jamot in 1920, mass surveys for sleeping sickness detection and treatment were set up, and these were later expanded into a service known as SGHMP (Service General D' Hygiene Mobile et Prophylaxis) covering smallpox, malaria onchocerciasis, meningitis, leprosy, schistosomiasis and trachoma. Of the six major endemic diseases sleeping sickness is the crucial in the Africa public health. In 1724 Atkins described it in West African and Winterbottom improved on this description clinically in 1803 Winterbottom's criterion being the swollen gland of the neck noticed among slaves (Winterbottom's sign). In 1901 the parasite was first noticed in human blood in the Gambia by Joseph E. Dutton of the Liverpool Tropical school with Todd Dutton started it study the foci of the diseases on both banks of the Zaire River near the Atlantic.

Starting in 1896, it spread right up this enormous river basin, and half a million died of it before 1905, In 1899 the Belgians set up a laboratory in Kinshasha and invited a commission from Liverpool to study the disease. Some of the recommendations of that commission worsened the situation. Large trees were felled instead of bush, and the enforced isolation and quarantine of sufferers led to the disease being concealed. The major emphasis was the use of the newly discovered drug, an arsenical called atoxyl This was partially effective, but control by treatment alone proved unsatisfactory.

In 1908 the Fonds Elisabeth pour l' Assistance aux Indigenes du Congo Beige, which later blossomed into a widespread tropical disease control network based on district hospitals.

Further trypanosomiasis centres were now set up to continue the work, which had already begun, was reflected in the character of the health services, and public health legislation. African Institute for Trypanosomiasis Research at Kaduna in Nigeria. The most notable of these workers in East Africa were Dr H. Lyndhurst Duke, E.M. Warrington – Yorke, A. Kinghorn C.F.M. Swynnerton EE Austen (author of a large work on tsetse) and J.F Corson and Africa Drs H.M.O. Lester J.L. McLechie and the entomologist T.A.M. Nash.

Some ideas which assisted the growth of the Medical Field Units and Sleeping Sickness Service in Nigeria were taken from Belgian and French

scientist when Johnson visited Jamot. Just as French doctors worked and interchanged between two main Zones (French West and French Equatorial Africa,) so British scientists covered British West, East and teams relied upon mass treatment and the British on tsetse fly reduction or elimination; though such a comparison is an oversimplification.

High quality trypanosomiasis work was also carried out by the Portuguese in their colonies; in particular da Costa's control measures on the Island of Principe and their work in Guinea, Angola and Mozambique (Azevedo, 1974; Egerton 1957).

When de Gaulle recognized the independence of the French territories, Upper Volta, Benin, Senegal, Niger, Mauritania and Mali joined in a fresh central organization, the Organization de Coordination et de Cooperation pour la Lutte contre les grandes Endemies, and many of its doctors were recruited in France as they still are today. At Bobo-Dioulasso the Ecole Jamot, a training centre for auxiliaries, was set up in Jamot's memory, and at Bamako in 1964 the Institute Marchoux was set up for work on leprosy.

In German East Africa, F.K. Kleine directed a team including M. Beck, M. Tame and eleven others to tackle trypanosomiasis. Professor Robert Koch, the world-famous Berlin bacteriologist, perhaps better known for his work on cholera, tuberculosis and malaria, was also engaged in the German attack on trypanosomiasis (Clyde, 1962).

The base for endemic disease control in the Sudan was a floating tropical research laboratory, an adapted Nile River steamer. This was the inspiration of Andrew Balfour, funded by Sir Henry Welcome (of Burroughs Welcome), who also built the Stack Laboratories in the Gordon. Memorial College at Khartoum. Twenty-two years later, in 1924, the Kitchener School for medicine opened. K.R.S. Morris, J. F.E. Bloss and K.C. Willett worked from this Welcome centre.

The provision of information on scientific progress was becoming essential to research workers, doctors, and field staff, not only in the field of sleeping sickness control but all tropical diseases.

Following the Royal Commission's work in Uganda, a Sleeping Sickness Bureau was set up in Burlington House, London, under Sir Anhur Bagshawe. By 1912 this expanded to include leishmaniasis (C.M. Wenyon's special interest) and became the Tropical Diseases Bureau. R.T. Leiper, who incriminated *Schistosoma haematobium* and who, establish *Schistosoma mansoni* as separate species while working in Egypt, helped to organize the helminth work. The directors in subsequent years, however, were men concerned especially with trypanosomiasis and tuberculosis: Sir Harold Scott in 1935, Sir Charles Wilcocks in 1942, Dr H.J. O' Burke-Gaffney in 1961 and Dr F. Ian Apter in 1968. The Bureau moved to the Imperial Institute in Kensington, and then into its present

offices in the London School of Hygiene and Tropical Medicine built by the Rockefeller Foundation in 1929, in Bloomsbury. The Mansion's School of Tropical Medicine, Balfour's School of Hygiene and Ronald Ross' institute were now all under one roof.

Here it was able to scan all the journals of the School Library as well as its own, a task it continues until today. Tropical Diseases Bulletin has been published monthly as an abstract journal since 1912 and since the 1980s includes information on AIDS.

The influence of the schools of Tropical Public Health outside Africa was immense. Mansion's school began in the London docks in 1899. Sir Robert Jones Liverpool industrialist whose interests lay in West Africa, supported the Liverpool School of Tropical Medicine, to which Ronald Ross came as a lecturer. In France, similar schools were founded in Marseilles and Bordeaux, and the fame of the Pasteur Institute is widely acknowledged. In Germany, schools were open. Hamburg and Heidelberg. In Belgium, it was in Brussels and later the Prins Leopold Institute at Antwerp, which treated the sick, engaged in research and taught students in similar ways. In Amsterdam, the Royal Dutch Tropical Institute was a similar foundation, perhaps more closely linked at first with Indonesia than Africa. Eventually Antwerp and Amsterdam had joint courses annually in English and in French *for doctors and senior health*

workers in health planning in the Third World.

The New World was somewhat slower in establishing tropical study a centre, partly because they never had a colonial past. But eventually courses were provided, and research teams gathered and combined with overseas expeditions in Harvard, Los Angeles, Tulane and Atlanta. They were supremely successful in assisting the small pox eradication programmes of the 1970s.

Several of these tropical schools built centres in Africa. The Amsterdam schools built centres in Africa. The Amsterdam school built research laboratories in Nairobi, and Pasteur Institutes were set up in several African cities, Government research councils did something similar. The Medical Research Council of UK set up a nutrition centre in Fajara, in the Gambia including a tropical pesticide research centre at Arusha, Tanzania; it also gives assistance against tuberculosis in Nairobi. But all these were post Second World War endeavours and we must return to the period before the First World War.

Industrial Health

Before World War I, government and missions including major industries provided considerable public health schemes, often much greater in extend than the industrial health services of similar businesses in Europe or America; this is because they were sited in remote areas with no health

care other than what they themselves provided.

The Germans did not have sufficient time as a colonizing power to evolve public health measures as great as those of France or Britain, or even the Belgians, but they did excel in creating highly organized industrial health services in the rubber plantations of the Cameroon's (Kamerun) , and UIC vast sisal plantations of German East Africa.

Only in industries run by the Germans was there anything like success in recruiting medical officers in numbers sufficient to provide an adequate doctor-worker ratio as laid down by the relevant legislation - indeed, the Germans were almost the only ones to produce appropriate statutes. Almost all legislation of a public health or occupational health nature was copied from (and often insufficiently to Africa) European legislation.

Major enterprises could afford to run their own health schemes, employing medical men and nursing staff: examples were the United Africa Company (UAC), and John Holt, the Camping Franchisee Africa Occidental, the Union Miner of the Katanga copper mines, the Oppenheimer Company in diamonds and the Rand gold mines. Public companies such as ports authorities and the railways also built up occupational health services.

Government health services of the 1880s had to operate on minute budgets several metropolitan powers expected their colonies to be self-financing with regard to health. *Noble efforts were made by colonial*

surgeons and district medical officers, with a handful of medical officers of health, but their services were limited to towns, barracks, railhead camps, harbours, prisons, schools, markets and residential areas on the outskirts of large traditional cities (in West Africa) or the commercial centers but not the semi-urban slums of 20th century cities (in East, Central and South Africa). If the cities were 20th century ones, government health services bore the full responsibility. And their meager resources were soon gone. Private industry could afford more.

Yet here too from 1900-1925 major health problems remained unsolved. Miners recruited for the South African gold mines came in from Malawi, Zambia, Zimbabwe, Lesotho and Swaziland. Many men died from pneumonia on these long treks. Sir Almroth Wright worked with Sir Spencer Lister to produce a vaccine against pneumonia in the Witwatersrand, and the former developed a typhoid vaccine in 1896 from killed bacilli. Within the mining belts pneumoconiosis and tuberculosis from dusty, ill-ventilated shafts. Particularly in the deeper gold and copper levels led to great mortality rate and crippling disability. On top of these occupational hazards, there was grave social disruption as the men left their families and villages to seek employment. As a result, venereal disease, alcoholism, violence and prostitution grew alarmingly. The migration was controlled, food and blankets were provided on the journeys and at the mines, and technological improvement in ventilation

and in wet-working methods led to a dramatic improvement in Southern African pneumoconiosis. In the Zambian copper belt and in Katanga, routine examinations of the miners, with thorough X-ray checks were organized by pneumoconiosis panels set up to detect, treat and prevent lung disease. Yet in parts of Ghana similar improvements did not occur until the 1970s, and no doubt, even suspicion that such a hazard might exist has not yet developed in some countries.

Nevertheless in many ways the labour forces were fortunate compared with their families back': home in the hills, the savanna or the forest. If curative care was still in its adolescence stage in' industrial areas, it was non-existent in remote bush or up-country areas. Maternal and infantile' mortality rates there were unmeasured, but reckoned to be very high, whereas in towns they dropped rapidly, or slowly but surely. In Lagos, the infant mortality rate dropped from 450 per1000 in 1900 to 175 in 1927, 86 by 1950 and 77 by independence (1960).

HEALTH IN AFRICA DURING THE FIRST WORLD WAR AND THE PERIOD BETWEEN THE WARS

The whole African continent was greatly affected by the repercussions of this greatest conflict the world had yet experienced. At the close of the war the Germany Kaiser lost all his African colonies.

Some places such as Togo, the Cameron's and Namibia, disappeared after

a few months of fighting, but Rwanda and Burundi surrendered only after the whole European conflict was over - thanks to the generous aid agencies did a very great deal in international health work, and in the restoration and brilliant generalship of Von Letlow- Vorbeck.

Kenya, Zambia and Mozambique were involved briefly, but the long drawn-out campaign in Tanganyika brought much hardship and suffering to both armies. The civil population suffered indirectly from the fighting but a great deal more suffered from famine and the massive influenza pandemic at the close of the war which hit Africa as badly as any other continent together with the spread of typhus and relapsing fever, malaria, plague and jiggers. Jiggers may seem a relatively minor affliction but it was extremely widespread between 1910-1920 and brought much misery to the long lines of infantry and to all travelers at that time. Troops tarred their feet, to avoid infection, but camps and rest hours were serious sources of the diseases (Jeffreys, 1952).

Epidemics of plague had broken out before the war, as in Ghana in 1908 (Scott, 1965). In 1924 Simpson with Dr J.A. Harran of the East African medical Service came from London and organized successful control in Ghana and throughout West Africa. Large-scale sanitary reforms were begun, leading to improvement of town and docks. In East Africa the plague was especially severe in Kampala and Nairobi. Worse than plague, however, were the famine conditions, which they met in the

1920s in those densely populated mountain countries. They drew attention to this in newsprint, did what they could in relief, and attracted international succor. The Belgians, given the mandate from the League of Nations for Rwanda and Burundi, were at first unwilling to let these, but they soon realized and appreciated the task.

Naturally, German medical help declined severely. In 1914 for all German East Africa there were 63 doctors, by 1918 there were only 13, and 6 alone survived until the armistice (Beck, 1977). German missionary effort, sadly, was reduced to a tiny fraction of those pre-war days. In 1906 the Tübingen Institute of Medical Missions was set up in Germany to serve all German and Swiss The First World War and the Period between the Wars missions, supplemented by medical missionary associations in Berlin, Braunschweig, Halle, Leipzig and Munich after 1908. The Hamburg and German Society for Tropical medicine also appeared in that year.

Communicable disease research and control continued rapidly. However, for an example, in spite of the vaccine discovered by Jenner, for smallpox the value of immunization was greatly reduced owing to vaccine liability irregular supplies and poor training of vaccinators. Vast numbers were immunized but epidemic control did not move easily. Eradication was out of the World Health Organization and US Agency for International Development. This campaign utilized surveillance and containment

tactics, a stable freeze-dried vaccine and the, bifurcated needle. Within six years small pox was totally eradicated across Africa, the last cases having been recorded on the Ethiopia-Somalia border. For both diseases quasi-military campaigns conducted on disciplined lines by 'armies' of health workers in many countries were necessary. These 'armies' existed as a result of an earlier set up of mobile units.

The same was true for yaws, which was recognized by all rural folk. When treatment became available it was so popular that some attributed the widespread faith in indictable cures to this campaign alone. Castellani in Sri Lanka discovered the organism *Treponema pertenu* in 1904, and Paul Ehrlich sent him samples of an arsenical drug in 1901. Arsenicals were used to good effect. *Dr. Harry Hastings, who worked 25 years at Uburu in Nigeria, was the first to introduce the drug and he treated 6,000 patients in one weekend alone. Once again, after the Second World War, and the introduction of penicillin, massive worldwide campaigns all but eradicated the disease.*

Little was done for leprosy sufferers between the wars. Chaulmoogra oil derivatives, publicized by Leonard Rogers in India, began to be used in the late 1920s in Africa, but they did little to halt the disease. Huge settlements grew into refuges where patients could survive, work, be accepted as human beings again, trade, and receive some education - but seldom had the hope of returning to their families and communities. Most

of this care was done by missions, with local authorities coming second. National governments were only too glad not to have to do more themselves, but willingly gave grants to these societies. Philanthropic bodies, such as the British Empire Leprosy Relief Association (later LEPRO) supplemented these grants though not large.

Missions particularly effective in leprosy work are the Sudan United Mission, founded in 1904 and the Sudan Interior Mission, founded in 1899; both of which worked from West to East Africa. Dr Andrew Starter founded the latter's settlement at Ibadan in Nigeria in 1901, and their work expanded into other parts of Nigeria, Liberia, the Ivory Coast, Burkina Faso, Ghana, Benin, Niger, Sudan, Ethiopia and Kenya. However, they had at different times withdrawn from some of these countries, only to return when conditions allowed. The settlements did however go into decline after 1950, and out-patient control became possible. A real reduction in prevalence occurred in several areas in Nigeria, Tanzania, Lesotho etc.

There is still no treatment for yellow fever, but the development of the 17D Asibi strain vaccine by Max Theiler, a Swiss south African in the New York laboratories of the Rockefeller Foundation in 1931, is closely bound up with work done in Accra and Yaba Lagos a few years earlier. The Walter Reed commission in the New World had incriminated the *Aedes aegypti* Mosquito and the Gorgas campaign to clear the Panama

Canal Zone was completely successful. Gorgas later attempted to come to Africa but unfortunately died of a coronary on his way to Europe. De Lesseps, the French engineer who had tried to cut the Panama Canal in the 1880s, failed because of the heavy Mortality rate from yellow fever. The Rockefeller Foundation sent several scientists, including the Japanese bacteriologist Hideyo Noguchi, to Africa. Noguchi at first convinced himself that bacteriology aetiology was correct following his work in Ecuador. He named the agent *Leptospira icterohaemorrhagica*. But he quickly agreed with the other in Africa that his work could not be repeated.

There happened to be no yellow fever in Accra or Lagos at that time, which was 1927. Ironically Noguchi, Adrian Stokes (a British pathologist) and William Young (Director of the Accra Medical Research Institute) caught the disease experimentally and died. The team did, however, succeed in infecting Rhesus monkeys, and this led to the discovery of the vaccine and consequently, the prevention of many thousands of deaths in the African and American countries. Since international air travel was just beginning, the possibility of spread into Asia was also prevented. The immense mortality rate from yellow fever that was prevented during the Second World War and afterwards is a permanent tribute to the labours of these pioneers.

Much later another serious virus disease, O'Nyong Nyong, was controlled

by research workers at the Rockefeller laboratory at Entebbe in Uganda. This laboratory had played part in yellow fever research in the days of Hadow and Lumsden, and later still in the outbreaks of Iassa fever and Ebola virus disease in Nigeria and Zaire O'Nyong Nyong disease was widespread and usually occurred in explosive outbreaks, but was seldom fatal. The other two viruses were small, limited epidemics, but with a high mortality rate that derived exceptional public concern abroad.

In the 1980s the laboratory at Entebbe, among others across middle Africa, moved into action against the AIDS virus, which is causing as much alarm as yellow fever in the last century. And syphilis in the 1900-1930 period. It is too early to assess this new work.

HEALTH IN AFRICA DURING THE SECOND WORLD WAR

In 1935 Mussolini ordered the invasion of Ethiopia, and in 1940 just as France was falling to the Nazi armies, he invaded her also. Thus the Italian colonies, Libya, Ethiopia, Eritra and Italian Somaliland became the sciences of renewed war in Africa.

The collaborationist French government at Vichy was very nearby responsible for further and large areas of African acting in a manner hostile to the Allies, but in the end, all French African came round to General de Gaulle. A small army even moved across the Sahara from Chad to join the 8th Army and the Americans who had landed in Morocco

during the last month of the desert war in North African. Cairo had been threatened in 1941, and some consider that had it fallen, all the Middle East would have succumbed, and German troops in the Stalingrad areas of Russia might fought in the Western desert and joined a large army of liberation for Ethiopia, fighting with Europeans, South African and Australians. Then they were sent to Burma (now called Myanmar). Where they fought under Mountbatten, bravely resisting the Japanese advance through mountainous jungles.

Health services for fighting forces were always improved in wartime, but indirectly civilian public health often improves also. Initially there were serious manpower shortages, but many African countries benefited economically. For example when the Japanese overran Malaysia and, caused shortages of rubber and tin, these industries grew rapidly in the Cameron's and Nigeria. The loss of quinine and Chaulmoogra oil was at first a setback, but their synthetic replacements, mepacrine and then chloroquine, were far better.

The elaborate plans for re-employment of demobilized troops often misfired, but the rehabilitation services for ex-servicemen became a part of the civilian health service. Harbours and airports were improved and increased in number, to cope with the shipment of tanks, planes and arms across Africa to war fronts, and to act as naval bases for the Battle of the Atlantic. This brought great development to the Harbours at Freetown

and Mombasa, and to airport at Accra and Ikeja.

Penicillin and other antibiotics replaced the antimony and arsenic preparations. Blood transfusion services were increased, mainly by the Red Cross. The Friends Ambulance Units ran the health service in Ethiopia after the fighting ceased (1,000 Italian doctors had left and no Ethiopians were then qualified).

A renewed interest in nutrition arose. The giving of amino acids to the victims of concentration camps in Europe saved many lives. Some of the new understanding of the management of such starvation enriched the value of health workers' efforts in the care of marasmic children and in kwashiorkor.

Cicely Williams had described kwashiorkor in Ghana before the war.

During the war she was interned in a prison camp on Singapore Island where she learned how to help many to survive. After; the war the long overdue attention that began at last to be given to maternal and child health was, closely tied in with nutritional rehabilitation. This was applied to infant and under. Fives clinics, and to the feeding of thousands of refugee populations of the post-independence wars in Nigeria, Sudan, Zaire, Rwanda and Burundi, Algeria, Angola, Mozambique, Namibia and Ethiopia-EritreaSomalia.

The great Sahel drought and repeated famines in the Ogaden and Wallo areas of Elhiopia only, re-emphasized the needs, but by this time many

relief agencies were quickly learning how to carry out effective emergency feeding programmes and how to encourage agricultural development. In the field of nutrition the names of Piau, McCullough, Autret, Brock, Nicol, Dr and Mrs. Jelliffe and Hugh Trowell were outstanding.

It was in Algeria in 1880 that Laveran had first identified malaria parasites in man. After his discoveries in India, Ross visited Africa on several occasions to encourage mosquito control schemes. When DDT became available during the Second World War, Rockefeller teams controlled a massive invasion of malaria in the Nile valley. With DDT, many insect-borne diseases could be controlled: typhus, relapsing fever, sleeping sickness, yellow fever and river blindness. But the great hopes of eradicating malaria in Africa were crushed. Half the world's malaria had been eradicated already, but the combination of Africa's poorly developed rural health services, its enormous geographical extent with few natural barriers and its lack of political will and co-operative assurances from neighbouring states followed by development of resistance to insecticides and to antimalarials proved too much.

L.J. Bruce Chwatt and A.B. Gilroy greatly improved the drainage of swamps around Lagos; and with Archibald, pilot schemes around Ham, Enugu and Argungu using DDT were successful. That around Argungu was later extended to the whole country, but nowhere could such control

schemes be made to work on a really large scale. Eradication was impossible. Bruce-Chwatt went on to become chief malariologist of WHO and then director of the Ross Institute following Ross and Macdonald. The world's malaria problems became his, but at his death in 1989, disappointment within Africa remained.

This is not to say that major scientific advances in our understanding were not made: witness the work of P.C.C. Gamham in 1949, who, with Shortt, Covell and Shute, made many advances, including the crucial discovery in Kenya that there was an exo-erythrocytic cycle in the human liver in malaria due to *Plasmodium vivax* and *P. ovale*.

Advances were also made in the understanding of filarial infections, onchocerciasis and Bancroftian filariasis, in which connection the names of Dyce-Sharp, Budden, Duke, Kershaw and Crosskey spring to mind. The role of *Simulium* flies, the parasites and their transmission cycles were all worked out in centres such as Kumba in the Cameron's, or in field research such as that of Professor George Nelson in Uganda. Or Dr Stanley Browne in Zaire. *WHO launched a special programme, headed by Professor Adetokunbo Lucas of Ibadan, based on research laboratories in Ndola, Zambia against six major diseases, including onchocerciasis and leprosy. Onchocerciasis had already been eliminated from great areas of East Africa, and now seven nations agreed upon a massive attack on the disease in West Africa, spraying vast areas of river*

breeding grounds.

Leprosy control was much slower. Frank Davey's outpatient schemes in Nigeria were successful. And Charles Ross encouraged the same techniques throughout the northern region, supported by drug trials research by Stanley Browne at Uzuakoli in the east. In Uganda J.A. Kinnear-Brown undertook a large B.C.G. trial on children at Kumi-Ongino settlement, in which he showed considerable protection. Other trials elsewhere in the world were less clear. R.G. Cochrane encouraged the American missionary, Dr Carl Becker at Oicha in Zaire when he thought he was able to cultivate *Mycobacterium leprae*. But although he failed in this, Becker did useful work on lepromin.

Perhaps the most significant centre in Africa is that in the Princess Zweneborg leprosy hospital outside Addis Ababa, where the All Africa Leprosy and Rehabilitation Training Centre was founded (ALERT). Doctors, physiotherapists and staff of all kinds are given short or long courses, and are taught the Paul Brand technique of tendon transplant and other surgical corrective measures adapted from Vellore, India. The Swedes contributed greatly to this centre, as did Dutch doctors. Dr Felton Ross, now the director of the American Leprosy Mission, was once the director of ALERT. The International Leprosy Mission also utilizes the centre.

Health Services During The Period of Independence in Africa.

All the colonies eventually found, won or were given independence, some through peaceful progress and some through war. First the German, then the Italian, British, French, Belgian, Spanish and finally the Portuguese colonies were free to design, organize and execute plans for their health services. But the heritage that was left varied enormously. Some were well ahead

Educationally with three or four -generations of an educated elite, but others had not a single qualified doctor or medical scientist

Many still depended on outside aid in the form of capital, staff, supplies and project skills, often from the same former colonial power, though new outside nations (e.g. Russia, Cuba and China) now came into the picture. *Many African countries inherited medical care systems not yet properly adapted to the needs of the country, or at least to those of the whole of that country.* The health services were, still only well organized for the reasonably well off town dwellers or those in public service or regular employment, and even in big cities the coverage in immunization of pre-school children could be very low.

A first essential was improvement in medical education. Apart from Alexandria there were no medical colleges until the 20th century, and the first were in countries relatively inaccessible to more African students, namely the colleges at Cairo, Cape Town, the Rand and Pretoria.

Nevertheless, the schools at Durban, Dakar, Khartoum and Kampala opened in the 1920s, although only in tiny classes, they were forerunners of great things to come.

Yaba Medical School followed in 1930. Its 66 graduates found conditions difficult in comparison with contemporaries who had qualified abroad, and half of them requalified in Britain under the auspices of the Royal Colleges of Physicians and Surgeons. In East Africa the transition from a Colonial government medical school to one with the status of the University of East Africa was smooth. In Nigeria a wholly fresh start was made at Ibadan in 1948. As the University College Hospital of Ibadan building was not finished until 1957, London University took over clinical teaching in the interim.

Most African states still had no medical school until after independence in the 1960s and 1970s, " and a few up to 1996 have none, such as Sierra Leone and the Gambia. *WHO estimated that a population of ten million was needed to support a University Medical College.* In early years overseas universities assisted many medical schools, as was the case with Glasgow and Amsterdam with, Nairobi, London with Accra, Ibadan, Makerere and Addis Ababa (which also received assistance, from Sweden and Switz.Zerland), Dundee with Kumasi, Louvain with Louvanium, and Marseilles with Kinshasha.

By the 1970s some were organizing postgraduate courses, particularly

in public health. The curriculum was criticized for being too Western European oriented. This notwithstanding, some students, fascinated by sophisticated medical research, were anxious to acquire doctorates in foreign universities in subjects only remotely concerned with the real problems in medical care in their own countries. Undoubtedly, several luxurious medical school institutions were absorbing far too great a proportion of their national medical budget, as' was pointed out by Professor David Morley of the Institute of Tropical Child Health, and Professor Maurice King, of Kampala, Lusaka, WHO and Leeds.

However, sweeping advances in curriculum adaptation and revision have taken place in the last three decades. At Makerere, Joseph Lutwama, dean in 1968 and a public health man, led a distinguished team comprising of Dick Jelliffe, Dennis Burkilt, Michael Hult, J. N. P. Davies, David Bradley, John Bennett, Maurice King and Paget Stanfield, to meet the needs of the rural poor and an equitable health care delivery system.

At Ibadan students were sent to learn how to operate under-fives clinics from David Morely at Ilesha and Imesi-Ile. Lucas drew attention to major endemic disease control for cholera and schistosomiasis. Professors Herbert Gilles and Rex Fendall of the Liverpool School advised the Ahmadu Bello University at Zaria in the 1970s, and Professor Eldryd Parry, Tony Bryccson and a group of workers with the MRC also helped

students become deeply involved in community care,

The second school at Kumasi in Ghana placed a great emphasis on the training of auxiliary as well as professionals. WHO played a large role in the programme. The numbers of medical schools in Africa rose from 15 in 1955 to 43 in 1970, and 83 in 1985, which 41 work in just four countries 14 in Nigeria, 11 in Egypt, 9 in Algeria and 7 in South Africa. There were over 8000 Nigeria doctors by 1980 (Schram 1996).

Appalling problems of mal-distribution of health care and public health services are not yet solved. Aid, either international or local, valuable though most of it was, could defeat that decisive essential self-reliance. If aid was given with political or economic ties; it sometimes bound that country to a pattern of health care it did not want or request; and if it was given without any ties it could be mis-spent or misappropriated. It is not that most aid supplies did disappear in this way, but the creation of a good balance between the needs of the recipient country and the relative wealth in money and expertise of the donor, and all the intricacies involved in the transfer was found to be more complex than it was once considered to be.

Doctor-population ratios did not necessarily reflect a true picture of health care. It is worth noting that even in the 1970s when the national ratio was 1:25,000, ratios for the rural areas were commonly 1:50,000 or even 1:500,000.

Little mention has been made of private practice, but once again the bulk of it concerns only the health of the city or town dweller, and it is only substantial as a contribution to the public health in a few cities. Many hundreds of fairly large towns across Africa have yet to see a family doctor. This has been compensated for by the contribution of the medical assistant, the clinical assistant. The dispensary attendant, and the many auxiliaries, nurses, midwives and health visitors. Yet these still need supervision (at least occasionally) and constant encouragement by those with fuller training.

Finally, a last pioneer of health services in Nigeria deserves mention in this historical survey, Dr Isaac Ladipo Oluwole (1892-1953). Born in Lagos, he gave his life to that city's people. He went into general practice for a few years in Abeokuta after qualifying in Glasgow at the close of the First World War. A strong desire to help introduce public health reforms into the capital sent him back to Glasgow to take his DPH. In 1925 he was appointed the first African assistant MOH to the city, He Opened the Massey Street Dispensary; acted as radio doctor; started a school health service; reclaimed swampy islands to aid in malaria control; supported measure; to control smallpox, rabies, plague; and built a new abattoir to improve food hygiene - all before 1930.

He started a *Healthy Baby Week* and opened the first old people's home before being appointed MOH in 1936. In 1940 he was given the OBE, and

when he died in 1953, after 29 years of continuous Public service, *he was recognized as the father of public health in Nigeria.*

The development of Flying Doctor Services - in Nigeria to a small extent, more substantially; - in Zambia, Botswana and KwaZulu, Lesotho and Swaziland has also filled a real gap. In Kenya and Tanzania Sir Michael Wood's flying surgical teams helped from as far as Uganda to Zanzibar; (Wood, 1987); and from this has evolved a splendid research and health education unit, also actively, engaged in publishing health education materials, the Africa Medical Research Foundation (AMREF). Other support agencies help get books at reasonable prices for health workers in Africa, including Teaching Aids at Low Cost (TALC) the cheap price versions of texts English Language Book Society (ELBS) and Appropriate Health Resources for Auxiliaries (AHRTAG) in England and similar organizations in Holland and other countries.

A glance back at the history of how health services grew and the enormous increase in public health measures in all African states can do nothing but encourage. Practically nothing has affected the health of nations more than all the parts of this story, though resolution of the political conflicts that remain would accomplish more still.

2.3.2. Health Services in Nigeria During The Colonial Period- Before 1960.

According to Schram (1971), the history of health policy and planning in Nigeria would be incomplete without mentioning the colonial period, because whatever is the situation today it took its root from the colonial period. Public health services in Nigeria began with the services provided by the British Army Medical Corp before independence. The colonial government extended her health services to the local civil servants and their relatives, and the local population living around government stations. At the time it was the policy of the colonial administration to provide free medical treatment to the Army and the colonial service officers, while the treatment of the other populace commenced later.

Efforts, of the missionaries also formed the bedrock of subsequent development in the provision of health care services. At independence in 1960, the missionaries accounted for about 75% of hospitals, dispensaries and maternity centres in different parts of the country. The patronage given to orthodox medical services then was poor because the services were culturally unacceptable to the people and these resulted in gross underutilization of the health facilities (Schram, 1971)

2.3.3. Health Care Delivery and Policies in the Immediate Post-Colonial Era of Nigeria: 1960-2004.

Umaru Shehu (1996), indicated that, after the attainment of political independence in 1960, Nigerians become involve in health care planning

and policy formulation. Health related matters were incorporated into the national development plans and policy measures of periodic budget plan. Since independence, Nigeria set for herself five important plan phases. The first phase (1st Development plan 1962-1968) contained the groundwork for the promotion of industrial development, building of hospitals in major cities, dispensaries and maternity homes in few rural towns and villages.

The second phase (2nd Development Plan 1970-74) incorporates development programs outlined in the first plan. Despite seemingly high relative rates of growth in the 10 years from 1963 through 1973, which was put at a compound rate of 10 percent per annum for economic sector, the health sector suffered a great neglect. The objectives of this phase were well defined and good; but they were not matched well with articulated projects and closely defined policies. The health component of this phase identified and aimed at correcting some of the deficiencies of the health sector carried over from the first phase.

According to Ejembi and Bandipo (1998), as at 1973, there were only five University Teaching Hospitals located at Lagos, Ibadan, Benin, Zaria and Enugu for the training of doctors, medical technologist, nurses and other medical personnel. Plan had also reached advanced state then to establish a teaching hospital at the University of Ife (Ejembi and Bandipo 1998). According to Shehu (1996), the Third National Development Plan

of 1975-1980 had the following policy guidelines and objectives: Federal and state governments were to resolve the main identified health problems of inadequacy, misdistribution and poor utilisation of health facilities, institutions and establishing comprehensive facilities for curative and preventive care for the population. The plan was scheduled to undertake medical research, to control communicable diseases and establish planning units, equipped to collect, process and publish data on major health problems. Other provisions for the health sector in the plan were:

- (i) Expansion of federal teaching hospitals;
- (ii) Provision of incentives for doctors to relocate;
- (iii) Creation of a cadre of workers called medical assistants;
- (iv) Production of nurses, midwives and technicians;
- (v) Establishment of state schools of health technology;
- (vi) Expansion of basic health services;
- (vii) Establishment of health management boards and the zoning of the state;
- (viii) Creation of council of medical research;
- (ix) Establishment of the federal health planning and research unit.

Consequent upon this plan, by 1979, the number of Teaching Hospitals had increased from five to six. The sum of ₦20m was allocated in this Development Plan for the National Malaria Control Programmes, and

intensive vaccination campaigns on small-pox were organised in collaboration with local and international voluntary organisations and individuals.

Shehu (1976) indicated that, in the 4th Plan (1981-1985), the major policy objectives and programmes were:

- (i) Establishment of 3-tier comprehensive health system (primary, secondary and tertiary);
- (ii) Concurrent health care responsibility from 3 levels of government;
- (iii) Establishment of Basic Health Services Scheme (BHSS) and of primary health care for all;
- (iv) Establishment of Local Government Areas (LGAs) as basic implementation unit;
- (v) Establishment of BHSS for a population of 50,000;
- (vi) Establishment of 4 categories of community health workers;
- (vii) Utilization of village voluntary traditional practitioners and leaders;
- (viii) Discouragement of expensive construction;
- (ix) Decentralization of decision-making; and
- (x) More balanced expenditure between hospitals and BHSS.

Although The Fifth National Development plan in the late 80s

and early 90s led to the establishment of the National Health Policy document in 1988 and 1998 with the focused on:

- (xi) Primary health care (PHC) as centre piece;
- (xii) Priority accorded underserved and high risk groups;
- (xiii) Emphasis on effective management through better planning, budgeting and control;
- (xiv) Increased funding and cost recovery including insurance;
- (xv) Reduction in capital development;
- (xvi) Improvement of efficiency and utilization through better support drugs;
- (xvii) Increased inter and non-governmental cooperation and community support;
- (xviii) More LGA's role in management;
- (xix) Services to focus on primary health care elements;
- (xx) Intermediate level manpower planning; and
- (xxi) Inspection of private services.

According to (NDHS, 1999), despite these five plans and the enactment of a national health policy in 1988 and 1998 the status of the health services provision in Nigeria is still defective as can be understood from the following areas:

- (a) The coverage is inadequate: less than half of the people of Nigeria have access to modern comprehensive health care.

Since majority of the people (80%) live in the rural area and cannot have access to health care facilities, because such services are urban based and out of reach economically.

- (b) There is proportional high investment on curative service to the detriment of preventive services.
- (c) Inadequate skill to properly manage and coordinate health formulation, planning, monitoring implementation and evaluation is still a major problem. As a result of this, health goals and targets are never met. The level of community participation or involvement in health formulation, planning, monitoring implementation and evaluation is still very low. Therefore, health problems are perceived from provider point of view rather than from the receiver's or the affected population's point of view.
- (d) Poor maintenance and servicing of health equipments and facilities such as vehicles or ambulance, medical consumables (drugs and vaccines) and buildings.
- (e) Poor management of health statistics constitutes a major problem on planning, monitoring and evaluation of healthy services.

2.4 Politics of Health Care Delivery in Post-Colonial Nigeria:

Like other countries of the world, Nigeria has had her share of the interference of politics in decision-making on matters of health delivery and medicine. The pre-eminence of politics in policy formulation, in general, and health care delivery system in particular, cannot be over emphasized. For example, a look at some nation's health systems (China and Cuba) has glaringly demonstrated the dependence of health policies on larger social and political events (Klein, 1974).

Politics and political processes usually mean the relationships of power authority or influence in the context of governance. The political process seeks to identify popular concerns to access the power distribution within a population, to propose the allocation of available resources, and to decide on the required course of action (Glaser, 1960).

In health planning, the influence of politics is well recognize as complement which when integrated should combine technical understanding of the health care problems with preference of the health care consumers and lead to a maximization of satisfaction.

Known dichotomies between social statuses, which manifest more in rural-urban differences, affect morbidity, mortality and access to health services. Attempt to improve on these characteristics by government requires political support because health does not necessarily develop priority by itself. This explains why the political culture of a particular

country influences the definition of health (Aderson: 1972, Akinkugbe: 1981).

While in some countries, health is seen as individual responsibility leading to the encouragement of private sector participation, in some other countries, health care is seen as a basic right to be guaranteed by the state (Heidenheimer: 1976). Recognition of the influence of politics in health care planning and management led to the Alma-Ata declaration on primary Health Care (PHC) which insist that there is the need for strong political will and support at national and community levels (Akinkugbe: 1981). This was also based on the fact that, the economics of health planning and management stresses cost recovery as a vital determinant. Some authors (Rice & Cooper, 1967) have even gone to the extent of trying to cost human lives. A nation in the event of dwindling resources faces tough choices on how to allocate resources between competing national demands. It is noteworthy to mention that even public expenditures decisions within or between ministries are usually made as a result of complex interplay of social, cultural, economic and political factors.

To elucidate the influence of politics in health a study by Kajang (1999), concluded that, generally the performance of any health care system needs to be judged in relation to the objectives inherent in the prevailing ideology in each country. Therefore the health planning process of a

country has to rely on theoretical and political models that recognize the constraints of political life.

However, while management may indeed help to sort health priorities and guide policy makers, it is not politically neutral and cannot itself alone increase rationalization and maximize the use of resources. That the management of social services including health are affected by political systems, implies the need to clearly recognized it in fashioning management alternatives for the health sector. It must also be recognized that within any political system, the national health system is affected by different groups of actors in overlapping areas. Specifically, decisions affecting health planning at national level are made in four essential areas central government, local governments, states, external donors and the private sector.

Policy makers are influenced through a variety of executive consultative advisory or administrative structures. While the central government may draw up plans for health care, they need to get the states and local government support in order to put their policy intentions into practice. This again may call for political manoeuvring.

In the case of Nigeria civil servants largely dominate the management of health services. And there are always considerable disagreement about policy goals between politicians, professionals and administrators. The

health manager may be faced with situations in which medical goals conflict with political goals.

2.5 Nigerian National Health Policy:

In 1988 and 1998 Nigeria was able to evolve a National health Policy, which attempted to streamline all political, social and economic interests. The National Health Policy principally looks at fundamental principles, development of national health system and strategy. These major components of the national health policy are discussed below:

(a) Fundamental Principles Underlying The Nigeria National Health Policy

The Nigeria national health philosophy is founded on the principles of social justice and equity. This philosophy is clearly enunciated in the 2nd National Development Plan, 1970-1974, which described the five national objectives to make Nigeria:-

- i. a free and democratic society;
- ii. a just and egalitarian society;
- iii. a united, strong and self-reliant nation;
- iv. a great and dynamic economy;
- v. a land of bright and full opportunities for all citizens.

These principles of social justice and equity and the ideals of freedom and opportunity have been affirmed in the constitution of the Federal

Republic of Nigeria. Therefore, the goal of the national health policy is also to provide a level of health that will enable all Nigerians to achieve socially and economically productive lives. The policy also stressed the overall fundamental obligations of Governments of the Federation and the nation's socio-economic development, the goal of the National health care delivery system, based on primary health care emphasizing protective, preventive, restorative and rehabilitative services.

(b) National Health Care Delivery System

The national health care delivery system is built on the basis of the three-tier responsibilities, which are of the Federal, State and Local governments:

Schedules of responsibilities which are to be assigned to the Federal, State and Local Governments respectively, are prepared for approval by the Federal Ministry of health. A variety of collaboration with non-governmental and private agencies, especially religious bodies, provide health care including both curative preventive services alongside the government bodies in an integral feature of the national health system.

2.5.1 National Health Strategies:

The section on national strategy in the national health policy, states that “the implementation of the national health policy, and progress towards the achievements of the goals, require the elaboration of strategies at the local, state and national levels”. The roles and responsibilities of these

different arms of government have been defined and to be renewed from time to time in order to enhance the establishment of managerial process for health development. The document also provided a list of the roles and functions of the federal Ministry of health, which to include the following:

- i. devise a broad strategy for giving effect to the national health policy through the implantation by Federal, state and local governments in accordance with the provisions of the Nigeria constitution;
- ii. submit for the approval of the federal government a broad financial plan for the federal component of the health strategy;
- iii. formulate national health legislation as required, for the consideration of the Federal Government;
- iv. act as coordinating authority on all health work in the country on behalf of the federal government, with a view to ensuring the implementation of the Nigeria national health policy;
- v. assess the country's health situation and trends; undertake epidemiological surveillance and report hereon to government;
- vi. promote an informed public opinion on matters of health;

- vii. support states and through them local governments in developing strategies and plans of action to give effect to the national health policy;
- viii. allocate Federal resources in order to foster selected activities to be undertaken by states and Local Governments in implementing their health strategies;
- ix. issue guidelines and principles to help states prepare, manage, monitor and evaluate their strategies and related technical programmes, services and institutions;
- x. define standards with respect to the delivery of health care, and monitor and ensure compliance with them by all concerned; health technology, including equipment, supplies, drugs, biological products; and vaccines, in conformity with WHO's standards; the human environment; and the education, training, licensing and ethical practices of different categories of health workers.
- xi. promote research that is relevant to the implementation of the national health policy and state health strategies, and to this end, to established suitable mechanisms to ensure adequate coordination among the research institutions and scientists concerned;

- xii. promote corporations among scientific and professional groups as well as non – governmental organisations in order to attain the goals of the policy;
- xiii. monitor and evaluate the implementation of the national health policy on behalf of Government and report to it on the findings;

On International Health: The federal Ministry of Health shall set up and maintain an effective mechanism for the co-ordination of external cooperation in health and for monitoring the performance of the various activities towards:

- i. ensuring technical cooperation on health with other nations of the region and the world at large;
- ii. ensuring the sharing of relevant information on health for improvement of international health;
- iii. ensuring cooperation in international control of narcotic and psychotropic substances; and
- iv. Collaborating with United Nations agencies.
- v. Working closely with other developing countries, especially the neighbouring estates within the region which have similar health problems, in the spirit of technical cooperation among developing countries, especially with regard to the exchange of technical and epidemiological information.

- vi. sharing of training and research facilities and the coordination of major intervention programmes for the control of communicable diseases.

Overall, the Federal Ministry of Health has the responsibility of strengthening the states Ministries of Health and local Government Health departments to become the directing and coordinating authority on health work within the States and in the local governments. With reference to the Nigerian 1999 Constitution 'Health' has been placed under the concurrent list. And by concurrent list it is meant that the federal sector is bestowed with the responsibility of health policy formulation, setting standards, planning and monitoring and evaluation while the states and local governments are to implement. But close observation of the situation on ground the practical scenario is that the issue of placing health in the concurrent list makes the Federal to dominate any health issue in the concurrent list. It is therefore required that a more explicit and clearly defined jurisdiction and roles of the Federal and other tiers of government in the health sector.

From the foregoing, it is seen that the Federal Government via the Federal Ministry of Health takes the lead in the development of the national health policy and it is also expected to ensure the implementation of programmes set out in the national policy aimed at improving health delivery services in Nigeria. This study evaluates the success or otherwise

of the Federal Ministry of Health as per its leadership roles defined in the national health policy despite the general mandate that health services is the responsibility of federal, state, and local governments as well as religious organisations and individuals. The services are organised in a three-tier health care system:

- iv. Primary health care being the chosen framework in the national health policy for achieving health for all the population of Nigeria) is largely the responsibility of local governments, with the support of the State Ministries of Health.
- v. Secondary health care, which provides specialised services to patients referred from the primary health care level and is the responsibility of the state governments.
- vi. Tertiary health care, which provides highly specialised referral services to the primary and secondary levels of the health care delivery system and is in the domain of the federal and state governments.

From the foregoing it is noted that much of the literature on health services in Nigeria has concentrated on the roles of health professionals especially medical practice and some elements of public health, while comparatively little is written on the contribution of “managers” or “management specialists” to the development of the provision of health

services in Nigeria. Understandably, this lack of attention to the ‘manager’ or to the management expert in the health sector reflects the relatively lack of the development of health sector management. It could therefore be inferred that despite the arrangement in the national health policy, the Nigeria health sector is still characterised by wide disparities in status and service delivery due to inadequate management systems.

It is also evident that the current health policy has become obsolescence and might have outlived its usefulness. This state of affairs is examined and investigated in this study.

2.5.2. THE IMPACT OF CIVIL SERVICE REFORMS ON MANAGEMENT SERVICES IN THE HEALTH SECTOR IN NIGERIA

CIVIL SERVICE REFORMS

Past Reforms

Since the colonial era in Nigeria, successive Governments had instituted various study teams or commissions to address problems of the Nigerian Civil Service. Such studies include:

- (i) Hunt Commission, 1934
- (ii) Harragin Committee, 1946
- (iii) Foot Commission, 1948
- (iv) Philipson/ Adebo Report, 1949/50
- (v) Gorsuch Committee, 1954

- (vi) News Committee, 1959
- (vii) Mbanefo Committee, 1959
- (viii) Morgan Salaries and wages Commission, 1963
- (ix) Wey Panel on Public Service Management and Salary Administration, 1968
- (x) Elwood Grading Team, 1969
- (xi) Adebo Commission, 1973
- (xii) Public Service Commission (Udoji Report) 1974
- (xiii) Study Team on Structure, staffing and Operations of the Nigerian Civil Service (Philips report), 1985
- (xiv) Presidential Task-Force on the Implementation of Civil Service Reforms (Koshoni Report), 1988.

The most comprehensive reform in the Civil Service was the Public Service Review Commission of 1974 usually referred to as the Udoji Commission. Unlike earlier reviews, which were mainly concerned with salaries and wages, the Udoji Report covered in addition to salaries and wages, organization and structure of the Civil Service, *new management techniques*, positive attitudinal change etc. which were required to move the Civil Service forward.

Some of the major recommendations accepted by Government were:

- (i) The establishment of a Code of Ethics which every employee in the Civil Service must subscribe to;

- (ii) The introduction of a results-oriented Service which emphasizes concrete achievement in terms of expenditure incurred or size of personnel;
- (iii) The introduction of three new management techniques namely, Project Management (PM), Management by Objectives, (MBO) and Programme and Performance Budgeting System (PPBS), into the management of the Civil Service;
- (iv) Replacing Confidential Report System with the Open Reporting System based on agreed targets and regular dialogue between the reportee and the reporting officer;
- (v) The merit system as basis of reward in the Civil Service'
- (vi) Massive training programmes for senior officers in the Civil Service in order to enhance their executive capacity;
- (vii) The introduction of a Unified Grading and Salary Structure (UGSS) for all staff in the Civil Service including Parastatals;
- (viii) A system of continuous job evaluation and grading, in order to restore an equitable system of equal pay for substantial equal work, and
- (ix) Establishment of an implementation agency that would review the Civil Service on a continuous and regular basis.

It is observed here in this dissertation that, in spite of the lofty recommendations by the Udoji Commission that were accepted by

Government, only the wages and salaries aspects were faithfully and speedily implemented. The others were either at all not or were partially or haphazardly implemented.

Following another Civil Service Review Exercise (Philips Report 1985) Government in January 1988 set up the Koshoni Task Force to implement aspects of the Report. This resulted in the promulgation of Civil Service (Re-Organization) Decree No. 1988.

The Civil Service (Re-Organization) Decree 1988

The stated aim of the Reforms was to make Civil Service virile, dynamic and result-oriented. Other objectives of the Reforms included:

- (i) Enhanced Professionalism
- (ii) Alignment with the Presidential System of Government;
- (iii) Decentralisation and Delegation;
- (iv) Combination of Authority with Responsibility;
- (v) Enhanced Accountability;
- (vi) Enhanced Checks and Balances;
- (vii) General Modernisation;
- (viii) Enhanced Effectiveness, Efficiency and Speed of Operation.

The Panel examined the objectives of the reforms and noted Government's intention to give a new lease of life to the Civil Service. Unfortunately, these objectives have not been fully realized to date.

Defects of the Repealed Decree

An examination of the basic provision of the Decree and the reality on ground showed that majority of the provisions were characterized by inherent short-comings that were in fact inhibiting factors to the realization of the objectives of Government. The Panel's observations in this regard were:

- (i) The statement in the preamble to the Decree that the Federal Military Government “accepts, as a principle, the existence of a civil service” is a derogatory and grudging acknowledgement of the existence of an institution which has been the hub of Government since its inception. It is also indicative of the disregard with the Decree treated the old and time-tested practices of the Civil service.
- (ii) The reform also resulted in a bloated Civil Service, out of tune with the economic realities of the country and contrary to the intentions of Government. For example, before 31st March, 1988 (before the inception of the Decree) there were only about 46 officers on Grade level 17, including the Permanent Secretaries. Today there are over 200 GL.17 Officers, the provision that each officer makes his career in a Ministry has led to the frustration of some officers and the fragmentation of

the Civil Service. The Decree also granted so much autonomy to the Ministries as to make them operate like separate Services. The management of Civil Service should be guided by the relevant provisions of the constitutions, the Civil Service Rules, the Financial Regulations and Circulars, and not fixed by decrees or other laws.

STRUCTURE OF THE MINISTRY

Position of Membership Before 1988 Reforms

Prior to the Civil Service Reforms of 1988, Ministry had a Minister. Reporting to the Minister was a Permanent Secretary. There was no uniform structure for all Ministries below the Permanent Secretary. Some large Ministries such as the Federal Ministries of Education , Works and Housing and External affairs had Co-ordinating Directors (GL. 17) who supervised a group of Departments in the Ministry. The Co-ordinating Directors were responsible to the Permanent Secretary. Other Ministries had Departments headed by Directors who were on Gl. 16. The heads of Department reported to either the Co-ordinating Directors or to the Permanent Secretaries as the case may be.

Though there was no uniform structure for all the Ministries, one of the Departments-Policy and Management-which was responsible for finance and Administration was common to all Ministries. Other units that were relatively common Ministries included:

- (i) Internal Audit
- (ii) Legal
- (iii) Information

Below the Departments were “Divisions” which were in turn subdivided into “Sections” or “Units.” Again, there was no fixed uniformity in terms of headship of these sub-divisions as they could be headed by officers of various grade levels.

It is also noted that the reforms, there was no fixed or prescribed number of Departments or Sub-divisions for a Ministry but the approval of the Federal Executive Council, on the recommendation of the Ministry of Establishments, had to be obtained before any department or division was created in a Ministry. Similarly, as a pointed out earlier, there was no uniform application of nomenclature in respect of the headship of any of the Departments or Divisions.

One other salient feature of the Civil Service during this period was the practice of granting of some officers salary Grade Level 17 (which was the highest grade level) as personal to them. In this regard, some Directors and Secretaries for Finance and Administration were placed on Grade Level 17.

Structure of the Ministry System under Decree No. 43 of 1988

Section III of the Schedule to the repealed Civil Service (Re-Organisation) Decree 1988 and its Explanatory Notes Volumes I and II, provided a uniform 8-Department 3-Unit Structure for all Federal and State Ministries.

Horizontally, each Ministry was structured into maximum of eight (8) Departments comprising three (3) “Common Services” Departments and a maximum of Five (5) “Operations” Departments. The common “Common Services” Departments were:

Department of Personnel Management (PM)

Department of Finance and Supplies (F& S)

Department of Planning, Research and Statistics (PRS).

The “Operations” Departments of each Ministry reflected the basic functions and areas of concern of that Ministry.

Vertically, each Department of a Ministry was sub-divided in descending hierarchical order into “Divisions” “Branches”, and “Sections”. These sub-divisions reflected the broad professional and sub-professional areas and specialized activities within the Department respectively.

The headship of each Department and Sub-division of a Ministry was specified as follows:

Department/ Sub-Division	Title of Head	Grade Level
Department	Director	GL.17
Division	Deputy Director	GL. 16
Branch	Assistant Director	GL. 15
Sector	Chief “X” Officer	GL. 14

Under the Reforms, each Ministry was allowed to have three prescribed sub-divisions called “Units” these were:

Internal Audit Unit,

Legal Unit,

Public Relations Unit.

It is assumed in this dissertation that the eight departmental structure resulted in a bloated Civil Service with its attendant huge overhead costs. Also the attempt to put Ministries into a straightjacket without reference to their objectives, functions and size was inappropriate.

Therefore the Panel on the 1995 reforms examined the position of the three “Common Services” Departments of Personnel Management, Finance and Supplies and Planning, Research and Statistics and appreciated their importance. The panel was critical of the existence of the three Common Services Departments in all Ministries at full departmental status. The panel was of the view that the functions of the Departments of Personnel Management and Finance and Supplies could easily be merged in most Ministries for efficiency and economy.

Department of Administration and Finance

In this dissertation we shall look at this department as an example: The panel recommended that the Departments of Personnel Management and Finance and Supplies be merged and be known as the Department of Administration and Finance. The Department should comprise the following Divisions:

- (i) Personnel Division
- (ii) Budget and General Services Division
- (iii) Finance and Accounts Divisions

The functions of these Divisions are broken down below:

(a) **Personnel Division:**

The Division will be responsible for the following functions:

- (i) Establishment Matters;

- (ii) Appointment, Promotion and Discipline of Staff;
- (iii) Staff Training and Welfare;
- (iv) Industrial Relations Matters;
- (v) Secretariat of the Ministry's various Staff Committee Viz:
JSC , SSC, and SMC;
- (vi) Maintenance of Personnel Records (Registry);
- (vii) Liaison with relevant bodies outside the Ministry.

(b) **Budget and General Services Division**

The Division will perform the following functions:

- (i) Budgeting (Recurrent Expenditure, Capital Expenditure, Revenue);
- (ii) Procurement of Suppliers (stationery, office equipment, materials, furniture, etc.);
- (iii) Stores;
- (iv) Management of Transport;
- (v) Maintenance of Equipment;
- (vi) Office Management;
- (vii) Liaison with relevant bodies outside the Ministries.

(c) **Finance and Accounts Divisions**

This Division will be responsible for the financial administration and accounting functions of the Ministry.

The Panel was also of the view that not all the Ministries require the Common Services Departments and Divisions at the same level because Ministries vary in objectives, functions, size etc. The Panel believed that although Ministries required the services of the Personnel Management, Finance and Supplies, General Services, etc, these functions do not necessarily have to be performed at departmental or even divisional level in ministries. This observation was to provide a leeway to ministries to take care of any management peculiarities. But such opportunity has not been fully utilized.

The Panel also recommended that the structure of the Department Administration and Finance should be as proposed in a general guideline for all Ministries. In this regard, the number of branches and sections to be created in each of the three Divisions will be determined by the functions, size and other peculiarities of each Ministry. Similarly, with respect to the Operations Departments, there should be flexibility in the creation of Divisions, Branches and Sections so that Ministries can effectively fulfil their mandates.

It is important to note here that the opportunities provided by the various Panel recommendations on Civil Service Reforms from 1934 to 1997 have not fully utilized by the Federal

Ministry of Health to create Health Management Division and introduction of full fledge 'Health Manager' cadre.

The 1997 Civil Service Reform Panel Report.

In October 1994, the Federal Government again appointed a seven man Review Panel on Civil Service Reforms, with specific terms or reference as follows:-

- (a) To examine the structure of Government Ministries and Parastatals, and to further recommend the appropriate manpower strengths of the institutions from the point of view of efficiency.
- (b) Scope of the Assignment included:-
 - (i) Examining the objectives and functions of the Ministries/ Extra-Ministerial Departments as well as Parastatals, identifying various areas of duplication or overlapping of functions and recommending appropriate organizational structure for each of the organisations based on their need and peculiarities and the Panel's views in the main Report;
 - (ii) Examining the objectives and functions of parastatals/ government owned companies with a view to

determining those to be retained, relocated, merged or phased out;

- (iii) Determining the appropriate manning levels of each Ministry and Extra-Ministerial Department, based on their mandates and functions as well as the need for efficiency and effectiveness;
- (iv) Advising on any other matter, which will contribute to the efficiency and effective operation of Ministries and Parastatals.

GENERAL AND PRELIMINARY OBSERVATIONS/FINDINGS OF THE 1997 PANEL ON CIVIL SERVICE REFORM.

Structure

1. The Panel found that in all the Ministries and Extra-Ministerial Departments, the structural stipulations of 1988 Civil Service Reforms were largely adhered to. Each Ministry/Extra-Ministerial Department strove to have the maximum of eight Departments. This resulted in the creation of departments even when they were not really needed.
2. The three common services Department of Personnel Management, Finance and Supplies and Planning, Research and Statistics were in place at departmental levels, regardless of the size and functions of the Ministry in question.

3. There was a tendency in many Ministries/Extra-Ministerial Departments to have a larger number of operations Departments than they would reasonably require. Some of these departments were found to arise from necessary splitting of functions and were too small in terms of size and functions.
4. It was found that all the Heads of Units reported direct to the Minister in line with the provisions of the 1988 Reforms. As recommended in the main Report, all Heads of Units should report to the Permanent Secretary.

Common Services Departments

5. In line with the Main Report regarding the common services departments, the Panel is not necessarily prescribing a rigid pattern for all Ministries/Extra-Ministerial Departments. However, prudence should be applied in the number and composition of these departments, based on the needs and peculiarities of the particular organization.
6. Also, as recommended in the Main Report, the Planning Research and Statistics Department (PRSD) was found to be unnecessary in most Ministries and should therefore be abolished. In its place, a Management Information Unit (MIU) should be established. The Unit will be responsible for central

data collection, computer services, plan co-ordination, efficiency monitoring and the Ministry's Annual Reports. In exceptional cases, the Department of planning could be retained as an operational one where the central planning functions are considered vital in the operations of the Ministry.

Operations Departments

7. The number of operators recommended for the various Ministries/Extra-Ministerial Departments depends on the peculiarities and the needs of the Ministry/Extra-Ministerial Department concerned.

In determining the Departments and divisions, which each Ministry should have, the factors considered were statutory enactments, cost implication, organizational harmony and fair distribution of workload. In this regard, wherever the existence of a department or division could not be justified, it was recommended for scrapping and where there were duplications or paucity of functions, a merger was recommended. Also, the departments/ divisions were constituted in such a way that similar jobs were grouped together.

THE REPORT OF THE 1997 CIVIL SERVICE REFORM PANEL ON THE FEDERAL MINISTRY OF THE HEALTH.

Introduction

Before independence there existed the Department of Health headed by the Chief Medical Adviser to the Government. The Department was transformed into the Federal Ministry of Health after independence. In 1993 the Ministry was merged with the Social Development Department of the then Federal Ministry of Social Development, Youth and Culture and renamed the Federal Ministry of Health and Social Services. The social development functions were excised from the Ministry and transferred to the Ministry of Women Affairs and Social Development in 1995. Thereafter, the Ministry reverted to its old name of the Federal Ministry of Health (FMOH).

Functions

- (i) Formulating national health policies and setting priorities for determining the scale and balance of services to be provided throughout the country;
- (ii) Advising States on appropriate objectives, priorities and standards of health care to be achieved in conformity with nationally approved objectives;

- (iii) Facilitating the provision of Federal funds in support of health care effort throughout the Federator;
- (iv) Monitoring the performance in the provision of health services to ensure consistency with national guidelines and that Federal allocation of resources is used for pre-stated objectives;
- (v) Co-ordinating all health activities through the Federation;
- (vi) Planning and developing national programmes for improving health care;
- (vii) Maintaining standards of education and practice in medical and allied professions through the appropriate statutory institutions;
- (viii) Co-operating with the affected State governments in coping with national epidemics;
- (ix) Undertaking responsibility on a national basis for:
 - (a) control and eradication of communicable diseases;
 - (b) port health and quarantine restrictions and control;
 - (c) control and registration of drugs and poisons including narcotics, both manufactured and imported;
 - (d) preventing the entry and usage of unregistered drugs;
 - (e) promoting and co-ordinating medical and allied research through the Medical Research Council of Nigeria;
 - (f) stimulating health education of the public;

- (g) supervising Teaching Hospitals, Federal Medical centres, etc;
- (h) psychiatric and orthopaedic hospitals.
- (x) Maintaining and disseminating national statistics on the state of health of the nation;
- (xi) Advising the Federal Government on all matters relating to the health welfare of the nation;
- (xii) Supervising relevant parastatals and relating with relevant international bodies.

Existing Structure

The Ministry is structured into 7 departments and 3 Units as follows:

- (a) Departments
 - (i) Personnel Management
 - (ii) Finance and Supplies
 - (iii) Planning, Research and Statistics
 - (iv) Primary Health Care and Disease Control
 - (v) Hospital Services
 - (vi) Food and Drugs Services; and
 - (vii) Community Development and Population Activities
- (b) Units
 - (i) Internal Audit

- (ii) Legal
- (iii) Public Relations

Functions of the Departments

Common Services Departments in the Federal Ministry of Health.

The three common services Departments, namely Personnel Management, Finance and Supplies and Planning, Research and Statistics perform their normal functions.

Department of Primary Health Care and Disease Control

- (i) Ensuring that the overall objectives of primary health care activities in Nigeria are achieved;
- (ii) Controlling communicable and non-communicable diseases in the country;
- (iii) Co-ordinating disease surveillance and notifying the World Health Organisation when necessary;
- (iv) Developing training programmes and curricula for public health workers;
- (v) Liaising with international agencies on the health of the nation and with countries that have bilateral cooperation agreement with Nigeria

- (vi) Setting standards for quality of air, water and general sanitation in the country;
- (vii) Co-ordinating Non-Governmental Organisations' (NGO) activities in the health sector;
- (viii) Providing technical assistance to State and Local Governments in the health sector;
- (ix) Providing guidelines on the implementation of national health policies.

Department of Food and Drugs Services

- (i) Responsibility for national and international policy matters relating to food and drugs and other related substances;
- (ii) Monitoring and evaluating the implementation of the National Drug policy
- (iii) Providing Secretariat for the National Drug Formulary/Essential Drug policy;
- (iv) Developing the National Drug Information System and Services;
- (v) Monitoring the implementation of the Drug Revolving Fund (DRF) programmes in Federal health institutions;
- (vi) Producing and supplying basic and essential drugs for Federal, States and Local Government health institutions in the country;

- (vii) Administering medical stores and psychotropic drugs;
- (viii) Providing pharmaceutical manpower needs of the Federal health institutions;
- (ix) Promoting clinical pharmacy practice and rational drug use in Federal and State health institutions;
- (x) Pre-registration training of internship of pharmacists;
- (xi) Liaising with State Schools of Health Technology in the training of pharmacy and health assistants;
- (xii) Developing training programmes for patent and proprietary medicine vendors;
- (xiii) Developing policy guidelines and regulations on food hygiene safety and nutrition; and
- (xiv) Liaising with governmental non-governmental bodies, parastatals and agencies, on matters relating to food, drugs and related substances.

Department of Hospital Services

- (i) Providing hospital services at tertiary and secondary levels;
- (ii) Establishing Centres of Excellence ie UCH, Ibadan, for Neurosciences, ABUTH, Zaria for Oncology and radiotherapy, UNTH, Enugu for Oncology Cardiothoracic Disorders, UNTH, Maiduguri for immunology and infectious Disease;

- (iii) Supervising relevant medical professional bodies;
- (iv) Developing health care equipment and maintaining training facilities;
- (v) Providing Forensic and diagnostic services;
- (vi) Handling and processing requests for overseas and local medical treatment;
- (vii) Formulating policy on, and regulating alternative medicine in Nigeria.

Department of Community Development and population Activities

- (i) Developing strategies for the active participation of both public and private sector for the successful implementation of community development and population programmes and projects;
- (ii) Liaising with relevant agencies of federal, State and Local Governments and non-governmental organisations to ensure adequate co-ordination and integration of population and development policies and programmes;
- (iii) Developing strategies for effective monitoring and evaluation of all community development and population related activities nationwide;

- (iv) Promoting the establishment of apex bodies of NGOs involved in community development and population activities to facilitate their active participation in community development and population activities' programmes;
- (v) Establishing population information Network nationwide;
- (vi) Servicing the population Working Group, the National IEC Committee and the National Consultative Group on Population and Development;
- (vii) Disbursing grants to States for self-help programmes

Manning Level

The total staff strength of the Federal Ministry of Health as at March, 1996 was 4,661. The distribution of staff according to Departments is as shown in the table below:

<i>Sub-division</i>	<i>No of Staff</i>
Minister's Office	88
Personnel Management	1818
Planning Research and Statistics	238
Finance and Supplies	
969	
Community Development and Population	
Activities	70
Department of Food and Drugs	291
Primary Health Care and Disease Control	720
Department of Hospital Services	467
<i>Total</i>	<i>4661</i>

Observations

Having studied the functions of the planning, Research and Statistics Department, the Panel is convinced that planning plays a critical role in

the health sector. It, therefore, recommends that the Department be retained but renamed national Health planning Department.

After considering the functions of the Departments of Personnel Management and Finance and Supplies, the Panel is of the view that two can operate efficiently as one Department of Administration and Finance.

This is in line with the Panel's recommendation in the Main Report.

The three common services Departments of Personnel Management, Finance and Supplies and Planning, Research and Statistics have a combined staff strength of 3025 which is 65% of the entire work force. As a professional ministry, with its total staff strength of 4661, the proportion of the support service staff is considerably high.

Recommendations:

(i) The Federal Ministry of Health should be structured into 6 Departments and 3 Units as follows:

(a) Departments

- (i) Administration and Finance
- (ii) National Health Planning
- (iii) Hospital Services
- (iv) Food and Drugs Services
- (v) Public Health
- (vi) Community Development and Population Activities

- (b) Units
 - (i) Internal Audit
 - (ii) Legal
 - (iii) Public Relations
- (ii) The Departments should be structured into Divisions as follows:
 - (a) Administration and Finance Department
 - (i) Personnel
 - (ii) Finance and Accounts
 - (iii) General Services
 - (iv) Budget
 - (b) National Health Planning Department
 - (i) International Health Organisations
 - (ii) Planning
 - (iii) Statistics
 - (iv) Computer Services
 - (c) Hospital Services Department
 - (i) Regulation and education
 - (ii) Hospital Services
 - (iii) Medical Services
 - (iv) Health Care Services
 - (d) Food and Drugs Services Department
 - (i) Food and Cosmetics

- (ii) Drugs Production and Distribution
- (iii) Pharmacy and Development
- (e) Public Health Department
 - (i) Epidemiology and Disease Control
 - (ii) Primary Health Care Services
 - (iii) Environmental, Occupational and Port Health
 - (iv) AIDS/STD Control and Health education
 - (v) Laboratory Services
- (f) Community Development and Population Activities Department
 - (i) Community Development
 - (ii) Planning Monitoring and Evaluation
 - (iii) Population Activities
- (iii) The Planning, Research and Statistics Department should be retained but renamed National Health Planning Department

Parastatals

National Agency for Food and Drugs Administration and Control

The national Agency for Food and Drugs Administration and Control

(NAFDAC) was established by Decree No. 15 of 1993.

Functions

- (i) Regulating and controlling the importation, exportation, manufacture, advertisement, distribution, sale and use of food drugs, cosmetics, medical devices, bottled water and chemicals,
- (ii) Conducting appropriate tests and ensuring compliance with standard specifications designated and approved by the Government Council;
- (iii) Undertaking appropriate investigations into the production premises and raw materials for food, drugs, cosmetics, medical devices, bottled water and chemicals.
- (iv) Compiling standard specifications and guidelines for the production, importation, exportation, sale and distribution of food, drugs, cosmetics, medical devices, bottled water and chemicals,
- (v) Establishing and maintaining relevant laboratories or other institutions in strategic areas of Nigeria;
- (vi) Pronouncing on the quality and safety of food, drugs, cosmetics, medical devices, bottled water and chemicals after appropriate analysis;
- (vii) Undertaking measures in collaboration with the National Drug Law Enforcement Agency to ensure that the use of narcotic drugs and psychotropic substances are limited to medical and scientific purposes,

- (viii) Undertaking and co-ordinating research programmes on the storage, adulteration, distribution and rational use of food, drugs, cosmetics, medical devices, bottled water and chemicals;
- (ix) Issuing guidelines on, approving and monitoring the advertisement of food, drugs, cosmetics, medical devices, bottled water and chemicals;
- (x) Compiling and publishing relevant data resulting from the performance of the functions of the Agency.

Existing Structure

NAFDAC has a Governing Council. Reporting to the Council is the Director-General who is the Chief Executive.

The Agency is structured into 6 Directorates and 4 Units as follows:

(a) Departments

- (i) Administration and Finance
- (ii) Planning, Research and Statistics
- (iii) Narcotics and Controlled Substances
- (iv) Regulatory and Registration
- (v) Inspectorate
- (vi) Laboratory Services

(b) Units

- (i) Internal Audit

(ii) Technical Services

(iii) Public Relations

(iv) Legal

Manning Legal

NAFDAC has total staff strength of 766 as at March, 1996

Observations

The Panel observes that a Director is deployed to the office of the Director-General to take charge of certain duties. The Director is not in charge of a Unit. the Panel considers this anomalous and recommends that the Director be redeployed appropriately.

It is observed that the NAFDAC Decree grants the Agency broad powers, including making policies on food and drug matters. The Panel considers this inappropriate. In its opinion, the responsibility for policy formulation should reside with the Department of Food and Drug Services in the Ministry while NAFDAC should concentrate on the implementation of such policies. The Panel recommends that the NAFDAC Decree be amended accordingly. The Panel also observes that the function of granting licences for import and export of narcotic and psychotropic substances is located in NAFDAC. The Panel considers this inappropriate and recommends that that function should be the

responsibility of the Department of Food and Drugs Services in the Ministry.

An examination of the function of NAFDAC, Standards Organisation of Nigeria and the Federal Environmental Protection Agency (FEPA) reveals that there are overlapping of functions amongst the three organisations. The Panel recommends that Government appoints a Committee of experts to review and delineate the functions of these organisations appropriately.

Recommendations

(i) The National Agency for Food and Drugs Administration and Control should be structured into 5 Departments and 5 Units as follows:

(a) Departments

- (i) Administration and Finance
- (ii) Narcotics and Controlled Substances
- (iii) Regulatory and Registration
- (iv) Inspectorate
- (v) Laboratory

(b) Units

- (i) Internal Audit
- (ii) Legal
- (iii) Public Relations

- (iv) Public Relations
 - (v) Technical Services
 - (vi) Management Information
- (ii) The Director now deployed to the Director-General's Office should be redeployed.
- (iii) The responsibility for policy on food and drugs should reside with the Ministry while NAFDAC should be responsible for its implementation.
- (iv) The responsibility for granting licences for import and export of narcotic and psychotropic substances should reside with the Department of Food and Drugs services of the Ministry.
- (v) Government should appoint a Committee of experts to review and delineate the functions of NAFDAC, SON and FEPA appropriately.

National Primary Health Care Development Agency

The National Primary Health Care Development Agency was established by Decree No. 29 of 1992.

Functions

- (i) Providing support to the National Health Policy;

- (ii) Providing technical support to the planning managing and implementing of primary health care at the State and Local Government levels;
- (iii) Mobilizing nationally and internally, the development of primary health care;
- (iv) Providing support for monitoring and evaluating the National Health Policy;
- (v) Promoting health manpower development;
- (vi) Providing support for the village health system;
- (vii) Providing health systems research
- (viii) Providing technical collaboration;

Existing Structure

The Agency has a Governing Board. The Executive Director, who is the Chief executive, reports to the Board

The Agency is organised into 3 Departments and Units as follows:

(a) Departments

- (i) Administration and Finance
- (ii) Operational Services
- (iii) Planning, Monitoring, Evaluation and Research

(b) Units

- (i) Consultancy

(ii) Internal Audit

(iii) Public Relations

Zonal Offices

The Agency has 4 Zonal Office located in Enugu, Ibadan, Kaduna and Bauchi.

Manning Level

The Agency has a total staff strength of 467 as at March, 1996

Observations

Having examined the structure and functions of the Agency, the panel notes that they are adequate for its operations.

The Panel observes that some of the functions of the Primary Health Care Development Agency are duplicated in the Primary Health Care and Disease Control Department of the Ministry. One example is that both the Department and the Agency are said to provide technical assistance to the States and Local Governments in the health sector. In the opinion of the Panel, the Ministry should limit itself to policy and monitoring and leave the implementation of programmes to the Agency.

A study of the Agency's staffing position shows that it has exceeded approved establishments in certain positions and has created certain posts without due authority. Examples of the former are those of Accounts

Assistant I(GL.06), Senior Personnel Assistant (GL. 07), Senior Secretarial Assistant (GL. 07) and Personnel Officer II (GL. 08), while examples of the latter are senior Typist (GL. 07), Principal Information Officer (GL.12) and Consultant (GL. 13). The Panel considers this irregular and recommends that the Agency takes necessary steps to rectify the anomalies.

Recommendations

- (i) The Ministry should limit itself to policy making in the primary health sub-sector, while leaving the implementation of the relevant programmes to the national Primary Health Care development Agency (NPHCDA)
- (ii) The NPHCDA should rectify the anomalies created by irregularities in its staffing positions.

Summary of recommendations

The Ministry

- (i) The Federal Ministry of Health should be structured into 6 departments and 3 Units as follows:
 - (a) Departments
 - (i) Administration and Finance
 - (ii) National health Planning

- (iii) Hospital Services
- (iv) Food and Drugs Services
- (v) Public Health
- (vi) Community Development and Population Activities.

(b) Units

- (i) Internal Audit
- (ii) Legal
- (iii) Public Relations

Parastatals

National Agency for Food and Drugs Administration and Control

(i) The National Agency for Food and Drugs Administration and Control should be structured into 5 Departments and 5 Units as follows:

(a) Departments

- (i) Administration and Finance
- (ii) Narcotics and Controlled Substances
- (iii) Regulation and registration
- (iv) Inspectorate
- (v) Laboratory

(b) Unit

- (i) Internal Audit

- (ii) Legal
 - (iii) Public Relations
 - (iv) Technical Services
 - (v) Management Information
- (ii) The Director now deployed to the Director-General's Office should be redeployed.
 - (iii) The responsibilities for policy on food and drugs should reside with the Ministry while NAFDAC should be responsible for its implementation.
 - (iv) The responsibility for granting licences for import and export of narcotics and psychotropic substances should reside with the Department of Food and drugs Services of the Ministry.
 - (v) Government should appoint a committee of experts to review and delineate the functions of NAFDAC, SON and FEPA appropriately.

National Primary Healthy Care Development Agency

- (i) The Ministry should limited itself to policy making in the primary health sub-sector, while leaving the implementation of the relevant programmes to the National Primary Health Care Development Agency (NPHCDA).

- (ii) The NPHCDA should rectify the anomalies created by irregularities in Its staffing positions.

General

The following Parastatals/Agencies should be under the supervision of the Federal Ministry of Health:

- (i) All the Federal Teaching Hospital Management Boards
- (ii) All the 13 Federal Medical Centres
- (iii) National Board for Orthopedic Hospitals
- (iv) National Agency for Food and Drugs Administration and Control
- (v) National Primary Health Care Development Agency
- (vi) National Board for Psychiatric Hospitals
- (vii) Pharmacist Council of Nigeria
- (viii) Nursing and Midwifery Council of Nigeria.
- (ix) Medical Technology Registration Board
- (x) Dental Technology Registration Board
- (xi) Health Records officers Registration
- (xii) Optometrics Registration Board
- (xiii) Physiotherapist and Medical Rehabilitation Board
- (xiv) Radiographers Registration Board
- (xv) National Eye Centre

The place of Health Management in the Federal Ministry of Health

From the review of reports on civil service reform in Nigeria from 1934-1997 it is obvious that there has been no significant information provided or attempt on direct issues of health management as a specialized function nor the recognition of the 'health manager' cadre. This is an indication that the function and the cadre itself even if they exist they exist as virtual. This lack of deliberate policy is more pronounced in the Tertiary Teaching Hospitals which have very weak internal control mechanism for both human and material management. In such institutions most of their activities are carried out through events instead of organized planning (Attah, 1995). The study will seek to examine such issues in the ministry environment and make appropriate recommendation in this dissertation.

2.6. Theoretical Framework of the Study:

The discussion on the theoretical framework has been approached at three levels, first by looking at the history of management thought and theories of management; second a description of the influence of management theories in the Nigeria health sector; and third a justification on the choice of theoretical framework for the study and presentation of hypotheses.

2.6.1 History of Management Thought and Theories of Management

The history of management thought can be divided into six phases (1) the early influences (2) the scientific movement (3) the management process approach (4) the quantitative or management science movement (5) the human relations/behavioural science school, and (6) the systems school.

The industrial revolution of 1780 changed and expanded the pattern of this classification because businesses grew larger and more complex which brought about the emergence of another school of thought known as the Scientific Management Movement which techniques included motion-study, work method and time study in contrasts with the management process school (sometimes called the classical school) which emphasis is on the functional approach- of specifying the management function in the organization that include, planning, organizing, commending, coordinating and controlling (Dale: 1978, Mcfarland: 1979). A close study of these management thoughts provides an understanding of management theories in the following ways:-

The Quantitative School also called the Management Science School, is consists of theories that see management as a body of quantitative tools and methodologies designed to assist the modern manager in making complex decisions that are related to operation and production, the main concern of this theory is on decision making.

The Behavioural School is more interested in the application of findings of social psychology and sociology for the purpose of understanding organisational behaviour for management of problems. This theory deals mostly with employees' satisfaction, morale and productivity.

The system approach indicates a primary interest in studying the whole situations and relationships rather than organization segments. It pays attention to the identification of all functions necessary for the achievement of organisational objectives. For an example, it holds that the form, product design, manufacture, and marketing should be accomplished collectively with one another by making reference to all specialize units and departments of the organization so that the procedure used would be consistent with the system approach.

Over time these management thoughts and concepts have been discussed, analysed and reduced to the form of theories by scholars, to serve as essential tools and guide for a clearer understanding of management thoughts and concepts. Basic among them are the (1) Classical theory, (2) Behavioural theory (3) Decision making theory, (4) Bio mathematical theory (5) System theory and (6) Contingency theory.

The Classical theory or Management process considers management as an ongoing process of interdependent activities having functions that are

common to all, focusing on authority, responsibility and accountability. So the organization lays emphasis on process and procedures.

The Behavioural theory recognised the influenced of people on organizational activities. In other words, the presence of people in an organization is bound to result in goals and aspirations, which can be at variance with that of the organization. This shows that it is possible for a person or people to act at variance with the organisation's objectives. This is a point of departure from the classicists.

The Decision- Making theory states that an organisation should be structured according to the points where decisions must be made. And in doing so experts are to be made responsible for decision in their various areas of expertise. The shortcoming of this theory is that it cannot be applied until the organization has come into being and the various decision-making points are known.

The Bio-mathematical theory draws from both biology and mathematics and analogies its existence from human system. It compares an organization with a living organism, which has different stages of life- birth, growth and peaks. It therefore advocates that organizational management should be based on the peculiar demand of these various stages. Secondly, it sees an organization as consisting of different parts as does a living organization. Thirdly, this theory further states that the various organizational parts have to be properly balanced in an arithmetic

progression in order to ensure a proper functioning of the entire organization. The major weakness of this theory is that most if not all the variables that affect the functioning of an organization are difficult to express in numbers. Therefore, it is believed that for now, this theory is more of a fantasy than a reality.

The System theory states that an organization is a configuration of many variables at play with each other and with the outside world including economic, social, cultural and political factors. It is premised on the idea that all human organizations are systems that inter-depend to function. In other words, the theory does not see an organization as formally structured along superior/subordinate line or a social interaction setting where people can influence one another. Rather, it sees an organization as a pattern of inputs, outputs, feedbacks, delays and flows with regard to information, physical objectives or both. By implication, the organization is not a static arrangement of jobs and functions that can be mapped out. This type of system can survive only in an internal and external influences and dynamic of inputs and output flows. A too rigid application of this theory would make the workers dependent on the system and this would have demoralizing effects. The manager is to be conversant with the many variables at play in the functioning of the organization and plan for exigencies, realizing the fact that any change internally and externally to the organization is likely to have some kind of

chain reaction and thus, complicating the problem of the organization (Rao and Narayana: 1982, Nwachukwu: 1988, Cole: 1996).

The Contingency theory is not construed as a theory as such, because it integrates all the other management theories in providing solution to management problems. It states that every theory is good as long as it is appropriate for or to situation at hand. It stresses the interrelationship between management functions and that, which is most important in a given situation. The logical conclusion from this theory is that managers should manage according to how circumstances dictate. As the problem comes they are solved based on the circumstance surrounding them. And that managers are to design organizations, define goals and formulate policies and strategies in accordance with the prevailing environmental conditions (Godowoli: 1990).

2.6.2. Influence of Management Theories in the Nigeria Health Sector.

Even though management has long been practiced in other fields, its application in health care delivery system in Nigeria has been emphasized only in the last fifteen years or so. It has been recognized that health care delivery organizations are the most complex existing in contemporary society. The management of health care delivery organizations and services have evolved into extremely demanding and difficult task (Godowoli, 1990.). Some of the factors which contribute to the increased

complexity in health sector management in Nigeria include, the increased demand for accountability and managerial efficiency; dwindling government allocation to the health sector which puts pressure on the health manager and management planning. There are also tendencies by management professionals in the health sector to pay greater attention to employees and labour/industrial relations' matters than on health care delivery development. The health manager is also constantly faced with the issues of demands for scaling up of material requirements in the health sector due to population growth which is always far ahead of health provisions (Kyari, 1990.)

From the foregoing influences and challenges of management theories, it is apparent that the role of management services in the health sector in Nigeria can be explained using either the system theory or contingency theory. But as revealed by the study the role of management in the health sector is best explained and understood from the perspective of a combination of all the six theories including the contingency in a mix form which this study described as the 'Mix Management Theory' (MMT). The mix management theoretical framework has been derived from the study because the study has to a large extent established that, the health sector in Nigeria is a complex organic entity, a system consisting of complex interacting people, tasks, technology and interdependent parts with variety of goals. In which the health manager is

expected to work towards maintaining a balance among the conflicting objectives, goals and activities of units and members of the health system internally and externally. Consequently, the derivation of the mix management theory, is premised in the fact that the management of the health sector in Nigeria is found to be or occur more in situational sequence rather than fix dogma. In other words it recognizes the fact that in Nigeria, there seem to be no one best prescriptive way to design and manage the health system, but rather the health manager in the health sector is to design health sector goals, policies and strategies only in accordance with prevailing, social, economic, political and other environmental conditions that affect health. Therefore the mix management approach is likely to contribute greatly toward making any health care organization effective and efficient. It will contribute to effectiveness by ensuring that the health sector is doing what it should be doing. The mix management regime will also satisfy the modern focus in management theorizing in relation to dealing adequately with strategic mission and issues optimizing stakeholder participatory approach and relationships in the health system.

In conclusion, let it be stated clearly once more that the choice of the mix management approach in this study has been influenced by the outcome of the study which strongly justifies the overriding need of flexibility in

managing the Nigeria health sector and responding to change in the polity within the political economy of resource allocation and management of health care resources allocation in Nigeria. This is informed by the fact that in Nigeria policy decisions in every sector is a profoundly political process. In which case politics plays the critical role in deciding who has to pay and who receive health benefits in Nigeria. The political economy of Nigeria dictates the shape of policy formulation and model health services and its management. This study locates management of health services within the Nigeria political economy. Therefore any anticipated improvement on the plight of health management in the health sector will depend on the position of the health system and that of the health manger in the political arrangement of Nigeria. Managers in the health sector should have a system in place which gives them a clear picture of the complex patterns of interactions which make up their job in the health sector.

2.6.3. Hypothesis:

The hypothesis of this research is not stated in a declarative manner but as alternative course. The latter was adopted and non-parametric method in proofing the hypothesis. This was informed by the fact that, management of health services is a novel approach in the study area and the hypothetical assumptions of the study were designed to address fundamental issues and questions implicit in the research problem.

Empirical data collected from both documentary and field research sources provided the basis for proofing the hypothesis. The hypothesis put forward is as follows:

The efficient institutionalization and management of healthcare services can enhance optimal performance and desired outcomes of the health sector in Nigeria. In other words; efficient management of health care services is capable of bringing about the achievement of national health goals.

CHAPTER THREE

METHDOLOGY

3.1 Introduction

This chapter focuses on the research methodology (research methods and approaches) adopted in the conduct of the study. For a research of this nature, two types of research methods are scientifically relevant thus: qualitative and quantitative method of data collection techniques. The justification for combining the two approaches is that we are provided with a wide range of opportunity to assess procedures, practices, and in-depth understanding of modalities of the impact of management strategies on health care delivery systems from the wider and robust perspective.

(a) Qualitative or Secondary Sources of Data:

Review of secondary materials or historical sources such as wide range of published literature on health related issues in Nigeria, document, topical articles related to the research problem, and official publications by both the Nigerian state and international organizations. Content analysis and review of official documentation and reports on various health programmes, health management and reforms therefore constitutes the first method of data collection. Data collection from this source assisted us in understanding the intricacies of the research

problem from the historical perspective. The bibliographical references provide a complete list of the series of sources upon which the study was based.

(b) Quantitative or Primary Sources of Data:

Primary Sources of data collection was also adopted. This included the use of a structured questionnaire supplemented by an interview schedule and follow-up interviews. Extensive interviews, focus group discussions, and follow-up interviews were also conducted with health care delivery senior managers who are key players in the health sector.

3.2. Location of the study

The research was conducted at the federal ministry of health Abuja the federal capital of Nigeria. Nigeria lies on the west coast of Africa between 4 and 14 degrees north latitude and between 2 and 15 degree east longitude. It occupies approximately 923, 768 square kilometres of land stretching from the Gulf of Guinea in the Atlantic Coast in the South to the fringes of the Sahara desert in the north.

The territorial boundaries are defined by the Republic of Niger and Chad in the north, the Cameroon Republic on the east, and the Republic of Benin in the West. The gulf of Guinea delimits the southern boundary.

Nigeria is a federal republic consisting of 36 states and a Federal Capital Territory. The states are further subdivided into 774

administrative units of unequal sized called Local Government Areas (LGA). The 36 states are also grouped into six geopolitical zones. The total population of Nigeria as estimated by the Nigeria National population Commission (NPC) in 2003 is about 120 million people. The Nigeria economy fluctuates between growth and decline in the range of 2.0 -37 per cent over the years.

The Federal Government of Nigeria through the federal ministry of health has several programmes and policies aimed at improving health services. A national health policy was adopted in 1988 and revised in 1998 that provide the framework for the organization and management of health services in Nigeria. The policy defines the roles and responsibilities of the three tiers of government (i.e. federal, states and the local governments) as well as of civil society and non-governmental organizations. The leadership role of the Federal Government (Federal Ministry of Health) in the organization and management of Nigeria health services was the focused of the study. The performance of the federal ministry of health vested with this responsibility has been evaluated.

3.3. Operationalization of Selected Research/Data Collection Methods and Approaches.

(i) The Questionnaire Method

A self administered questionnaire which consisted of both open ended and close ended questions covered four broad areas, namely: background information on the respondents (such as place of work and unit , job title, sex, age, educational attainment, length of service, salary grade level etc), this was followed by assessment of health sector performance, role of health stakeholders, resource for health, role of donors, organization and management services and suggestion on enhancing the performance of the health sector.

(ii) The Interview Schedule

This structured interview method was targeted at senior health managers and professionals in the federal ministry of health head quarters and its parastatals. The interview centred on health policy issues, organizational and management structure, evaluation of health programmes, stakeholders, health reforms etc. (see appendix i)

(iii) Follow- Up Interviews

Follow-up oral interviews using unstructured questions were conducted with some of the respondents to clarify and elicit further explanations on some of their responses to their answers in the questionnaire. The follow-up interviews provided incisive information

in such areas such as involvement of donors in health care delivery in Nigeria, the status of management services in the health sector and views on health sector reforms (see appendix ii).

(iv) Content Analysis and Review of Literature

Reviewing of documents, reports, policies related to the subject of the study.

The official documents and reports were consulted to compliment some of the issues raised from the responses of both the questionnaire and interview schedule.

3.4. Research Population and Sampling.

As it is not normally possible to investigate 100 per cent of research population due to limitations normally imposed by costs, time, and unlimited scope of work required. The investigation at the Federal Ministry of Health was not different either. However sampling procedures were employed and it is believed that the sample drawn from the universal population for the research reflected the general tendencies of the population from which it was drawn.

(i) The Research Population

The research population is defined in this study to include all staff and units at the Federal Ministry Health Headquarters and its parastatals, all resident at the Nigerian Federal Capital Territory in Abuja, Nigeria.

(ii) Sampling Frame

The sampling frame used covers the population and in line with the objectives and purpose of the survey. Also in order to ensure high degree of accuracy it was ensured that no non-existent units were short listed for the research been. And for the convenience all the sample list used were quite accessible and found suitable for the purposes of the sampling.

(iii) Sampling (Purposeful Simple Random Sampling)

Quota sample of the population was used. The selection of the primary and secondary sampling frame was on random basis. The primary sampling frame was the list of units and employees at the Federal Ministry of Health headquarter and parastatals in Abuja. Each had equal probability of being selected to respond to the structured questionnaire. The number of respondents included was based on the proportionate size of managers in the heath sector.

The justification for the use quota sampling selection procedure and the choice of the sample size of 50 respondents for structured questionnaire and 15 for the interview schedule was purposeful and considered of sufficient merit to meet the objectives of the study. It is also believed that the sampling has reduced costs and in effect provided greater spread, accuracy, in –depth information and high degree of preservation and coverage of units of the population.

The secondary sampling unit was the list of top managers in Ministry of Health for the interview scheduled. Of the sixty (60) questionnaires

distributed 50 (83.4 per cent) were completed and returned. And of the 15 top managers contacted for the interview schedule 13 (87.0 per cent) obliged. Similar success was recorded in the follow-up interviews.

3.5. Research Variables

The Independent variable was the organizational and management structure at the federal ministry of health. The dependent variables included: the availability of health managers and capacity to effectively implement key elements of management services in the federal ministry of health.

3.6. Methods of Data Analysis and Statistical Techniques Used In the Analysis of Data Collected.

The data and information collected were qualitative and quantitatively analyze on the organization and management of health services in the Federal Ministry of Health.

This was due to the fact that the research data were a few number of observations which distributions were not known and a skewed data not easily normalised. The data also included graded responses that are not measured in any form of unit but numbers assigned to them to give or indicate inclinations of change. Therefore, the numerical difference between any two numbers on the ordinal data collected and presented was of little importance. Consequently, the main statistical method employed are of frequency distributions.

The hypothesis was stated alternative course of action and therefore non-parametric statistic or free distribution method was used in testing and proofing the hypothesis with respect to the degree research objectives and type of data collected in line with the research design. The Bibliography at the end of the research follows a combination of the APA and Harvard School style.

3.7. Problems Encountered in the Field

The first problem encountered in the field was the apathy exhibited by some of the respondents. They were initially reluctant to fill the questionnaire or grant audience for interview. This also contributed to the difficulty encountered in retrieving the questionnaire. This situation prolonged the duration of the field work. The busy schedule of some of the top management officials of the Federal Ministry of Health also prolonged the interview period which took almost eight weeks instead of two weeks planned for this task.

Another was that the researcher was called upon to travel out of the country on missions at different intervals during the field work which interrupted the collection of data and the final report. These problems were resolved by converting and devoting all weekends and non office hours to the research. Time savings were also made from the daily office hours in order to actualize the production of the dissertation.

CHAPTER FOUR

PRESENTATION AND ANALYSIS OF DATA

On Organization and Health Care Delivery Management in Nigeria:

4.1 Introduction:

This chapter focuses on the analysis and presentation of empirical data. It is divided into three main sections. The socio-demographic characteristics (gender, age, level of educational attainment, years of service and cadre and rank etc) of respondents is analyzed and presented in the first section. Section two dwells on respondents' perception of the performance of Nigeria's Federal Ministry of Health and its parastatals' in terms of the effectiveness of the country's health care delivery system with respect to efficiency, equity and sustainability.

The third section discusses respondents' opinion on issues that border on how the structural, organization and management strategies of Nigeria's health care delivery system facilitates the achievement of the national objectives of the health sector.

4.2 Socio-Demographic Characteristics of Respondents:

Of the 50 respondents who returned the questionnaire, 37 (74.0%) are males and 13 (26.0%) are females. Although the national employment policy does not openly discriminate against women, the low level representation of women could be a function of social and cultural factors. In the first place, parents prefer to send boys to school and ignore

girls. The belief is that girls are going to be married out. It therefore makes economic sense not to waste time and resources in educating them. This in part explains why the percentage of women in formal employment is low compared to men.

The ages of the respondents are shown in Table 4.1

Table 4.1: The Age Composition of Health Managers in the Federal Ministry of Health.

AGE (YEARS)	FREQUENCY	PERCENTAGE
26-35	3	6.0
36-45	20	40.0
46-55	17	34.0
56-60	10	20.0
61 and Above	0	0.0
Totals	50	100

Table 4.1 shows that most of the respondents 74.0%, are between the ages of 36 and 55 years. The Table also shows that while 6.0% are 35 years or younger, only about 20% are above 55 years. The data shows that majority of the respondents, 35 (70%) have put in about 11 to 15 years of service, 6 (2%) 14 years or less, while only 9 (18%) have put in 25 years of service or more. Most of the respondents are in their youth and middle ages. Most of them are also at the middle of their careers full

of strength. Which means their ability to perform will be a function of how best the system is structurally organized and managed.

Respondents were asked to indicate their educational attainment. Data collected shows that the bulk of them have attained one form of formal education or the other.

Table 4.2: Formal Educational Attainment of Respondents.

Level of Education	Frequency	Percentage
None	Nil	Nil
Secondary	3	6.0
Post Secondary	8	16.0
First Degree	25	50.0
Post Graduate Degree	14	28.0
Totals	50	100.0

Table 4:2 reveals that 68.0% of the respondents have acquired at least a graduate and postgraduate degree. The remaining respondents, either possessed secondary or post secondary education. A statistical analysis of the relationship between level of education and age using cross tabulations illustrates that most of these public servants between the ages of 36 and 45 years are those who hold either graduate or postgraduate education. The fact that a large proportion of respondents possess

graduate or postgraduate education implies that most of them are well fitted to assume assigned to them.

Respondents were further asked to indicate their program or cadre and salary grade levels. Their responses are tabulated in Table 4:3.

Table 4.3: Salary Grade Levels of Respondents

Grade Level Range	Frequency	Percentage
1-7	2	4.0
8-12	8	16.0
13-14	22	44.0
15-17	16	32.0
Consolidated	2	4.0
Totals	50	100.0

managerial responsibility in the health sector's management cadre.

They are therefore technically equipped to surmount managerial challenges in the performance of official tasks

Table 4.3 shows that 38 (66.0%) respondents have attained grade levels between 13-17, the bulk of them are professionals in the areas of medicine, Pharmacy, Para-medicals, fields of science, social science and administration. Most of these officers are university graduates. Their qualifications might have enhanced their rapid progression or promotion to the managerial grades in the Nigerian civil service. This is an

indication that there is indeed a large group of prospective Managers in the Health Sector.

4.3 Health Sector Performance

The respondents were asked to indicate if they think the objectives of the Federal Ministry of Health are being achieved. Of the 50 respondents 36 (72.0%) indicated that the Health sector was not meeting its objective and only 8 (16.0%) felt that the Health Sector was meeting its objective. The rest of the 6 (12.0%) respondents were undecided on the question. Several reasons were given by majority those who indicated that the Health Sector was not meeting its objectives. These include the following: Poor funding, Poor Planning, Management Lapses, high level of Infant Mortality Rate (IMR), Maternal Mortality Rate (MMR), high rate of HIV/AIDS Prevalence and general collapse of health care delivery services in government establishments.

On what can be done to enhance the provision of effective health care delivery services at the Federal Ministry of Health, respondents were unanimous. Most common suggestions by respondents centered on the need to enhanced the supervisory capacity of *personnel* over health care delivery programs, increase allocation to the health sector, harmonization of schemes of service and the activities of the various professionals in the health sector; provision of equal opportunity to all cadres and the

institutionalization of health care planning for effective health care delivery management in the Federal Ministry of Health. Other suggestions include the need to, grant autonomy to the health sector reforms and reorganization and restructuring of health Sector.

These suggestions seem to agree with the general feelings that the Nigeria health sector is overdue for major reforms. Respondents also rated the level of stakeholder involvement and participation in the national health care delivery decision-making process and management to be weak. Others reasons adduced to this weakness is that there is poor coordination, which result in weak collaboration between government effort and that of the Private Sector.

Respondents were asked to express their opinions on how health care delivery should be financed in Nigeria. Respondents expressed a litany of opinions, which is presented in Table 4.4.

Table 4.4: Respondents' Opinions on how Clients pay for health care Services at point of delivery.

Mechanism	Number	Percentage
Taxes	7	14.0
Obligatory Insurance	11	22.0
Voluntary Insurance	2	4.0
Out-of-Pocket Payment	28	56.0
Other Medical Refund	2	4.0
Totals	50	100.0

Table 4:4 shows that over half of the respondents believed that individuals directly take the responsibility of payment for medical services at point of delivery. What this implies is that the majority who cannot pay directly would not have the means to acquire medical care when the need arises. If this opinion is a reflection of the empirical reality in Nigeria, it would have negative implications on the health and well being of majority of Nigerian citizens who are considered to be living below the poverty line.

Respondents were also asked to give an outline of the major sources of funding and health care financing of the Nigerian national health care

delivery scheme. The varying responses on sources of funding and health care financing in Nigeria are tabulated in Table 4.5.

Table 4.5: Respondents Opinion on the Major sources of funding Health Care in Nigeria.

Funding of funding	Number	Percentage
Government	30	60.0
Private Sector NGOs	6	12.0
International Donors	6	12.0
Individual	8	16.0
Totals	50	100.0

The data in Table 4:5 show that government is perceived to shoulder about a third of the burden of health care financing in Nigeria. Therefore any under-financing of the health care by government will invariably wreak the health system in the country.

4.4 Role of Donors in Health Care Delivery in Nigeria.

Respondents listed their feelings on major international donors and funding agencies of the Health Sector in Nigeria. Organizations mentioned by the respondents include:

World Health Organization (WHO), United Nations Children Fund (UNICEF), The World Bank, through International Bank for Development (IDA), and International Bank for Reconstruction (IBRD),

Red Cross – Nigeria, The Red Cross International, United Nations Education and Scientific Organization (UNESCO), United States Agency for International Development (USAID), and The British Department for International Development (DFID).

All the agencies listed are credible organizations known to champion development World Wide. Whether the activities of these sources of funding have affected the Nigerian health Sector positively is a different issue entirely. Some of the respondents went further to list what they think are the major constraints on donor sources of funding the Nigeria health-care system. Major constraints listed by the respondents include: donors rigidity, stringent conditionality and cumbersome procedures attached to grants which sometime compromised and distort existing government policies, most proposals from donors require payment of counterpart funds which put pressure on health budgets, often time donors insist in using their own system instead using existing structures and core competencies, some time there is complete misapplication of funds due to donors promotion of stand alone programmes at variance with the principle of health system approach. This at times even slows down and distracts normal and routine government programmes already on the ground. Unfortunately these problems always go no unchecked due to what the respondent described as “Nigerian factor” in reference to

corruption which make it difficult for government officials to be objective in negotiating, supervising and evaluating donor programmes.

Most of the respondents suggested that considerable measures be put in place in selecting funding modality for donor funds so as to reduce the foregoing constraints listed. The measures should include: adequate budgetary allocation for counterpart funding of externally assisted health programmes in order to enhance systemic ability, leadership and local ownership of such programmes after the disengagement by donors, only priority programmes should be allowed by government and donor conditionality should not be allowed to deflect viable government policies and guidelines of government causing shock to the system. Therefore, as much as possible government policies priority should determine the entry point of donor programmes and assistance. The respondents also insisted that the health sector should not be allowed to donor driven and called on government to ensure that it maintains its statutory leadership mandate for provision of health services in the country. They suggested the consideration of some factors for fashioning out both government and donor programmes in order to make health delivery in the country more effective, such factors include: prevailing health problems in the country, pattern and rate of epidemics, population growth and government priority.

4.5 Nigeria's Health Model

Respondents were asked to state the type or model of health care delivery suitable and more effective to Nigeria. Majority of the respondents indicated that the health care model as the most emphasize in Nigeria.

The responses are tabulated in Table 4.6.

Table 4.6: Type of Health Care emphasized by the Federal Ministry of Health.

Category of Health Care	Frequency	Percentage
Health Care	25	50.0
Medical Care	15	30.0
Medical Aid	0	0.0
Capitation	0	0.0
Others: Preventive care, User Charges, Immunization	10	20.0
<u>Totals</u>	<u>50</u>	<u>100</u>

The tabulation in Table 4.6 implies that government has the greatest responsibility for the provision of health care delivery to the Nigerian citizenry.

Respondents were asked a follow up question to rate the overall performance of Nigeria’s health care delivery system. Their responses are tabulated in table 4.7.

Table 4.7: Respondents Rating of the Provision of Health care in Nigeria

Overall Rating of a Health Sector	Frequency	Percentage
Highly Satisfactory	0.	0
Satisfactory	15	30
Uncertain	20	40
Unsatisfactory	10	20
Highly Unsatisfactory	5	10
Totals	50	100

From the result in Table 4.7 it is obvious and evident that about half of the respondents are not certain with the level at which the health sector is performing in Nigeria. This could either be attributed to apathy or in the true sense of it the respondents are actually very unimpressed of the state of health services in the country. In follow-up interviews and group discussions on this particular issue the respondents were unanimous in their views stating that government health services have deteriorated to a

level that they no longer mean anything to them and do not offer them any health security despite the fact they too have to pay for the services offered in government establishments. They reported that even in areas where the government health services or clinics facilities exist, the population targeted have lost confidence in the quality of services provided in such centres. They also asserted that they get prompt attention and are offered more quality services when ever they can afford to pay for health services in private health establishments. The inference that could be drawn from this is that the Nigeria health sector is not functional enough as to adequately cater for the health needs of the citizenry.

4.6 Management Issues in the Health Sector (Federal Ministry of Health Headquarters).

Respondents were asked several questions on issues that border on structural organization, management and coordination of the activities of the national health sector by the federal ministry of health.

Their responses are summarized as follows:

4.6.1 Factors that disrupt the implementation of health programs in Nigeria

The factors as listed by the respondents which they feel account for the poor performance of the health sector include: poor funding due to late and non releases of budgeted funds to the health sector, delayed and

incomplete reporting of health issues, lack of motivation to staff especially the administrative staff who get lower salary packages than their colleagues in the medical profession. The design of health services have been altered substantially due to change in the management curve, which remains a major challenge in the attainment of health goals. The respondents would like to see coming up with a strong policies to address these challenges. Other factors include, misplaced government and donor projects, lack of maintenance culture, poor collaboration with private sector, shortage of personnel especially of health administrators, tribalism and sectionalism leading to poor utilization of available resources and poor handling and management of health issues. The respondents further stated that there is always late responses to management of health crisis by the top management cadre of the of federal ministry of health due to their insufficient management skills because most only possess professional health skills, poor coordination of collaboration with stake holders especially with the private sector, vertical health programme planning and implementation by government and donors, over compartmentalization of the Ministry of Health, poor evidence based decision making by top managers of health establishments. Other factors include, government bureaucracy, shortage of health managers in the Federal Ministry of Health, poor prioritization of health programs, poor job schedule for staff, over dependency on donor funds, inadequate

Office space, delays in promotion of staff which kills morale and lack of management training and skills by majority of directors at the Federal Ministry of Health headquarters most of whom are medical personnel. On this last point in follow-up interviews and group discussions most of the respondents insisted that there is the urgent need to break up the monopoly of the medical profession over health tasks and remoulding of the health workforce using role models specifically designed to reach majority of the people and decentralization of policy making. They insisted that the Nigeria health care system is already weak and badly under-managed and is facing incredible pressures. This further reinforces the need for management services to be accorded high priority in the health sector.

4.6.2. Factors that can facilitate implementation of health services.

The respondents after listing the problems that disrupt health services also listed or made suggestions on factors that could facilitate implementation of Health Programs in the Federal Ministry of Health. The factors as listed by the respondents are: ensuring availability of sufficient funding of the health sector, regular training/capacity building and retreat for staff, effective monitoring and evaluation of health programmes, training of health professionals in management and leadership skills, effective collaboration with other sectors and good working relationship with stakeholders, availability of skilled health managers, prudent

management of fund, right posting of staff for effective coordination of programs and emphasis on evidence-based interventions health programmes. Other factors include improvement of health infrastructure, motivation of staff, adequate supply of drugs and equipment and general re-orientation of staff in management services.

4.6.3. Role of the Health Manager in the Health Sector

The respondents also made some specific suggestions what the Health Managers is expected to do in order to improve provision of Health Services in Nigeria. The following are some of the issues that health managers should be mindful: Constant review of health policies and advocating for sufficient funding of the health sector, paying more emphasis on preventive medicine and capacity building in leadership and management skills for senior staff of the Ministry of Health, ensuring judicious use of resources, proper prioritization of health Programmes and creating enabling management environment for staff to function without hindrances.

4.7 Policy Issues that Affect Organization and Management of Health Sector (Federal Ministry of Health).

Essentially the enabling environment that was emphasized centres on the issues of meeting welfare needs by health managers.

An interview schedule was administered to top management and professional staff of the Federal Ministry of Health. The interview

scheduled addressed issues that have bearing on the implementation of national health policies, institutional, operational and management problems that impede achievement of the mandate of the health sector. Their responses are presented in this subsection.

4.8 Interview Schedule – Synopsis of Responses of the Senior Managers of the Federal Ministry of Health.

4.8.1. Health Policy Formulation

During the interview schedule the senior managers expressed their opinions on the process of health policy formulation. They stated that the Federal Ministry of Health always involves interest groups in the formulation of health policies. It does that in order to ensure: participation and successful implementation of health policies, increase and ensure legitimacy of the health sector and also to ensure that participants or stakeholders of the health sector are well informed and gaps in policy frame work are minimized or even eliminated. Special attention is also given to the effect of poverty in the development of priority health programmes and in determining outcomes and to inter-governmental coordination and political support in order to ensure continuity and sustainability of health policies. Another dimension reiterated by the respondents was that the current National Health Policy is outdated and incapable of providing the required results expected from the sector in Nigeria.

4.8.2. Organization and Management of Health Services

The top management and professional staff opined that the greatest challenges to the health sector rests on several fronts. In the first place, they were unanimous on the need to rebuild an effective service delivery system through training and retraining of existing management staff in the core topics of health management (ie policy, management of health care organizations, health economics, human resource management system and sociological perspective of health and illness) to handle increasingly complex intricacies of national health problems in the country. They also suggested that problems associated with inadequate utilization of health care facilities especially at the teaching hospitals, be tackled in order to enhance provision of medical services. They were of the view that the absence of legal and constitutional backing for health in the concurrent list in Nigerian Constitution encourages poor coordination of health policies between the Federal, States, and Local Governments including relationship with the private sector and donors. The current 1999 Nigeria Constitution only makes a vague reference to States and Local Governments responsibility for health. Unfortunately, the issues of health are just mentioned in passing just about three times in the Nigeria 1999 constitution.

They stated other factors that disrupt national health programs, to include the unpredictable nature of the behaviour of the health system which is

very difficult to control; rising cost in health care and medical care; rising health needs of citizens which put more pressure on government health resources. Other factors include limits on the capacity of citizens to pay for medical care due to rise of poverty which affect their ability to satisfy their health needs; scepticism of government in embarking in conventional approaches or organizational reforms; external shocks, both economic and political which affect the health sector; dependence on international funding institutions which disrupts health planning and slows down the health Sector; and absence of financing strategy which is a major hindrance to public health development in Nigeria.

4.8.3. Relationship of the Nigeria Health Sector with Donor Partners.

The top management also obliged views on what they feel has been the constraints on the use of donor use of donor funds in the health Sector. They stated the factors to include: poor project identification, conception, preparation and appraisal, poor articulation of donors' mission which leads to the inability of donors and recipients to coordinate their respective efforts. They further stated that donors generally fund vertical (top-down) projects as a result of which some segments of the population may be well served while others are largely neglected. There has been a lot of health grants, to Nigeria but with little impact in National health indices –and therefore recommended the development of an aid policy and strategy for the health sector.

4.8.4. Institutionalization of Managerial Skills in the Health Sector.

The top Management while bearing their minds in leadership transfer and development of managerial skills in the health Sector, stated that there are written guidelines for the transfer of both Managerial and Leadership position to successors at the Federal Ministry of Health. However, the veracity of this claim and the extent to which this is being practiced is contestable because of the obvious weakness of management services in the health sector that is likely to cause systemic failure in the future. The respondents were unanimous in suggesting the adoption of the concept of Management By Objectives (MBO) in the health sector. MBO stands for six key pillars as follows:- Joint goal determination; goal made 'attainable'; responsibility backed with adequate authority; continual guidance of subordinate; periodic joint review of accomplishment; and reward based on contribution. The respondents were optimistic that the MBO technique would go a long way in addressing the management issues and problems facing the Nigerian health sector.

4.9 Conclusion

The main finding of this study presented in chapter four is that the health sector in Nigeria is performing at a very low state. Consequent upon that, many Nigerians cannot adequately cater for their health needs. The shortfalls in health services are further compounded with the problem of weak organizational and management bases in the health sector. In other words,

the state of the Nigeria health services are largely a function organization and management which influence state of health services in terms of availability, access, quality etc

The study also revealed that other costs to access to health care that are not directly related to treatment are sometimes more important as influences on access to health care. There is therefore agitations that Health should be treated just like other public goods and services with respect to armed forces, highway, public information campaigns, public health interventions, public schooling, public water system etc for which individuals can not pay. For example people can not be expected for the services of armed forces and those provided by the police. Health should be treated like wise.

CHAPTER FIVE

Discussion of the Results

5.1. Introduction

This chapter discusses the data and results obtained from questionnaire, interview schedule and also from content analysis and methods of inquiry listed in the methodology which have been presented and analyzed in chapter four. The results are discussed under two broad sections which capture all the array and shades of the findings. The first section dwells on three major themes with respect to, health resources; health financing; organization and management of health services. The second section covers themes on the constitutionality of health; collaboration in the health sector; and welfare matters.

5.2 Health: Resources, Financing, Organization and Management in Nigeria.

(a) Health Resources

From the data gathered in the study it is established that operations in the health system for delivery of health care involves three actions, this are: System Inputs, Health Production and System Output. System inputs include, finance, facilities, personnel, equipment and suppliers that are required for health production by Health Providers who offer health services as system output to patients. In this regard the study revealed that after years of neglect Nigeria's public health system is failing to

deliver even the basic health services due to inadequate provision of funds and poor management has led to deterioration of equipment and facilities, lack of drugs, poor standards of care. In addition to that, poor conditions of services and working conditions have left professional staff highly de-motivated.

The situation is not different in the private sector which is also characterised by general lack of benchmarks in terms of facility standards and quality of services. Private health services have grown markedly during the past two decades, but many of them are still too expensive for most people to use, especially the poor. About 60 per cent of health services expenditure is out pocket and now occurs outside of the public sector on a range of for profit non profit, traditional and other practitioners. These findings are consistent of those of the World Bank and World Health Organization findings in 1998 and 2000 respectively. According to the World Bank, public financing of the social services (including the health sector) in Nigeria is put at 0.3 per cent of GNP which is lower in real per capital terms compared with the late 1970s and early 1980. Health management information system is weak. Actual records of national health expenditure to capture total spending contribution to spending from various sources and claims on spending by different users of funds are either incomplete, inaccurate, or not readily available.

On human resource management, there is evident of rigidity due to medical hierarchical bureaucracy and resultant lack of control by the professional health managers over the day to day operations of health facilities. There are no performance based incentives for the professional health manager and therefore because of the lack of accountability the scarce resources available to publicly run hospitals are most often ineffectively or inefficiently applied. With respect to capacity building and training, the study revealed that the training of health personnel (continuing medical education and training) has not been properly funded or implemented and even when this is achieved, their continued retention is not guaranteed due to poor service conditions and incentive (brain drain syndrome). This has further compounded the inadequacy of trained and skilled manpower.

Respondents also reported that public procurement system in the health sector is characterised by lack of transparency and inefficiency. Also that the security and maintenance of physical assets procured, as a culture, is poor such that the expected life span of such assets is severely compromised while replacement costs cannot be met. Thus government health institutions are characterised by dilapidated physical structures and broken equipment.

Reform programme should therefore embrace initiatives involving fundamental shifts in the area of financing options, purchasing and payment mechanism for health in order to improve the situation.

(b) Health Financing

With respect health financing, the study revealed that the major financing strategies of the Nigeria health sector to be from out of pocket expenses. This implies that public expenditure on health services in Nigeria tend to benefit the rich disproportionately because the wealthy or the rich can readily pay for their health needs. This also implies that real cost of health services may not be known in Nigeria because there is no national health accounts (NAH) system in place, this makes health care financing more complicated. These are the issues health managers in Nigeria have to note and pay attention to in order to address both the issue of equity and efficiency in the health sector. Health Managers need to pay special attention to the pros and cons of each financing strategy before deciding on financing policy in the health sector. What ever policy is chosen it must be a broad base financing strategy for results.

The results of the study further revealed that the role of stakeholders in health financing particularly that of donors are normally and originally skewed towards creating shift in health policy, improvement in institutional arrangement and improve Health status of the population. But the actual thing that is commonly found on ground is that most of the

donors often advocate for these changes on an ad hoc basis rather than fashioning out permanent schemes. It is therefore advocated that this culture needs to change so that external funding of the health sector should be hinged on the need to create a permanent enabling environment in order to enhance government capacity to sufficiently confront health problems (like emergence of new disease or resurgence of old one); minimization of health systems inequalities in access; quality assurance and development of partnerships and transforming Health Services of the Country.

The result further prescribed an ideal relationship of Government and Donor(s) for successful donor intervention. The relationship should be built around partnerships which should ensure that donors readily accept to work within existing government structures, core competencies and system rather than creating parallel structures; merging and matching donor and government funds to priorities, in a transparent manner and donors should be more flexible in developing collaborative working arrangements with government while they still retain their identity.

The findings as submitted in this sub-section are consistent with those of Cole and Ojo 1998 and World Bank 1984-1998.

C. Organization and Management of Health Services.

i. Organization in the health sector

The result of this study corroborate with the general agreement among organizational theorists and sociology of complex organizations that the structure of an organization affects (and often determines) the ability and willingness to innovate. Different organizational structural patterns stimulate different responses from members. Features of organizational structure which tend to retard innovation and conform to attributes of Weberian model are: centralized authority; formalized communication; centralized vertical line of communication; hierarchical structure ; a system of procedures and rules for dealing with all contingencies relating to work activities; and impersonal relations and selection and promotion based on technical competence and seniority. However the extend to which this is operationalized in the health sector depends very much on the management function.

ii. **Management in the health sector.**

From the result of this study it has been established that many less informed health sector workers Nigerians have some naïve ideas of what management is, or of what the manager does. Some still think of the manager as the former colonial master bossing a group of Nigeria workers. Many perceive him as the Nigeria elite occupying a white man's

post. A few see him as the official who goes on tour, has a secretary, and who appends his signature to important documents. A group sees him as the university graduate pen-pusher sitting in a cosy office in one of the state capitals. The most hostile have the impression that he is an official who does nothing but bark out orders, and act like the proverbial baboon that “chops” the fruits of the labour of his “monkey” subordinates.

Many also follow the traditional view of only applying the word “manager” to top executives of business or public co-operations

Although we would like to pause here and make some distinction between the manager and high level manpower. Managers are a subset of the country’s high level manpower which includes all technicians and professionals who have undergone long periods of formal or on the job training, and whose duties includes making vital decisions which affect human welfare. The physician, the professor and the research scientist are example of high level manpower. However, they become managers only when they directly supervise the activities of a large number of people carrying out tasks. One other difference between a managerial job and the jobs of other high level manpower is the quality needed to do the job. What the professor or the physician needs most is technical expertise. He can be very effective and efficient even if he cannot be “nice to people.. On the other hand, the manger deals basically with human beings. Technical training per se just ushers him into the portals of his

managerial career. With it he gains a foothold. But as he progressively ascends the echelon of management, he becomes less of a specialist and more of a generalist and coordinator.

More importantly a rather fine distinction between the jobs of managers and other high-level manpower hangs on the practicability of *delegating authority*. A manager can delegate his function to subordinates. In fact, the ability to delegate authority and still get the job effectively done is the acid test of managerial talent. A businessman who cannot assign some of his duties to others remains a sole trader, while the one who can may rise to become the chairman of a giant corporation. An army general who cannot rely on feedback from his subordinates loses the legitimacy of his authority.

On the other hands, many non-managerial professionals do not find it practicable to delegate their function to subordinates. For example a surgeon who hands over his knife to a subordinate is risking the loss of patients and his license. A professor, similarly, has no choice but to conduct classes himself.

A distinction must also be made between the manager and the entrepreneur. The essential difference pivots on their relationships with the organization. The owner is the source of life of the organization. He founded or inherited it, and can at any time terminate its existence. The manager on the contrary is simply an employee. He was hired by or on

behalf of the owner and holds office at his pleasure. One other distinction is that the remuneration of management is contractual and so, fixed, while that of the owner is residual and not fixed. The owner takes whatever is left after has paid for all the expenditure of the organization.

From the foregoing what would be expected to happen in the health sector is the urgent need for re-designation of roles and responsibilities for some of the staff of the health sector focussing in strengthening skills in health management. There is the need for a deliberate policy for attracting and retaining suitable health managers into the health sector, which should be accorded high priority. This could be actualised through a comprehensive customised training structure both for short term and long term. It is the view of this dissertation that, the curriculum should as much as possible be structured to incorporate Drucker's (1974) and Grossman and the American Management Association (AMA) (1979) course outline. Which stipulated a list of 18 generic competences required for management tasks, responsibilities, and practices. The clusters include the following: *Intellectual abilities* (i.e. logical thought, conceptualization and diagnostic use of concepts); *socio-emotional maturity* (i.e. self control, spontaneity, perpetual objectivity, actual self-assessment, stamina and adaptability); *entrepreneurial abilities* (i.e. efficiency orientation and productivity); *Interpersonal abilities* (i.e. self presentation, development of others, concern with impact, use of unilateral power, use of socialised

power, oral communication skills, positive regard and management of groups) Equally the technical specialist managers should also be properly delineated from those of the core management specialist in the health sector.

The results further revealed the need to carry out some sort of reforms of the health sector. Such a reform should be seen to provide opportunity for well articulated health problem definition, diagnosis of health problems, clear policy development and gaining political commitment for implementation and evaluation of the outcomes of such reforms. The Federal Ministry of Health is expected to evolved the reforms in this conventioneer manner because health systems anywhere they are found are generally complex socio-economic entities in their structure and their functioning are often influenced by rational action of all interest groups and views of all stake holders and helps to prevent gabs in policy frame work of health reforms.

The results would like to see the organization and management of the health sector fashioned along the line of ensuring managerial and technical efficiency in the provision of health services. There is also a requirement to enact a strong health policy which should serve as the major control knob for health systems in Nigeria. This needs to be so because changing any health care system is a political process and

recognizing the fact that ethics, politics and economics all influence how health system work and how they are judged.

Therefore towards improving the performance of the Nigeria health sector policy makers should apply a variety of organizational and management reforms. The reform strategies should seek to maintain (predominantly) public financing as well as public ownership while simultaneously “mimicking” best practices from the private sector. Which ever way it is done the main objective should be the realization of positive health outcomes and creation of efficient workforce in the management of health care organizations.

5.3 Constitutionality of Health in Nigeria; Collaboration in the health sector; and Workers Welfare.

(a) Constitutionality of health in Nigeria

The result of investigation in this study shows that, the Nigeria 1999 Constitution is short of specifying what roles the local, states and the federal governments must play in the national health care delivery system. There is no adequate provision in the constitution on issue of health being in the concurrent list for the participation of the three tiers of government in Nigeria. The subject is merely mentioned just about three times in the 1999 constitution with commitment. Therefore what is seen in real sense because of the omission is that the state ministries who supervise the local governments are answerable to the state Governors not

to the Federal Ministry of Health. There is a disconnect between the Federal Ministry of Health and the State Ministries of Health to the effect that there is very weak sense of cohesion between the states and the Federal Ministry of Health. This makes it difficult for the Federal Ministry of Health to be accountable for health of the nation as legislated in the national health policy. It is expected that such lapses would be addressed by revising this aspect in the Nigeria constitution so that the Federal Ministry of Health can be in the best situated for its leadership role for the Nigeria health system. It is revealed by the study that constitutionally and operationally the Federal Ministry of Health was created to supervised the bureaucracy required for the day to day functioning of the health system. However like most bureaucracies, the ministry has now developed obtuse structures that are dysfunctional and inconsistent with the mandate of the national health policy.

(b) Collaboration in the health sector in Nigeria

The study revealed the existence of weak collaboration in the health sector to the extent that the national health system is replete with many areas of ill defined, conflicting and overlapping functions. There is a disconnect between the public and other sectors of the systems. Due to the seeming inadequacies of the public sector healthcare delivery system there is a parallel system of healthcare delivery in the private sector of the economy, there is a disconnect between the public and other sectors of

the systems. Despite the fact that the private sector has grown exponentially in the past decade largely fuelled by the poor financing and poor fiscal cycles, slow moving bureaucracy and general decay of the public sectors. There is still no proper interface between the activities of the public and private sector services providers. The general scenario is one of fragmented and uncoordinated care and services.

This lack of proper coordination is also made manifest in the activities of donors in the health sector. Donors generally fund vertical (top – down) projects or work in a particular state or zone. The result is that some segments of the population may be well served while others are largely neglected. In most instances, while aid may cover capital costs, recurrent costs (e.g. maintenance and salaries) fall on government and have never been sustainable. That is why despite the large list of grants, donor funds and NGO activities in Nigeria has been made very little impact on national health indices as reported by international assessment by the World Health Organization in 1999-2000. The Federal Ministry Health should be henceforth be required to define and enforce partnership relationships in which assistance is used to support national defined policies and strategy rather than the (present practice of separately financed health projects initiated by donors sometime parallel and stand alone programmes.

(C) Welfare Matters in the health sector

The issue of meeting the welfare needs of the workers was also investigated. Of course, one of the basic assumptions of managerial practice is that workers can be motivated to high productivity by satisfying their needs. This assumption presupposes that every worker has some internal urges which propel him or her in specific directions towards self-fulfilment, not only for job satisfaction in the work place, but also towards the realization of his entire life's ambition.

Naturally, the directions of these urges or needs differ from one worker to another. The question has always arisen – what are these needs? On a general level, certain uniform clusters of needs have been identified and classified. What has not been very easy to determine is the exact nature, sequence and magnitude of needs necessary to keep a group of workers functioning optimally at all times. The important goal of welfare and management development in an organization is to ensure that competent and trained individuals are always available for staff, managerial and executive positions as the organizations grows. Therefore, to attract and retain such individuals will require the provision of compensative rewards, enhancement of career paths and employees perception of the organization as a stable and fair employer.

Three theoretical perspectives have direct relevance to the analysis in this dissertation. The first is the need theory usually associated with A. H,

Maslow and Frederick Herzberg. The second is the cross – cultural theory which seeks to determine if differences in socio-economic-cultural setting also cause differences in the requirements for worker motivation. The third is the class theory which looks at the implications of structural linkages of different socio-economic groups as they relate to the productive process, the reward system and the consumption of economic goods.

On the first theoretical consideration, there is a tacit acceptance that workers have needs, all or some of which that may as yet be unknown or unsatisfied. This arises from the fact that despite often fair wages and amenities, some workers still perform below expectation. This proposition is important to this assertion in so far as it resurrects the ghost of Maslow's theory of the hierarchy of needs. Maslow's was the first psychologist to formulate a coherent theory of motivation which sought to explain why workers often still feel dissatisfied despite the provision of very comfortable amenities. Maslow argued that there is a hierarchy of needs that exists for the human being and which must be satisfied in the sequence suggested by him:

1. Physiological needs: Hunger, shelter, sexual gratification;
2. Safety needs: protection against danger and threat either from the environment or from people;

3. Social needs: After the physiological needs and safety needs are fairly well satisfied, the needs for love, affection and 'belongingness' tend to emerge;
4. Esteem need: These have to do with the wish that most of us have for self-respect and the good opinion of others;
5. Self-fulfillment: Last, but perhaps most significant. This concerns the individual's feeling about the value and satisfaction of his work (Nzimiro, 1975).

To Maslow, these needs are cumulative and the satisfaction of one makes the next dominant. Moreover, as any one remains unsatisfied, so long will it be a source of discontent. In attempting to identify the needs of workers therefore, one must first locate them along this needs' continuum.

Further insight into the needs theory of motivation was also provided by Frederick Herzberg. He attempted to explain another paradox of the work situation in which an efficient and apparently satisfied worker leaves a job that pays him well for another that pays him less. He developed a two-factor theory of job satisfaction in which he identified 'motivator' factors and 'hygiene' factors. The motivators satisfy an employee and comprise achievement, recognition, responsibility, advancement and the work itself. These are factors intrinsic to work itself and workers positively aspire to achieve them. The 'hygiene' factors include company policy, administration, supervision, salary, interpersonal relations and

working conditions. These are extrinsic to work and workers always have a negative attitude towards them. They therefore cause dissatisfaction. Herzberg's major thesis is that 'what motivates people is the challenge and pleasure they get out of work itself, the sense of a achievement they get from doing the work, the recognition for a job well done, a feeling of responsibility, and the desire for advancement.

The application of any version of the need theory to the Nigerian situation does however raise doubts as to its explanatory value. Indeed none from the result of the study of the theories tells us anything concrete about the needs of the Nigerian health sector worker.

However, if Maslow's needs theory is assumed to be true for the Nigerian situation, then the needs of the Nigerian health sector worker can, at least for conceptual purposes, be identified in terms of lower-order and higher-order drives.

Also the application of the cross-cultural theory to the Nigerian situation implies that Nigerian socio-economic-cultural environment is unique. The protagonists of this view insist that it is absurd to transpose the internal dynamics of one environment to another because they are not and cannot be exactly the same. The implication is that the needs of the Nigerian health sector workers may have culturally-determined peculiarities which might not exactly fit into the Maslow model of need and motivation.

History tells us that the Nigerian post-colonial state inherited the socio-economic system known as capitalism. It emphasizes free enterprise and is characterized by materialistic social values. It gives rise to an unequal distribution of resources and the development of social class categories. According to Nkrumah, each class 'is the sum total of the individuals bound together by certain interests which as a class they try to preserve and protect; (Nkrumah, 1970)

The Nigerian society is stratified into class group, not necessarily in the orthodox Marxian sense of owners and non-owners of the means of production. The identification of classes in Nigerian has fallen more in line with the Weberian conception of classes as socio-economic groups competing in a market situation. (Nzimiro, 1975, p.227).

This dissertation believes that classes (defined from any perspective) exist in Nigeria. For example the proletariat in Nzimiro's classification belongs to the lower and exploited class. That is where the Nigerian health sector worker may be classified. The major concern is to show how the stratified Nigerian class structure, deriving from the imported capitalist system, creates a mono-culture needs dictated by those of the upper and middle classes because they have a preponderant influence on the lower class.

For purposes of this dissertation analysis, the Nigerian worker (health sector worker) is seen as the wage earner whose sources of livelihood

and property holding are derived from no other source except the wages he receives through the sale of his labour. He buys in the same market as his employers and has similar social engagements. Market prices for his basic needs are therefore always above his income and he is always clamouring for wage increases. It is therefore not difficult to understand why wages or money should, and actually, do, dominate the needs of the Nigerian worker. In the capitalist system, in which he operates, property ownership is the primary *raison d'être*. Money is the soul of the system. It is the essence of capital. In symbolic and concrete terms it represents property, power and status. The capitalist system puts money first and last. Money purchases all material needs including the food which the worker must eat. Those who have money, because of the premium the system places on it, have tremendous influence. They intimate and tantalize those who do not have it. They set and dictate the type and pace of social life and those who do not have it look forward longing to having it. Thus the myth of money emerge and corrodes the mentality of the worker. In contemporary Nigerian society, the worker has surrendered to the hegemonic power of money. This supports Obi 1981 assertion that "Pay is the greatest source of job dissatisfaction". (Obi, 1981). That is to say the reason behind the clamour for money should be seen in the market situation. The prices are always too high for the worker's wages. Since his image of social reality has been distorted by money, the

Nigerian worker sees money as a primary need despite the historical inability of his wages to come to terms with market prices.

In the course of investigation during the study, there was a casual discussions with different sets of workers about their needs. Discussion centered on the prohibitive cost of garri, rice and various other food items in the market. Those who talked of promotion saw it only in terms of higher wages. Some workers complained that they are overworked and yet receive the same or lower salaries than some of their colleagues who did not work so hard. This was a clear indication that they needed recognition and not necessarily responsibility. Moreover, that recognition should have money value.

The most striking (at last for this analysis) is the revelation that has emerge out of the observations and involvement with the Nigerian workers is the concern by the workers of what they will acquire for their future use. They talk about pension schemes and old-age benefits. It became clear that for theoretical purposes, what the workers need must be conceptualized along different dimensions from the existing theories of need.

Most of the theories on need have conceived it primarily in static terms. There is no doubt that needs are dynamic. They change from time to time and with circumstances.

Our understanding of needs may be further clarified if we conceptualize them in temporal terms. Immediate needs are all those acquisitions, which fulfil only the short-term desires of a worker. They may be 'lower-order' or 'higher-order' needs according to Maslow and his worker. These are essentially material needs. The non-material or psychological aspects of them are by-products of the material needs but then, they are no longer needs in the sense that they do not motivate any more. Ultimate needs are those, which the workers aspire to at all times while still on active service. Once acquired, the possessor gets contentment from having obtained them. The link between both sets of needs is that the immediate needs are necessary and preparatory to the ultimate needs. Neither is superior to the other in strictly quantitative terms. They are only ordered along a time scale.

The implication therefore is that as long as the socio-economic system remains capitalistic, what the Nigerian public sector workers need and will continue to need(not necessarily what they should need) are high wages, recognition for the job he/she performs, pensions rights and a house (or even houses) of their own to ensure a comfortable life, not only while still on action service but also long after the service years. Such scenario is capable of making management of human resource in the health sector more conducive and more result oriented and consequently providing the enabling

environment for high performance in the sector and a robust health sector.

Conclusion

In this chapter the findings on the data presented on the result of the study as presented in chapter four have been discussed extensively. The discussion of the results as could be seen in this chapter shows that the findings in many respect are consistent with existing knowledge and in some respect new findings have emerged from the investigation. Also to a great extent the outcome of the study is consistent with research objectives, Research Questions and the hypothesis of the study and agrees with the suggestion that the health sector can only be effective if a mix management regime is institutionalized as set out in the theoretical framework. That management services are needed for the effective running of health institutions so that they are not longer run health by events without proper objectives and planning as reported by Attah, 1995.

CHAPTER SIX

Summary of Findings, Conclusions and Recommendations

6.1 Introduction

This study has set out to examine the trends of organization and management of health services in Nigeria for a span of over forty years in Nigeria from 1960 to 2004. The summary of the findings of the study which is presented below shows substantial achievement the objectives of the study in the following manner:

Generally in Nigeria, as each social sector grows, so too does its bureaucratic organisation. However, the pattern of growth in one institution differs from those in other due to different historical experiences, values, the ideas of its founders, geographical location and the cultural background of members who work within it. This is the scenario of the Nigeria's health sector as reflected in the summary of findings reported in this chapter as follows:

(a) Summary of Findings

(i) Over the years, specifically since independence, structural organization of the health sector was created to superintend the delivery of health services and the health system in Nigeria. But over the years the management mechanism of the Nigerian health sector have been affected by several issues that border on organization, financing, management and

welfare, which have affected the optimal functioning of the health sector. This is so because these same factors are the ones that shape the provision of health services, they are pluralistic and complex. Such complex issues are the primary responsibility of the Federal Ministry of Health to deal with. The result of this study points to the facts that the Nigeria health system is inadequate because the Nigeria's overall health system performance was ranked at the 87th position among the 191 member states of the United Nations by the World Health Organization (WHO) in its 2000 report. The 2003 WHO's report does not show any significant improvement on the Nigerian health system. As the outcome of study has shown, health status indicators are still one of the worse in Sub-Saharan Africa. Worst still is the fact that, the Federal Ministry of Health which has national responsibility for the health sector is not living up to expectation to deliver on its mandate. There is lack of control by health care managers over the day to day operations of health Institutions. This is compounded by the fact that in most government organizations procedures appear more important than results and discretion is limited. This is largely due to the fact that civil servants or public servants to which the health sector personnel also belong, who run the Nigerian government establishments would not want to take blame for a mistake. Consequently, the so -called 'managers' in the health sector are likely to take minimal risks for fear of having to explain to the ministry the bold

decision that has not worked out well. In effect, poor management or the lack of it in the health sector is a major issue and serious challenge that reduces peoples access to health and thereby hurting the health system.

Management services or rather the ‘health manager’ position is likely to minimise costs and waste and in the long run provides more prospects of producing the desired health out puts and outcomes in the health sector.

Other issues revealed in the study that have affected organization and management of health services at the Federal Ministry of Health includes:

- Health management at the Federal Ministry of Health is weak and incapable of providing incentives for good policy, programme development and implementation.
- Poor budgetary controls in the health sector.
- Poor internal controls and inadequate operations research.
- Dilapidated physical structures and broken down equipment in health facilities that Provide medical services which is a reflection of the maintenance culture in the management of public utilities in Nigeria.
- Lack of institutionalized mechanism for continuous managerial training and development for health Sector Staff thereby limiting managerial accountability in the health sector.
- More worrisome is the fact that the issue of ‘health’ is down played in the current ‘Nigeria 1999 Constitution’, where reference is made only about thrice on health under section 45 in the 1999 constitution. The

Federal Ministry of Health is only entitled to a moral oversight over the States and Local Governments on health matters; the constitution is not explicit on what roles the states and the local governments should play in the national health care delivery system. The current 1988/98 Nigeria National Health Policy which has attempted to provide roles for every tier of government is by now also obsolescence and will need to be replaced with another legislation, preferably an Health Act in order to re-engineer and reposition the health sector, especially the Federal Ministry of Health so that it can live up to expectation.

- With respect to the private sector involvement on the provision of health care in Nigeria; the findings revealed that private health care providers in developing economies to which Nigeria belongs appear to be more interested in selling product than in producing health. This is common place in the private sector in Nigeria, which is more engaged in the production of goods and services for profit. While there is nothing wrong with that, but the production of profit might or might not produce health. In effect, some of such health practices may even become more harmful than total neglect. While it is true that any private or economic sector has two roles- to provide services to some and to provide income to others, where some of the income are profits and some are wages, none of which must be allowed to affect the provision and quality of health services to the Nigeria populace.

(b) Conclusions

It is the conclusion in this study that, the Nigeria health care system is already weak and failure to mount an effective re-organization and management regime will lead to more challenges than is currently being experienced with grave consequences. The issue rescue of the health sector must start with an improvement on the stewardship role of the Federal Ministry of Health in the following areas:

i. Proper definition of roles for health Management in the health sector to serve as tool for rejuvenating the Federal Ministry of Health.

ii. Conducting more health sector performance assessment and researches, in order to make health management or “health bureaucracy” more efficient and effective and meeting the mandate of the health sector.

One of the biggest construct is the rigidity of the civil service which does not allow the Federal Ministry of Health to recruit freely the type of personnel they may deem relevant to its sector. Therefore any failure to mount an effective management regime to correct this state of affairs will further lead the Nigeria’s health sector to worse challenges, except measures are taken to address the issues involved urgently.

(c) Recommendations

Based on the findings and the conclusions of this study, the following specific recommendations are made on the organization and management of health services in Nigeria.

The main recommendation is the enactment of an 'Health Act' to replace the outdated 1988/98 National Health Policy. This should proceed by commissioning of a 5 to 10 years health Sector reform plan in order to correct the system-wide problems in the Nigerian health Sector discovered in this study which hinders the delivery of priority health services. The goals and objectives of the reform should include:

To reposition the Federal Ministry of Health in the area of setting priorities and providing legal oversight for the health system in Nigeria.

The legal oversight role should cover the whole health system including the public and private sectors and interface between the two sectors with the aim of achieving health improvements at lowest cost, best quality, with equity, client friendly services and ensuring sustainability. This is necessary because health services have four things in common: it is for people who need services; people who provide health services; people who support health services; and people who supervise and manage health services. Therefore running the Nigeria health system should involve everybody, every sector of the economy and every stakeholder, so that affordable health services and safe clinical services could be made available to the populace, in an equitable manner so that no one is denied access to basic health care. The reform should also ensure that the health system can continue to achieve its goals using available resources ad infinitum and the creation of the career health sector manager cadre in the

Nigeria health sector should be a priority. This can be achieved through direct recruitment or conversion of experienced health care specialists to managerial positions and providing them the relevant capacity building and training in management. This will be a positive factor in adopting and institutionalizing the art of mix management regime as set out in the theoretical framework of the study. The study revealed that the introduction and institutionalization of the mix management theory in the health sector is an achievable goal. The road map has been laid in this dissertation. The findings in the study show that this can be done through further researches because the issue of management in the health sector is currently under researched; introduction of mandatory managerial training for all officers in the health sector who have been promoted to the current civil service managerial grade level (GL) 15 and above. This will help produce a set of management staff who are sensitive to the special roles and operational modalities of the health sector. This should be one of the urgent steps in the quest for strengthening the administrative capabilities and management services in the health sector in line with the hypothesis of the study, 'that improving management services in the health sector, focussing on key management objectives is capable of producing efficient organization and management of health services and attainment of health goals and achieving the mandate of the Nigeria's health sector'.

With respect to the relationship of the health sector with the donor community which was also investigated; it is the recommendation of the study that, on donor funding, there has to be a shift from donor dependency to self sustaining mode in the health sector. Further to that internally, there has to be a strong alignment of the health sector to relevant sectors of the economy which make of the health system. Sectors like: agriculture, education, labour, science and technology, Industry, finance, housing and transport etc. This will ensure that the functions of health care are visible, known and felt by all.

Overall, the findings, discussions, conclusions and the recommendations of this study have tried to set out the tempo and direction for strategic reforms and investments in the key areas of the Nigeria's national health system within the context of the overall Government macroeconomic framework. It is envisaged that the proposed Health Sector Reforms (HSR) agitated and recommended by the study will emerge as a fulcrum for investing in the health sector for attainment of positive health by the citizenry in Nigeria.

In conclusion, although the recommendations in this study have focussed on the health sector, other sectors of the economy can also benefit from the outcome of this study as a component of the Nigeria's development process.

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APPENDIX -I-

QUESTIONNAIRE SCHEDULE

C/o National Action Committee on Aids

Plot 823, Ralph Shodeinde Street ,

Central Area, Abuja- Nigeria.

June, 2004.

**ORGANIZATIONAL DEVELOPMENT AND MANAGEMENT OF
HEALTH SERVICES IN NIGERIA [1960-2004]**

(A Case Study of the Federal Ministry of Health, Abuja-Nigeria)

Dear Respondent,

This questionnaire is designed to elicit your response on some questions regarding salient aspects of health management in the health sector in Nigeria.

The information sought is purely for academic exercise and consumption. Confidential treatment of the information supplied is assured. To fully guarantee anonymity of respondents, identity is not required.

Your anticipated cooperation is kindly acknowledged.

Thank you immensely.

Kajang, D.R.

Ph.D. Student.

St Clements University

BACKGROUND CHARACTERISTICS

1. Place of work:
 - a. Ministry _____
 - b. Department _____
2. Occupation or job title of worker _____
3. Sex:
 - a. Male _____
 - b. Female _____
4. Age _____
5. What is your highest level of formal educational attainment?

6. For how long have you been working with your organization? _____
7. In what capacity? _____

INFORMATION ON THE HEALTH SECTOR (FEDERAL MINISTRY OF HEALTH)

8. If you are familiar with the Health sector, would you say the objectives of the Federal Ministry of Health (FMOH) are being achieved?
Yes _____ No _____
If Yes, how? _____
If no, why not? _____
9. What can be done to enhance the provision of health services by the

FMOH? _____

10. Describe stake-holder's involvement in health management at the FMOH? _____

11. What factors facilitate implementation of health programme in the FMOH? Please List: _____

12. What factors do you think disrupt implementation of health programmes in the FMOH? Please List: _____

13. In your view, which constraints hampered health management services at the FMOH? Please List _____

14. Indicate the process of making personnel, materials and money available for health management services at the FMOH. Please list: _____

15. What would you suggest as measures for steaming the staff turn over rate in respect of health sector management? Please List _____

16. In the FMOH, is poor performance by employees accompanied by opportunities for improvement? Yes_____

No_____

If yes, how?_____

If no, why not?_____

17. In the FMOH, is good performance by employees properly rewarded?

Yes_____ No_____

If _____ yes,

how?_____

18. Is there written guideline for the transfer of leadership position to trained successors in the FMOH?

Yes_____ No_____

If yes, please explain how it is done_____

HEALTH CARE RESOURCES AND MANAGEMENT

19. What is the policy position of the FMOH on the mechanism for payment of health services by clients? Please tick:

- a. Taxes_____
- b. Obligatory insurance_____
- c. Voluntary insurance_____
- d. Out-of-pocket payment_____
- e. Other state_____

20. In your opinion who are the major actors in health financing in Nigeria? _____

21. In your opinion who are the major actors for providing donor funds (development assistance) for the health sector in Nigeria?

Please list

22. What in your opinion are the constraints in the use of donor funds in the FMOH and Nigeria?

23. What are the key considerations in selecting financing modalities in the FMOH?_____

24. What are the principles and criteria use for allocating available funds and other health resources in the FMOH?_____

25. What type of care does the FMOH emphasize most?

- a. Health Care_____
- b. Medical_____
- c. Medicaid _____
- d. Capitation_____
- e. Other List_____

26. Has the ministry been evaluating health performance and programme? Yes_____ No_____

If yes, briefly explain how_____

If no, why not_____

27. Please kindly list the strategies employed by the FMOH for quality assurance in the Health sector:_____

28. Out of the five options below, please indicate your level of satisfaction with the effort made by the Federal Ministry of Health to organize health services with respect to **personnel, equipment, health facilities** and **coverage** in Nigeria.

- a. Highly Satisfactory_____
- b. Satisfactory_____

- c. Uncertain_____
- d. Unsatisfactory_____
- e. Highly Unsatisfactory_____

Please, explain the reason of the option chosen above_____

29. What in your perception, managers of the health sector must do in order to improve provision of health services by the FMOH?

30. Please express your general view and recommendations on the management of the health sector in Nigeria.

APPENDIX-II-

QUESTIONNAIRE/INTERVIEW SCHEDULE

C/o National Action Committee on
AIDS (NACA),
Plot 823, Ralph Shodeinde Street,
Central Area,
Abuja.
June, 2004

Dear Sir/Madam

INTERVIEW SCHEDULE FOR TOP HEALTH MANAGERS

I am presently conducting a research on the topic: ORGANIZATIONAL DEVELOPMENT AND MANAGEMENT OF HEALTH SERVICES IN NIGERIA (1960-2004): { A Case Study of the Federal Ministry of Health, Abuja-Nigeria}; as part of the requirements for award of Ph.D. degree in Health Systems Management of the St. Clements University.

You have been identified as one of the health managers whose opinion should be sought on health management in Nigeria.

In view of the above, I hereby request you to grant me an official interview on a date and time suitable to you.

Before the interview date, it will be important for you to consider providing the researcher information in the following areas:

- (a) What has been the basic health policies of the Federal Ministry of Health (FMOH) ?
- (b) Has the Ministry been evaluating its health programmes?
- (c) What factors facilitate implementation of health programmes in the FMOH?
- (d) What factors disrupt implementation of health programmes in the FMOH?
- (e) Are there personal goals set for personnel of the FMOH for their work?
- (f) Is there written guideline for transfer of leadership position to transferred successors in the FMOH?
- (g) What are the major financing strategies for the health system in Nigeria?
- (h) What is the level of health development assistance to the FMOH from donor agencies?
- (i) What are the constraints in the use of donor funds by the FMOH?
- (j) What is the relationship between donors and the FMOH with respect to objective of donor funds, roles, success or failures of such funds?

- (k) What would you suggest as management measures that need to be adopted for strengthening the coordination of health services in the FMOH?
- (l) What are the health reforms cycles and critical stages areas used by the FMOH for its health plans?
- (m) What variables do you think the FMOH should adjust in order to improved its performance?

Thank you immensely,

Kajang, D.R.

Ph. D. Student.

June, 2004.

APPENDIX –III- LIST OF TOP MANAGEMENT STAFF

INTERVIEWED.

1. Departmental Directors
2. Divisional Heads
3. Sectional Heads.
4. Heads of Parsastatals.