Primary Health Care

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Funds squeezed and stretched: the predicament of health care

Funding for health in Ogun State, Nigeria is reviewed in relation to the health-for-all targets. The author examines the ways in which money is spent, with particular reference to the impact of wages, salaries and allowances on budgeting in a manpower-intensive sector.

In 1988, Nigeria introduced a comprehensive national health policy recognizing primary health care as the key to the attainment of health for all and aiming to fulfil the terms of the country’s constitution, which makes primary care a responsibility of local government. The secondary and tertiary levels of care are broadly the responsibilities of the state and federal governments respectively.

In Nigeria there is a declining availability of public funds at all levels of government. As in most other developing countries the world economic recession has worsened socioeconomic conditions. Thus the federal health budget for 1988 was only about a quarter of that for 1981 in real terms. Recurrent expenditure on items such as maintenance, medical supplies and drugs has continued to be reduced, whereas personnel costs have either remained constant or, more often, increased. It was decided nationally that the transfer of responsibilities for primary care to local government should be completed by June 1990. In Ogun State this process was actually finished by the beginning of 1990.

Ogun State covers 16,410 square kilometres and in 1988 had an estimated population of 3.2 million. The main population groups are the Awori, Egba, Egbado, Egun, Ijebu, and Remo, Yoruba being the principal language. The majority of people are either Christian or Muslim, and traditional religions are embraced by a small percentage. Some 71% of the population is literate and English is widely spoken. At least 45% of the population is under 15 years of age. Employed persons constitute approximately 52% of the population, the bulk of them earning very low incomes. There are 15 local government areas, five of which have been created since 1988.

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Health facilities and health status

Ogun State has 448 modern health care facilities, mainly geared for primary or secondary care. The tertiary care institutions are the Ogun State University Teaching Hospital at Sagamu and the Neuropsychiatric Hospital at Aro-Abeokuta. There are 38 hospitals, nine comprehensive health centres, 17 primary health centres, 56 health clinics, 164 maternity units, 128 dispensaries and 34 other special facilities. There are also many providers of traditional care, including herbalists, spiritual healers and traditional birth attendants. About 70% of the health institutions are publicly owned. Of the primary care facilities, 72% are public. The local governments own 84% of public health facilities.

The total fertility rate is about 6.2, the maternal mortality rate is estimated to be 15 per 1000 births, and the infant mortality rate is 90-120 per 1000 live births. This dismal picture is largely attributable to malaria, diarrhoea, respiratory and infectious diseases, and accidents. At least one in four children dies before reaching the age of five years. It is believed that reductions in deaths among infants, young children and childbearing women could be achieved through the improvement of primary care.

Local government revenue and health expenditure

The local governments spent 95 and 111 million naira (US$ 12.8 and 15 million) in 1988 and 1989 respectively, of which 11% and 10% went to the health sector. For individual local government areas the proportions going to the health sector ranged from 4% to 23%. Per capita health expenditure ranged from 2.2 to 5.8 naira ($ 0.30 to $ 0.80) in 1988 and from 1.2 to 5.8 naira ($ 0.16 to $ 0.80) in 1989.

Particularly in newly created local government areas the health sector tends to suffer inadequate funding while preference is given to infrastructural development. In 1988 and 1989 the health sector received only 60% and 54% respectively of proposed funding. Wages, salaries and allowances accounted for 58% and 61% of expenditure instead of 48% and 49% as had been proposed. In real value, however, less money than proposed was spent on personnel. This means that if the funding targets had been met, more money would have been available for non-personnel recurrent and capital costs, on which the success of many health programmes depends.

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The health sector continues to be manpower-intensive and thus carries a high bill for wages and salaries. Capital expenditure for 1988 and 1989 averaged 18.5% of total health expenditure, whereas personnel costs averaged 60%. The latter have to be carefully controlled if the local government areas are not to fall into the trap of spending an unsustainably large part of their health sector allocation on wages, salaries and allowances.

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Nigeria having adopted the target of health for all by the year 2000, it is important to examine funding and other critical factors from time to time. It is hoped that the present observations will stimulate comparable studies elsewhere in the country.
and contribute towards a national re-examination of financing policy in respect of one of the most important constitutional responsibilities of the local governments. At a time when much thought is being given to national health insurance in Nigeria it is desirable to appraise its relationship with the funding of primary care.

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**Women in poverty**

If poverty is measured by the number of people lacking a standard of living that includes adequate food, safe and sufficient water, sanitation, a secure shelter, and access to education and health care, over 2000 million people live in poverty — some 40% of the world’s population. A high proportion are women and children, who are more vulnerable to environmental health risks. Within households it is generally women who look after the children, manage the household, and care for the sick; as such they suffer more from the diseases associated with inadequate water and sanitation and from the defects in the provision of basic services. Women who head households also usually face discrimination in looking for jobs and in obtaining access to public services, housing, and credit.