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HEALTH ADMINISTRATION IN NIGERIA

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MAIN CONTENT

PAD 411
HEALTH ADMINISTRATION IN NIGERIA

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NATIONAL OPEN UNIVERSITY OF NIGERIA

MODULE 1

Unit 1 Principles and Concept of Health Administration
Unit 2 Nigerian Health Administration
Unit 3 The State of Health of Nigerian
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UNIT 1 PRINCIPLES AND CONCEPT OF HEALTH ADMINISTRATION

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1.0 INTRODUCTION

The concept of health transcends mere absence of disease and infirmities in an individual. It incorporates adequate psychological and psychic balance, a decent housing and unbridled access to daily intake of nutritive and balance diet (Mumen Lugard 2009) Based on the above must be demystified and made all embracing, if total spectrum of human races it to be captured.

Although recently, Nigerian government has taken giant strides in tackling the hydra headed problems relating to curative medicine, the 5-giants – disease, squalor, ignorance, poverty and illiteracy have continued to do the foot of health administration in Nigeria.

Before the advance of the colonial master, the pre-colonial Nigerian society had means of health administration e.g. traditional medicine for healing and prevention of diseases. For instance, Bendel – Igbo tribe uses Utezi a local bitter herb for treating diabetes. Names are abound to testify traditional and native headers in Nigerian society.

- Wombai ib Hausa/Fulani ethnic groups act as armies and red cross.
- Gozan in Nuoe ethnic group represents Barbar surgeon
- Ada-haise/Alawo performs medical functions in Yeruba ethnic group.
- Dibia is prominent in Agbor people and Ibo land.

Traditional birth attendant also perform the work of modern nurse in many Nigerian societies.

Brief Historical Background of Health Administration in Nigeria

The modern health practice in Nigeria originated from British Army Medical service which served British Colonies and protectorate. The British colonial gun boat diplomacy resulting in the formation of West African Frontier Force (WAFF) needed medical services for her soldiers. The British masters required health services for colonial soldiers. These medical services were later extended to local communities new government stations.

The colonial medical services were lather extended colonial service officers, their words and relatives and communities before it was extended to native community after Second World War.

Lord Lugard development plan had first hand plan for health for colonial Nigeria

This enables the Anglo-Saxon government to plan for effective health administration in Nigeria. The ten-yearned programme was designed as a catechism for subsequent health care programme for the people of Nigeria.

The first and second development plan, in health sector, was designed to correct, some injustice and deficiencies that existed in health administration in Nigeria. The third National development plan was a deliberate attempt to draw up a comprehensive national health policy, dealing with issues of man power development, provision of comprehensive health services based on basic health care service scheme, disease control, and efficient utilization of health resources medical research, health planning and management.

1978 saw the adoption of Alma-Ata declaration which emphasized community based participation. This means that the people at grass-root must participate firmly in the provision of services at village level and street level through planning implementing and managing the system through collective endeavour, it ramified self-reliance, and treated healthcare as an element of development. This mean that community need not wait until a doctor is available before health services can be delivered.

We can conclude healthcare services in Nigeria has evolved through our epochal phrases; serungbe (1992) emphasized that Nigerian health services evolved through a series of historical development, succession of policies, introduced by each governments.

Traditional birth attendants also existed as a means of delivery of healthcare services to the people. 1988 reorganization of the federal civil service presented an excellent opportunity for the crystallization of internal reorganization of healthcare system in Nigeria. This reform were targeted at professionalization of ministries, it provided for three mandatory deportments, personnel and management, finance and supplies, planning research and statistics. The honourable minister was made chief executive and the recruiting offices, instead of permanent secretary. The permanent secretary was replaced by Director General. At the end of the reform, the Federal Ministry of the health had the following deportments:

i) Personnel and management
ii) Planning research and statistics
iii) Disease control and international Health
iv) Finance and supply
v) Primary healthcare
vi) Population activities
vii) Hospital services training

The above marked a democratic epoch in democratic health administration in Nigeria

2.0 OBJECTIVES

3.0 MAIN CONTENT

3.1 Principle and Concepts on Health Administration

In scientific studies of health administration injuries core based on the use of principles and concepts. Principle of administration have been researched upon or written about; Woodrow Wilson 1941, the study of administration, Mooney and Reiley 1939 principle of organization, Mumen Lugard 2009 introduction to health Administration in Nigeria, theories and practice of Administration, principles are fundamental statement which core universally accepted truth or proposition. The principle of health administration must be able to describe in words, exactly local health organization look like and how exactly it work or operate. The principle of health administration must be able to describe in words or construct a vocabulary that permits such description. Principle of health administration work successfully everywhere irrespective of ethnic group, society and environment. They help administrators and health director to make sound and useful decisions. They are not necessarily laws but help to reveal to administrators and managers the best and most common ways of viewing and taking decisions, caring for potential customers consuming healthcare services.

The word concept is an attract word that describe and characterized a phenomenon. A concept is class or range of phenomena with destructive characteristics. They help to convey perceptions, world views and information about a phenomenon. The science of health administration begins with formulating and defining or providing meanings to concepts that describe a distinction phenomenon like health, healthcare on interest based on observations.

If concepts are to be useful in health administration, it be defined clearly, precisely, and unambiguous to achieve the target. People that

cannot define their object of their studies do not know what they want; and cannot know whether they have found it. Based on the above, defining concepts and principles are necessary for better understanding of health administration.

Principles of Health Administration

There are many principles of health administration. These include, Equity, justice, fairness, community participation, economy effectiveness, ethnical principle, value for much productivity. Emergency confidentiality, principle of public goods welfare.

Equity

The principle of equity entails that from the top to the bottom of human being are entitled to have access to hospital or health facility. Health is recognized as public goods and services. Health care services are based equal access to healthcare and Medicare.

Justice and fairness represents that government deemed to be fair to both rich and the poor, sick and the welled for having free access to reaching medical officers and health workers, with less cost, and affordable to all without one being favored than the other. This regarded as procedural justice and fairness in health administration.

Community participation

This principle is practiced through the primary healthcare scheme. Where the community being catered for are brought into the main stream of healthcare delivery system. The Nigeria health care national health policy is to achieve health for all Nigerian based on the philosophy of social justice and equity. In the words of ransom Icuti 1986 cited in Mumen Lugard (2009) primary healthcare is based on socially acceptable methods and technology made universally to individuals and families in the community, through their full participation and the cost the community can afford to maintain at every stage of development in the spirit of self-reliance and self-determination". The above forms can integral part over health system and overall socio-economic development of the community. This is first level of contact of the individuals, the family and the community within the national health system bringing healthcare as close as possible to where people live and work.

The primary healthcare projected by national healthcare policy is based on the philosophy of social justice and equity use the scheme of primary healthcare as instrument for achieving the goal. It integrates preventive, promotional and curative service. Principle of community participation

means that the people at grass-root must take part fully in the use and provision of services at village and street development through planning, implementing and management the system through collective endeavour.

Self-Reliance

Another component of principle of health administration is self-reliance. This principle is based on health as an element of development that means that community need not wait until a doctor is available before health care services can be delivered.

For self-reliance to be effective as a principle, health worker must have the skills to run the services efficiently and to measure their effectiveness.

Economy

We need basic economic principle to effectively administer health administration in Nigeria. We must understand how economic concepts, principle, technique assist in understanding and resolution of critical. Problems in the delivery of health services (Ann Clewer 2008) In UK. National Health Service, a public service funded from general taxation, structured as an internal market where provider units such as hospitals compete to provide service to industry, which is largely private. The U.S healthcare industry is largely a private sector system where health insurance companies pay bills for insured patients and the government provides some safety-net services for those who cannot obtain or afford health insurance.

Nigeria government only provides for workers in public sector which the private provides for their workers. The aged and the vulnerable class are not taken care; though government hospitals are visited by patients to pay through their nose. The economy as a principle was decoyed to prevent excess cost to people going to demand services of health care delivery.

Effectiveness

Effectiveness as a principle of health administration in Nigeria is based on the extent to which hospital and its workers performance reaches hospitals goals and objectives. People expect the services rendered in healthcare institution to be effective. Hospital to produce percepts because health gains or reductions in suffering where we want effective procedure. We want it to be provided and do not want to wait for it. The waiting line and cues in healthcare delivery in Nigeria is against the gains of effectiveness.

Efficiency

Another principle of health administration is the principle of efficiency. Efficiency is producing a minimum of waste of effort and resources (both human and material) while holding quality and quantity constant. Quality is the degree of acceptability as defined by standards or objectives (David Matins 2009). It also address, resources, and resource usage inputs and outputs analysis. A healthcare delivery may be judged to efficient is only if it can meet the above principles.

Productivity

Another fundamental principle of health administration is the question of productivity. The principle of productivity has remained a dangling but recognized instrument for measuring healthcare institution and its service delivery.

There are lots of misconceptions about productivity. Productivity is often equated with production, if more output of goods and services are attained, productivity is assured to have increased, but production only represents top of the equation (Bleach 2006). Based on the above, we cannot reach a conclusion about productivity without considering the changes in inputs that were refined to improve the output of productivity as a principle in health administration we mean how well organization or healthcare institutions utilizes and converts its resources man, material and equipment capital, energy into tangible items or services to achieve collective goods and services. a healthcare institutions can only be regarded productivity if only it can meet the above requirement.

Confidentiality

Confidentiality is achieved when healthcare workers keep detailed information highly classified as secret. This means that hospital and its workers are not expect to like official secrets curtained in case file of patients or end users of their services. When, this is done, the customers or patient can go into litigation. The healthcare institution are legal entity, they can sue ad be sued when the case arise.

Ethnical Principle

Ethnics determine an approved or unapproved behavior expected of doctors, and other health care professional and may put them into conflict with those who manage recourses and end users of healthcare facilities. A case in point of medical ethnics, it the relationship between doctors and patients, patients and nurses. Health workers are not allowed to have carnal knowledge with their patients.

Another aspect of medical ethnics is the assumption that the consumer are to be able to make fully informed decisions but when it comes to health care consumer is generally ill-informed. The consumer, the principle, consults the well-informed doctor the agent, for advice, in the perfect agency relationship. The consumer would then make a fully

informed decision about treatment, and this would be the same as the one the doctor would have made. In practice, the doctor may also tale the responsibility of making the decision for the patient. The doctor may, in many cases, supply the healthcare that has been recommended. Many doctors in many hospitals especially government hospitals refers patients to their private chemists for special drugs after they must have diverted from government health institutions; that unethical practical. This typified that, doctors usually manipulates the situation for their selfish financial gain. The patients has right to reject being treated by a selfish doctor and the patient is also protected from abuses by the doctor's ethnical and professional code of conducts.

3.2 Concepts in Health Administration

There are many concepts relevant in the study of health administration in Nigeria and health administration as a course of study, a discipline and as a profession.

Health administration is course of study, a discipline and a profession. At this part of the world, health administration is handicapped by generalists who don't want the discipline to advance in the educational enclave like the Army where the discipline was germinating the administrative generalist who formed themselves into elites drawn the discipline. We only university of Ibadan running master degree in Health administration.

Health

One of the concepts dominating the study is health. Health has been defined by experts and lay man. Health has been conceptualized as wealth. Others have seen it as the provision of portable water and things of life.

World health organization (WHO) has a broad meaning of health. WHO conceptualized as a state of functional well-being, a complete physical, mental and social, well-being not merely absence of disease and infirmity. The office of health economics of Britain states that, "a person would be regarded as healthy, provided he could socially and economically active even though he man have suffered some health disabilities or discomfort" (Peter Conrad 2009). This depicts that a healthy person should be economically and socially active despite disability.

Writing in the same veior, Mumen Lugard (2009) opened, that the modern concepts of health extend beyond the proper functioning of the body, it includes a said efficient mind and controlled emotions. This implies than an individual who cannot control his or her emotion cannot be deemed to be healthy. Health therefore, is a state of being hale,

sound body and mind. The individual judged to be healthy must possess mind and body functioning harmoniously together. Man therefore, man is an integrated psychosomatic unit, whose behavior is determined by social, Political, physical and mental factors.

Health therefore implies, physical fitness, normal appetite, sociability, cheerfulness, calmness, regulated emotion and instincts and wills, normal sex consciousness, optimism, freedom from anxiety, and tension, freedom from complex and prejudices receptive to new ideas, constructive outlook and healthy philosophy of life.

DEFINITION OF PUBLIC ADMINISTRATION

Various authorities have defined public administrations. Some of these definitions include:

(i) Public administration is the action past of government, the means by which the purpose and goals of government are realized' (Dwight Waldo 1978).

(ii) Public administration is a field mainly concerned with the means for implementing political values'.

(iii) Public administration can be identified with the execution branch. The executive function in government the executive on public policy (Jay M. Shafritz 1985).

(iv) Organizing and managing people and other resources to achieve the goals of government (Howard E. Mccurdy 1986).

(v) The Art and science of management applied to the public sector, it embraces management of the political, social, cultural, and legal environments that affect the management of public institution (Jay .M. Shafrilz and Albert C. Hyde 1986).

(vi) The process of "public administration consists of the actions involved in effecting the intents or desire of a government. It is continuously active, 'business' part of government, concerned with carrying out the law, as made by legislative bodies (or other authoritative agents) and interpreted by the courts, through the processes of organization and management."

(vii) Public administration differs from political science in its emphasis on structure and behaviour and in its methodologies. Public administration differs from administrative science in the evaluative techniques used by non-profit organizations, and

because profit seeking organizations are considerably less constrained in considering the public interest in their decision making structures and the behavior and their administrators (David .H. Rosen bloom 1993)

(viii) "Public administration is a cooperative group effort in public setting, covers all three branches;- executive, legislative and *the* judiciary and their interrelationships, has an important role in the formulation of public policy, and is part of the political process of organization and management." (Mcfarlin & Sweeney 1998).

(ix) Mortain Marx (1968) defined public administration as a type of cooperative human endeavour, characterized by high degree of rationality in the management of government activities.

(x) John Y. X Corson and J.P. Harris (2000) conceptualized public administration as the "action part of government, the means by which the purposes and goals of the government are realize"

(xi) John Pfimmer and R. Presithus (1989) defined public administration as a "field mainly concerned with the means of implementing public value"

(xii) Marshall E. Dimock and G. 0. Dimock, defined public administration as the "accomplishment of publicly defined objectives of a political state."

(xiii) Negro and Negro conceptualized public administration as a cooperative group effort in public setting that covers all the three branches of government, the executive, the legislative and the judiciary.

(xii) Glover Starling (1989) defined, public administration "accomplishing side of government." 11 comprise all the "activities involved in carrying out the policies of elected officials and some activities associated with the development of public policies."

(xiii) Philip J. Cooper and Linder Brandy (1997) conceptualize public administration as a field that "emphasizes the elimination of corruption, improvement of efficiency and the enhancement of better service delivery in pursuit of the public interest."

(xvi) Leonard R Whites (1989) defined public administration as the "management of men and material in the accomplishment of the purpose of the state."

(xvii) Preathus Prfiffer (2000) defined public administration as the

persecution of public policy as enunciated in law by the government. This definition makes law a distinguishing factor in public administration. This definition was echoed by Swart John (2001), who maintained that public administration is "decision made in public policy backed by law, and it operates within the framework of the law." This perspective must have influence David Rosen Bloom (1993) to opine that public administration is the "art of applying and enforcing the law in concrete circumstance."

(xviii) David K. Hart (1984) defined public administration as the "process- that consist of actions involved in effecting the intent or desire of a government with carrying out the law as made by the legislation bodies or other authoritative agents of the state and interpreted by the courts, through the processes of organization and management."

Legester Salaman (1987) conceptualized public administration as a "cooperative group effort in public setting that covers the three branches of government and their interrelationship, which has important role in the formulation of public policy and policy process."

(xviii) Ofoegbu (1986) looked at public Administration as the "activities that come directly under the government of any society." This definition is different from Taiwo's (1978) which emphases that public administration is the basis through which the "state delivers public goods and services to the citizenry."

Other authorities have regarded public administrations as "public management." In this regard, they defined, "public administration as field that examine personnel management, organizational control, policy management and organizational machinery for achieving policy goals." (James Perry 1983). Viewed from these various definitions of public administration, we can summit that public administration is a technical, academic field of study that required good scientific skills to gauge out its meaning. Besides, we can regard public administration as art and science of administration channeled towards achieving effectiveness and efficiency in publicly define goals, and objectives. It is also action part of government, the means through, which government achieves her target. It is also the process of managing public sector to achieve productivity and to enhance the delivery of public goods and services.

(ii) ADMINISTRATION

There are many definitions of administration, but sometime management

has been misconstrued to mean administration by some rookies in administrative science. The purpose of this section is to attempt to define this concept by looking various literatures in the explanation 'of the phenomenon. According to Advanced Learner's **Dictionary,** the concept administration refers to the activities that are done in order to plan organize and run a business or other institution.

(i) The process or act of organizing the way that something is done. The above definition is not enough to elicit what we need to understand about science of administration. The Dorsey Dictionary of American Government and politics conceptualized administration as follows:
(ii) The management and direction of the affairs of governments and institutions.
(iii) A collective term use for all policy-making officials of a government.
(iv) The execution and implementation of public policy.
(v) The time in office of chief Executive such as the president, Governor or Mayor. This Babangida Administration refers to those years (1985-1993) when Babangida was the executive military president in Nigeria.
(vi) The supervision of the estate of a dead person to pay and assign assets to heirs.

Viewed from the lexical analysis we summit that the term administration means many things to different people. Administration occurs as a result of interaction between individuals channeled towards achievement of stated goals and objectives; before any actions can be administration, efforts most be related through co-ordination of various activities.

Dwight Waldo (1955) defines administration as "a type of co-operative human endeavour that has the degree of rationality characterized by management and organization." This definition is slightly different from Moraine Marx (1968) definition who posited that administration is a "pervasive action, a systematic ordering of affairs and calculated use of resources aimed at making things happen." This definition entails that administration must be goal directed, and effective and efficient in the use of both material and human resources to attain a predetermined goals of an organization or an entity.

Stevens Robin (1989) conceptualized administration "as the efficient completion of activities with and through other people." This definition further reveals that administration is a process, a laundered concept that is tailored towards attainment of commonly agreed purpose. This must have influence John Mooney (2001) to define administration as a

process that form human organizations for the attainment of common purpose define by the groups of organization.

Henri Fayol defines administration in the narrow sense of management and regarded administration as a discipline, which deserved to be taught as a universal activity that any organization should be involved in. He maintained that administration has fine elements.

(i) Foresight
(ii) Organization
(iii) Command
(iv) Co-ordination and
(v) Control

The principles of administration he maintained include:

(i) Division of Labour
(ii) Authority
(iii) Discipline
(iv) Unity of command
(v) Unity of direction
(vi) Subordination to general interest
(vii) Remuneration
(viii) Centralization
(ix) Hierarch, order etc.

The above reveal that the science administration is very difficult to define.

Adebayo (1989) defined administration as "the organization and direction of persons in order to accomplish a specific end." Olaboye (2004) sees administration as "the dynamic process of arranging the scarce human and material resources available to an on Validation for effective and efficient attainment of its aims." Administration is also the "process of skillfully arranging the human and material resources, project and programmers designed to provide public goods and services to the society."

Olaitan Karimu (2000) defined administration "as the management of affairs as in management of public affairs." He also posited that administration, "Are those in the top management level or decision makers in an organization."

Aghenta (1998) Sees administration "as the process of getting the people in an organization through the efficient (doing things right) and effective (doing the right thing), use of available scarce human resources and material" to achieve define goals and objectives.

(iii) MANAGEMENT

1) Managed Care:

This is a new terminology that crept into management of health services. This is the arrangement whereby an organization assumes responsibility for all necessary health cares for an individual in exchange for a fixed payment. A successful implementation of managed care involved the development of clear protocols for determining:

(i) What symptoms and signs should be present before a patient is admitted in hospital?
(ii) Out of hospital treatment
(iii) Drugs to be used to treat certain conditions.
(iv) When specialist's counsellors or allied staff should be involved in case management

ADVANTAGES OF MANAGED CARE

(i) Protocols are evidenced_ based and enhance or ensure that patient receive scientifically validated treated.
(ii) Screening of need for hospital care can lead to significant savings of time and money.
(iii) It is cheaper than fee-for-service plans.
(iv) Out-of-date and ineffective treatment cannot be imposed on the patient.

DISADVANTAGES

(i) It may lead to under servicing of patient, which may result in not providing necessary care and services for patients.
(ii) It may undermine freedom of choice of the patient or clients
(iii) It may minimize short run cost and prevent the state-of-the-art care.

The balance of risks and benefits of managed care depend on the design or managed care policy. Jackson (1996) identified a number of features:

(i) Clarity of Policy: The policy coal must be well articulated to emphasize either cost saving potentials or provision of a more comprehensive and responsive mix of services.
(ii) Should managed care be voluntary supplement for defined population or a compulsory and universal approach?
(iii) Development strategies to ensure public accountability.
(iv) Introduction in phrased way managed care should be e.g.

Involved management skill and capacity building.

(v) Introduction in phrased way managed care should be e.g. involved management skill and capacity building.

Note that managed care was developed recently from the need to attract patients, from those wishing to obtain private health care packages.

2) TELEMEDICINE

This is electronic transfer of medical information, data voice or video-via telephone lines or satellites. It ranges from simple phone consultations between primary care doctors and patients to sophisticated electronics links for the shaping of medical information among hospitals, universities, research centres, rural clinics and private homes. It alters fundamental face-to-face relationship, which has police medical care for generation. With telemedicine, physician can analyze patients, X-ray and CT and MRI Scans, perform sonograms on Feluses, conduct psychiatric evaluations, analyze biopsies, listen to a patient's heart and lungs and examine eyes, ears, stomach, bladder, and other organs without travelling across to the patient or hospital when the tests are being conducted. This is practiced in develop countries not in Nigeria.

ADVANTAGES

(i) Specialists can be instantly available to anyone.
(ii) Rural hospitals can tap service from medical experts.
(iii) Developing ration can tap or have access to 21' century health care facilities.
(iv) It saves time and cost to patients.
(v) It prevents unnecessary medical treatment.

DISADVANTAGES

(i) It can be very expensive. Two way video can be very costly.
(ii) Insurance companies will only pay for patients they examine in-person.
(iii) Liability is not possible. When physicians are licensed e.g. in some countries, the physician may not be liable in his decision through telemedicine.
(iv) There is the problem of temporary high science with common sense.

3) An Institute

This is a society of learned men and women. Such people are usually leave it have common professional orientation, and invariably engage in similar academic and intellectual pursuits. They are three kinds of groups of people who within the context of the politics-economic organization of any society prescribe for themselves a code of conduct and work ethics. They are the set of people Peter Drucker refers to in his book "The practice managements" knowledge workers. Those who work in organizations with their brains, as opposed to those who work with their brains.

They are trained workers and intellectual gatekeepers of health organizations.

4) Health Administration

The commission on Health Administration in United States Government in 1974 conceptualized Health administration as the planning, organizing, directing, controlling, coordinating and evaluating the resources and procedures by which needs for health and medical care and a healthful environment are fulfilled by the provision of specific services to individual clients, organization and communities.

5) Profession

Abraham Flexner was the first to draw attention to the criteria for an occupation to possess to quality it as a profession.

(i) Profession must be intellectual in their judgment
(ii) Possess a large body of knowledge
(iii) They must possess technical techniques that can be used for problem solving
(iv) They must be organized into association committed to the regulation, education, and protection of their members. (v) They must be governed by altruism.

MC Glothlin added other criterion that profession must deal with matter of urgency and significance.

CONCEPTS OF PRODUCTIVITY

There a lot of misconception about the concepts of productivity. Productivity is often equated with production. For example if more output of goods and services are attained, then productivity is assumed

to have increased; but production only represents the top of the equation. Therefore, we cannot reach a conclusion about productivity without considering the changes in inputs that were required to improve the output.

Besides management, misconception about productivity is the definition of input. Managers and non-managers assumed that the word productivity applies exclusively to the labour inputs. This assumption has no rational basis, as an organization success is dependent upon the effectiveness with which it utilizes all its resources, raw materials, capital equipment, and energy, as well as labour.

Furthermore, the view that productivity improvement only applies to the labour input is dangerously narrow and short sighted. This may well result in a failure to capitalize on significant opportunities to improve organizational performance through better, equipment utilization, reduction in material losses and the conservation of energy.

Beyond these common misconceptions productivity issues is fraught with practical complexities. An organization output may be difficult to define. The output of a manufacturing organization may be obvious to productivity observer, but what is the output of a Hospital, or Health Service Administrator? Many organizations have jettisoned or thrown aside the issues of productivity because of their inability to relate this concept to theft organization. Besides, in white collar job or environment may fail to produce the desired result.

The question now is what is productivity? John G. Beleher Jr. (1987) defines "productivity as the relationship between the output of an organization and its required inputs." He further maintained that we can "increase productivity by improving input/output ratio", that is by "producing more output or better output, with a given level of inputs resources." This definition is slightly different from David Connell's definition (1989) that productivity is "how well an organizations utilizes and converts its resources (man power, materials equipment, capital and energy) through some type of production process into company or organization output tangible item or services to achieve the predetermined goals and objectives." Efficiency in productivity emphasizes producing the desired results, while effectiveness in productivity entails producing at a minimum waste, expense or effort while holding quality and quantity constant, quality means the degree of acceptability as defined by standards or objectives of the organization and services or goods delver)] and quantity entails measuring countable output in terms of increasing or decreasing magnitude. Timeliness is producing the goods and services at an acceptable schedule.

Other definitions of productivity exist as follows:

Productivity: The relationship between the production or provision of certain goods and services measured by volume and one or more of the corresponding input factor measured by volume. (David Martin 2005) A deliberate and systematic attack on waste in the use of resources that involves a change of attitude to work and a constant desire to find a better way of doing things. (Johnson A. Akinbade 2004).

Cacolyn Burstein (1988) defines productivity as the "efficiency with which resources are used to provide a government service or product at specified levels of quality and timeless, efficiency is achieved by deducing unit costs (total Naira value of input divided by total number of output) associated with a product or service."

Quality is the extent to which a product or service meets consumer requirement. Timeless implies meeting schedules for design, development and delivery of a product or service. John G. Blelcher Jr. (1988)' Productivity is a simple notion that is the relationship between the output of an organization and its required input.

David Connell (1988) "productivity is the relationship of how well an organization utilizes and converts its resources, manpower, materials, equipment, capital and energy into company's outputs (tangible items or services)"
We can develop measures consistent with the above definition of effectiveness producing the desired result. Efficiency producing a minimum of waste, expense or effort while holding quality and quality constant.

Quality a degree of acceptability as defined by standards or objectives

Quality measuring countable input in terms of increasing or decreasing magnitude timeless produced or provided an accepted schedule.

David C. Martins (1991) Productivity is efficiency concept that gauges the ration of outputs relative to inputs into productive process.

Effectiveness relates to the extent to which performance reaches organizational goals. Efficiency addresses the' resources, the resource usage (inputs) involved resource in achieving outcomes (outputs) productivity is aimed at assessing the efficiency aspect of organizational performance the ration of output relative to inputs. As such, productivity can be useful tools for manager, because it helps them track progress towards the more efficient use of resources in producing goods and services, organizational productivity is measured by using this equation,

Productivity - goods and services produced
Labour + capital + energy + trends + material

Total factor productivity approach that considers all the input partial factor productivity a productivity approach that considers the total output relative to a specific input such as labour.

Glover Starling (1988) productivity is a measured of the

Healthcare and Health

Healthcare systems provides services, but what exactly are raise serviced intended to produce? Presently, the purpose of healthcare is to produce an improvement in health, the maintenance of good health and/or a reduction in suffering. UK healthcare system is publicly funded, with a small private healthcare sector, the US health system is largely privately organized, funded from private health insurance schemes and has limited public safety-net provision. Nigeria healthcare system is government driven, why private sector help to argument government policies for healthcare. Healthcare can be bought and sold as public and private goods, health cannot. To be in state of good health is not to be just alive, but capable of enjoying life to the full. This is a state in which individual's capacities for taste and role performance are maximize (Twaddle 2009). The definition of health by government may well have implications for the range of services offered by them national healthcare services.

There are just different degrees of ill-health and dimensions. Paris, mental impairments and physical disability are all aspects of ill-health. Government managers and clinicians may view their health services as sickness service in which is any state which has been diagnosed as such by health service professionals. The above perceptions influence the kind and nature of healthcare services provided.

Healthcare and economics

Economics is the study of the way in which choices are made about how best to use scarce resources to satisfy human wants (David Pakins 2006 P.11) because resources are scare and the means of satisfying them are remote, not all needs are met. Objective conflict and choice must met immediately, which are evenly and which are not met at all.

The application of economics to health and healthcare rouses some difficulties for example, health is difficult to define and measure and the benefits of health are often difficult to assess because it is not only restrict6ed to healthcare irrespective of their ability to pay for it. The

Nigerian example in healthcare is different from United Kingdom and United States of America.

The individual have right to healthcare irrespective of ability to pay for it. In U.K. there appear to be a greater concern with equity of provision than there is in the USA. The methods by which healthcare is financed very greatly from country to country, so to do the methods by which production and delivery of services are organized, but all healthcare system face the same basic economic questions.

- Which good and services to product?
- How many resources should be allocated to different specialists
- Should cosmetics surgery or infertility treatment be provided at public expense?
- How to produce the goods and services
- Will the mentally ill be cared for in small community-based units or in large hospitals? What proportion of surgical operation and procedures will be carried out on a day-care basis?
- Who receives the goods and services? Should the state provide health services only for the poor? When funds are scare, will preference be given to patients of fund-holding practitioners?

The healthcare system all knew the world both developed and underdeveloped has being facing the same problems of ever-increasing demand and rising costs. The poor cannot afford the high cost in private market healthcare system without looking for safety nets which the state can provide.

We have attempted to evaluate the relationship between Healthcare and economics, he shall know more when we deal with health economics.

The Basic Economic Questions

We begin basic economic question with Nigerian health service HHIS. A public service funded from worker's taxation structured as an internal market, where providers such as hospital compete to provide services to purchaser such as government workers and private individuals. Where health insurance companies pay the bills for insured, patients and the government provides safety-nets services for those who cannot obtain or afford health insurance. The Lagos State Government provides safety nets for the aged and pregnant women for paying for their treatment.

Nigerian government operates the same healthcare services in the USA market for healthcare services are less-highly regulated. The distribution of the output of the economy between healthcare and other

goods and services is largely determined by forces of demand and supply (Market force).

Basic Question

i) Have hospital administrators failed to plan and budget effectively for the financial year?
ii) Is hospital being run inefficiently and not making the best use of its resources
iii) Has hospital failed to obtain enough drugs, and it so why?
iv) Why are expensive facilities lying unused there are waiting list for treatments?
v) Is this situation an inevitable result of the market forces introduced by the NIHL system?
vi) It NHIS underfunded?
vii) Is there problem if corruption in our NHIS) system.

The first five question, is concerned with the demand and supply of services, the ways services are being planned and organized, the characteristics of the marketing in which the hospital is operating, the efficiency or otherwise of resources used and the pricing and the marketing of services.

Question 6, 7 and 8, are questions which can be answered only by using value-judgments. They are outside the conventional or positive economics which does not tackle problems which requires interpersonal comparison of welfare (Buchanan 2000) Positive economics attempts to establish cause and effects in scientific manner.

By contrast, normative economics is concerned with establishment means by which socially desirable outcome can be achieved. It is perspective. It suggests what "aught" to be. Question about whether the distribution of income and output is equitable are normative since there is no universal agreement about what is fair question such as question 6, about health consequences for patients are also normative because they require interpersonal comparisons of health status and the measurement of health status requires value – judgments.

It could be argued that all economic questions about the allocation of resources in healthcare are normative, since the final outcome is generally some change in healthcare status of patients.

Nevertheless, managers and health service administrators, operating the services on a day-to-day basis are more likely to contrite on intermediate and easily measurable outputs such as number of patients treated and will treat such questions about resource allocation in healthcare are

normative or positive and many lie at the root of some of the conflict between health service managers and clinicians.

Question 7 and 8 are clearly normative. For instance, the question of whether the service is underfunded or not requires us to consider what level of fund ought to be, bearing in mind that if more public funds are devoted to healthcare there will be less available for education and other public services. Similarly, a question such as question which asks is it fair that requires us to make judgments about what is fair and what is not.

Fairness, like needs is in the eye of the beholder if all are to have, fair shares, someone or some group of people must decide what shares are fair – and they must be able to impose their decision on others (Fried M 1980). No matter how the question, are positive or normative Nigeria healthcare sector have being suffering from underfunding and embezzlement of funds.

Basic economic questions enable us to pose the right questions and evaluate the workability or otherwise of healthcare delivery system.

The cost of poor health

Poor health in an individual imposes costs on the individual in terms of reduced ability to enjoy life, earn a living or work effectively. Improve health allows the individual to lead a more fulfilling and productive life. Poor health in an individual will have an impact on and may pose threats on others for example:

- A person with an infectious disease may infect others. Tuberculosis and AIDS is case in point.
- The family of a breadwinner in poor health may suffer the consequences of reduced income, a poor diet, less good hansing.
- Family members may have devoted time and resources to caring for the sick person and in addition may be unable to take paid employment.
- The employer of a workforce in poor health may suffer reduced productivity and hence incur higher average costs.
- Other workers in the same department of the sick may have cover load of work as the work activities of the sick will be distributed to others who have had a fair share already
- More people in poor health pose extra costs on tax payers if health services are funded through taxation. This may become an increasing problem as the ratio of the retired to the working population, sometimes called the dependency ratio, increases
- The knowledge that some members of the population are in poor health may cause distress to other healthier numbers.

Viewed from the above, we can surmise that improved health care services provide benefits to the society as a whole if they result in improved health individual. Besides, the process of providing benefits to the individual the careers and their families (Mooney 2004) scholars such as Mckcouen (2006) Mumen Lugard (2009) have argued that the role of medicine in improving the health status of the population has been exaggerated and that factors such as housing, education, diet, hygiene and standard of living have had a more significant impact on levels of health than what we conventionally think of as health services.

4.0 CONCLUSION

The definition of healthcare services by the state and its agents will reflect on missions on healthcare administrator. This will have implications for the range of services offered by national health services. The example health review 2009, demonstrated increased budget for curative medicine in Nigeria rather preventive and promotional medicine. This is reflected in many hospitals for treatment of diseases, sickness rather healthcare institutions established for promotive and preventive medicine. The historical background of Nigerian health administration revealed how colonial master took over from traditional birth attendants, nature doctors for treating sickness and diseases. This influences our modern healthcare system.

5.0 SUMMARY

In this unit, we have tried to define, health administration, brief history of Nigeria health administration, principles, and concepts in health administration, the relationship between health administration and public administration, relevance of health service administration and basic economic question in health administration. These basic questions enable us to address issues relating to healthcare system in Nigeria environment.

6.0 TUTOR-MARKED ASSIGNMENT

1. Define health service administration?
2. Critically examine the evolution of Nigerian health administration?
3. What are the relevance of health administration?

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UNIT 2 INTRODUCTION

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1.0 INTRODUCTION

Nigerian Health Service Administration: Health transcends the mere absence of disease and infirmities in an individual; it incorporates "adequate psychological and psychic balance, a decent housing and unbridled access to a daily intake of nutritive and balanced diet" (Akin Mabogunje 1991) Based on the above, the perception promotion, protection and delivery Of healthcare services must be demystified, diversified, and made all embracing if the total spectrum of human-being is to be captured. (Farm Hense Dialogue 1999).

Nigeria has taken great strides forward in tackling problems of basic manpower training in the health sector and continues to deploy considerable human and material resources to the area of primary healthcare that incorporates both preventive and curative. Level; (Oritejolomi Thomas 1991).

A brief analysis of health services evolution in Nigeria reveals the problem of curative and. medicine against promotional aspect. The new

national healthcare policy is based on the directive principle of social justice and equity with end goal of actualizing the WHO slogan of "health for all by the year 2000: The year 2000, have come and gone, yet the state of health services remains problematic and pathetic.

2.0 OBJECTIVES

At the end of this unit you should be able to:

- Understand the Tiers of Health Service in Nigeria
- Explain the Component of Primary Healthcare (PHC
- Understand the State Of Health of the Population
- Defined Referral to Primary Health Centre

3.0 MAIN CONTENT

3.1 The Health Services

The health services in Nigeria originated from the British Army Medical Services, which previously served all the colonies and protectorate of West African Frontiers Force.

With the integration of government, treatment w and their relatives and e living close to government stations.

Thus, the colonial medical service developed to provide free medical treatment to the Army and the colonial service officers. Medical services were provided at local level as an incidental service.

After the Second World War, the British colonial master had ten-year development plan and welfare, this mean extension of existing service, this serve as a thorough plan and subsequent health plan for Nigerians.

The Second Development plan (1970-1974) the health policy was aimed at correcting some of the health services. The third national development plan was a deliberate attempt to drew up a comprehensive national health policy with such issues like, health, manpower development, provision of comprehensive healthcare services based on basic health scheme, disease control, and efficient utilization of health resources, medical research, health planning and management.

The health contact of fourth national development plan reflected in the national health policy adopted in 1987.

3.1.1 Tiers of Health Service in Nigeria

There are three basic tiers of health services in Nigeria the primary health service, which is the closest to the people and is constitutionally the responsibility of local government. The secondary health service, which is for those problems that cannot be solved at the PHC level and are delivered in general or district hospitals under the supervision of the state government; and the tertiary health service, is the most sophisticated and costly for government and patients or clients.
The tertiary health services deals with the most difficult cases refers from the secondary healthcare systems to teaching and specialists hospitals and are supervised by the federal ministry of health.

It must be observed that, "the challenge at primary level is to establish a healthcare system that will reach the lives of every citizen and treat the conditions that cause the highest morbidity and mortality. The system must *be* organized from the grassroots and woven into the fabrics of the community through the process of community participation.

The United Nations through WHO and UNICEF declare the concept of primary healthcare (PHC) in 1986. (Gamel Mutime 2007) the Alma-Ata declaration 1978 confirmed the principles and the definition of primary healthcare. P. N. Odunsi (1991) observed, the most important principle of primary healthcare as defined at Alma-Ata in 1978, is community participation. It concedes with present administration's thrust to mobilize the nation for social justice, self-reliance and economic reconstruction."

The Nigerian government adopted the primary Healthcare system in 1987. The Alma-Ma Declaration of 1978 gave birth to Primary Healthcare (PHC) as a global consensus derived from the democratic ideals of liberation, self-reliance, and equity. It can be said that "PHC is a revolutionary movement poised to transfer some power to the people who hitherto have been alienated and marginalized by a health system that was elitist, urban based and western in origin. Yet operating within a cultural environment in which 70 percent of the people are rural dwellers with health beliefs about disease causation, diagnosis and cure that are entirely at variance with the orthodox medical systems **(M.A.** Ojo 1991).

3.2 Definition and Conceptual Clarification

The concept Health has been subjected to different definitions and conceptualization. Some viewed health as wealth; others have looked at health as indices for fitness and robust mind for creative zeal and development (Sola Aina 2007).

Farm House Dialogue (1991) maintained that healthcare could not be reduced to physical well-being. It maintained that, "a healthy individual must be physically fit, and enjoy spiritual, psychic and psychological balance as well as access to a balance nutrition, diet and a good environment, and maintained that WHO's definition of health "as being a state of complete physical, mental and social well-being is subsumed within the above broad definition."

World Health Organization (WHO) defined health as "complete state of physical, mental and social well-being and not merely the absence of disease and infirmity" J. T. 0. Osunwa (2007) observed that the concept of health also embraces "a good state of spiritual well-being." He based his locus of argument that "there can be no good health in the "absence of spiritual purity." He observed further that, "a healthy body and social entails:

i) A life free of disease.
ii) A life free of physical disability.
iii) A life of mental retardation.
iv) A life free of social shortcomings.
v) A life free from psychological problems.

Observing the shortcomings inherent in the concept of health J. F. 0 Osunwa (2007) maintained that "few people if any, can be said to *be* healthy in the true sense of the definition in both developed and developing countries, both rich and the poor are unwell." He maintained that "may be WHO will redefine health by perhaps, allowing these shortcomings in man since they cannot completely disappear."

Another critical factor that reveals the inadequacies in the definition is that, healthcare is not synonymous with medical care, even though they are both mutually re-enforcing. This means that, Healthcare is a multi-disciplinary effort and it takes a combined effort of curious professionals, groups to provide and maintain efficient and effective health care services.

This also demonstrates that, hospitals that provide medical services cannot provide family good health without assistance from other sectors. This is why experts in healthcare delivery have introduced programmes such as primary healthcare, social medicine, and inter-sectorial health. This further explained the resurgence of unorthodox health services in our Health sector political economic in Nigeria.

3.2.1 Primary Health Care

The national Health policy to achieve health for all Nigerian is based on the philosophy of social justice and equity.

A Health system based on primary healthcare is adopted as the means of achieving the goal for health for all Nigeria. 0. Ransome Kuti (1986) Alma Ata Declaration (1978) defined primary Healthcare as "essential healthcare based and socially acceptable methods and technology made universally to individuals and families in the community and through their full participation and at a cost the community can afford to maintain at every stage of their development in the Spirit of self-reliance and self-determination. It forms an integral part of both country health system and overall socioeconomic development of the community. It is the first level of contact of the individuals, the family, and the community within the national health system bringing healthcare as close as possible to where people live and work."

3.2.2 Component of Primary Healthcare (PHC)

Healthcare service is that service that is responsible for looking after the health of all the people in a country. (Longman 2006) Healthcare services represents quality of life services which enables the individual live most and to serve best (Kurbir Singh Sidhu 2006) effective and efficient healthcare service enable the people to get a sound efficient and controlled emotions, body and minds working harmoniously with integrated psychometric units. The challenge of healthcare system is to establish an efficient healthcare system that "touch the lives of every citizen and tackle the conditions that cause the highest mortality and morbidity." The system must be organized from the "grassroots and woven into the fabric of the community through the process of community participation" (Olukoye Ransome Kuti 1986). This is what G. Nonekosso (1987) maintained that, "the fundamental strategies of the primary healthcare approach is implemented within a well-defined districts, smallest viable politico-administrative units that individuals, families and communities living in district villages can forge partnership with their governments."

The grassroots nature of primary healthcare and community involvement was demonstrated *by* Patricia M. (2007) when she maintained that. "Primary healthcare will not succeed unless the community health workers have the skills to run the services efficiently and to measure their effectiveness."

The national healthcare policy designed to achieve health for all Nigerian is based on the philosophy of social justice and equity was

based on primary healthcare as the instrument of achieving the goals. The primary healthcare integrates preventive, primitive and curative services, using the types of technology. The community will accept at the level it can afford, and with an efficient and effective system of supervision and referral. The most important principle of primary healthcare as defined it Alma-Ala in 1978, is community participation. This means that the people must participate fully in the provision of services at village and street level through planning, implementing and managing the system through collective endeavour.

Another component of primary Healthcare is that of self-reliance, Healthcare as an element of development is linked with the issues of self-reliance, that is, "community needs not to wait until a doctor is available before health services can be delivered."

Other authorities, WHO, and UNESCO have observed that, "many communities through the principles of self-reliance are being served by categories of healthcare manpower down to the level of village health workers with excellent community acceptance and satisfaction and a measurable impact on the diseases that most afflict them." To promote self-reliance, community-based training, volunteer health workers, were conducted. Upgrading of existing healthcare facilities and implementing integrated healthcare service delivery was promoted.

Furthermore, reinforcing the principle of self-reliance is the principle o appropriate technology. No healthcare system can be possible without effective and efficient technology accepted by the community. This assumption was maintained by Smith (2007) whatever task are carried out to deliver the services, they must be of a kind that can be executed effectively, and maintained at the technological level of, the community. It is wrong to install an x-ray machine or a dental chair in a village where there is no electricity or piped water, let, alone radiographers or dental technicians."

The above, demonstrates that principles of self-reliance must be fuelled with appropriate technological knowledge applicable with the local community self-reliance and appropriate technology will be serviced by teaching mothers local birth attendants, how to prepare their solutions using salt and sugar that are available in their kitchens to deal with dehydration in children. A critical examination of the Nigerian experience in primary healthcare 1980-2000, revealed healthcare delivery system is yet to meet the aspiration of the people.

Furthermore, implementation strategies for actualizing health for all by the year 2000 are "more talk" and "less effort by the government. That, the government cannot cover the cost of health service in its entirely,

and communities must increasingly share in these costs, although community-based health activities require government support.

Besides, the Nigerian government budget allocation to health sector has fallen short of WHO's recommendation for health sector. That, the commitment to PHC at immediate and operational levels needs planning, management and evaluation to ensure its operational effectives.

That, many diseases that have been death with or controlled is resurging with debilitating alarm due to poverty and the divides between the rich and the poor due to policy of deliberate exclusion and mystics inherent in our social milieu. What is more, malaria and other childhood diseases are still leading causes of morbidity and mortality rates in Nigeria.

That grassroots information system, and manpower, and critical skills, must be mobilized to cope with the responsibilities of planning, implementing, monitoring, and evaluation PHC at local government level.

3.2.3 Nature of Health Service Background

There is no comprehensive information about the nature of healthcare, but publications from, USAID, NESCO, WHO, Nigerian universities and surveys conducted by tiers of government revealed good information about the state of health services in Nigeria has evolved through epochal phases. According to A. O. O. Sorungbe (1991). "The health services of Nigeria have evolved through a series of historical development, succession of policies mainly introduced by previous administrations." Despite, the above, the health services are observed to be unsatisfactory and inadequate in meeting the perceived health needs, demands and aspiration of the people. Oloko cited in Sola Aina (2006), maintained that, "the state of health of people is depreciating as regards man-hour cost as people report, to health centre for most illness ranging from joint plans to headshake." This situation demonstrates that, the healthcare series and the state of health of the people has fallen short of the mark for effective healthcare delivery recommended by United Nations.

The public health service administration in Nigeria has its inception in Nigeria has its colonial root age in British Medical services, which bench marked the services rendered to all British colonial territories in west Africa, through West African Frontier force. As the Army emerged with the colonial administration, medical services were given to colonial civil servants, their wards, and the local communities near the government headquarters and administrative stations.

It must be observed that the colonial medical services were decoyed to provide services for the colonial Army and service officers, rendered incidental services to the local communities. By the same token, missionaries, private agencies ran hospitals, dispensaries, and maternity centres in different parts of the country.

Besides, the unorthodox medicine with traditional birth attendants also existed as a means of delivery healthcare services to the people. The aftermath of the Second World War marked the water shield in the history of public health administration in Nigeria. In the world of A. O. O Sorungbe (1991), "the first attempt at planning ahead for the development of health services in Nigeria took place in 1946 after the Second World War: It was part of the exercise that produced the overall ten years plan for development and welfare 1946-1956 covering all aspects of government activities in the country. Despite its in built relevance, the scheme was "peopled" by colonial expatriates, the scheme did not relate to economic targets.

The gaining of political independence in 1960 gave an impetus to resurgence of healthcare policy that bore a little relevance to our social and political milieus. The national health policy inherent in the second national development plan (1979-1974) was designed to eradicate the imbalances and deficiencies in colonial health service administration. 1975-1980s marked another deliberate intervention; this was encapsulated in the third development plan. This plan dealt with health man power plan, and development, provision of adequate and comprehensive healthcare services, dealing with disease, prevention and control, efficient and effective use of health material and human resources, medical research, healthcare financing and management.

The fourth national development saw the introduction of primary Healthcare service delivery in Nigeria public health administration. This epoch saw the emergence of national health policy aimed at achieving health for Nigerians based on social justice and equity. A healthcare system based on PHC was adopted as a means of achieving the goals.

The 1988 reorganization of the federal civil service presented an "excellent opportunities for the crystallization of the internal reorientation of healthcare system in the federal ministry of health." The reforms were targeted at professionalizing ministries, making it more effective and productive. It provided for three mandatory departments, personal and management, finance and supplies, planning research and statistics. The honourable minister was made the chief accounting office instead of permanent secretaries replaces with Director General. After the reform, the Federal Ministry of Health had the following departments:

(i) Personnel and management
(ii) Planning research and statistics
(iii) Disease control and international health.
(iv) Finance and supply
(v) Food and Drug administration and control
(vi) Primary Healthcare
(vii) Population activities
(viii) Hospital services and training.

The above epochs marked democratic governance in healthcare administration in Nigeria. To make healthcare delivery more vibrate and effective, the principle of equity and justice was introduced through primary Healthcare.

3.2.4 The State of the Health Service Administration

Despite the apparent success in the public health policies adopted since independence in Nigeria, the state of health service administration is yet to achieve some desired goals, and effects.

(i) The state of health of the people is begging the question. Pregnancy and childbirth constitute a major threat to the lives of women between 15 and 45 years. They lack effective and efficient care during pregnancy and childbirth.

(ii) The coverage of Healthcare administration is inadequate WHO (2000) estimated that more than 30% of the population has no access to modern healthcare services.

Urban and rural poor are not well serviced.

(iii) The management of healthcare services and resources have resulted in wastage and inefficiency, are results of failure of healthcare team to meet with targets and goals. The activities involved in inter-sectorial healthcare services delivery are poorly coordinated.

(iv) There is poor orientation to curative medicine to the detriment of prevention or promotional healthcare.

(v) There is poor community participation in critical decision-making level. The communities are incapacitated in rational decision-making, as they are not well informed on the matter affecting their health.

(vi) The healthcare financing from the government is inadequate,

because of globalization and its antecedence of less government involvement in the political economy. The concept of self-reliance made it expedient for local communities to fiancé healthcare or find solutions to local health problems through the contribution of labour and materials. This policy has forgotten the divides and policy of exclusion and poverty of the people.

(vii) Lack of basic health statistics, poor resources allocation, politics of healthcare, problem migration of labour and professional in healthcare from Nigeria to other countries. Level of attrition, poor utilization of skilled manpower in healthcare sectors.

(viii) Poor establishment of village and neighbourhood health services which saw the resurgence of parasitic and infective diseases.

(ix) The provision of essential drugs, the effectiveness of health services in Nigeria is severely handicapped by shortage of drugs, the most serious competence or constraint occurring at primary Healthcare level.

Besides, fragmentation and duplication among survival institutions exacerbate the problem of drug. The shortage of drugs has increased the availability of fake drugs, and results in under-consumption and utilization of health services; a concomitant increase in self-mediation and lose of public confidence in health services. The private sector have a more reliable supply of drugs at a cost too distance for the poor to pay.

It must be observed, that one of the key indicators, of successful implementation of a nation primary healthcare strategy, is the availability of essential drugs to the entire population, but this seem to be lacking in Nigerian healthcare system.

The above lists, may not be representative of all defects of Nigerian healthcare system, it suffice to say that most of the defects have been attended, but the hydra headed nature of some of the detects makes it rears its ugly tentacles in every regimes.

3.2.5 State of Health of the Population

The dictionary conceptualization of health as freedom from disease or pain is no longer motivating or exciting, as health has been defined to mean, more than normal functioning of the body. Health has been defined on the locus of quality of life, which enables the individual to live most and serve best. This demonstrates that, the physical aspects of health alone are not enough. (Kurbir Sigh Sidhu 2006).

This is more of the reasons B. Kuppuswamy (2006) maintained that, "a healthy individual is not only physically healthy but is also mentally healthy. The model concept of health extends more beyond the proper functioning of the body. It includes, a sound, efficient and controlled emotions. It means that the body and minds are working together effectively and harmoniously."

Based on the above, it must be analyzed that, man is an integrated psychometric unit whose behaviour is determined by both physical and mental factors. This also demonstrates that individual mental health is significant of one's total health status as well as social effectiveness. It is positive and relative aspect of life. It implies, all round health, physical fitness, normal appetite, sociability, cheerfulness, calmness, regulated emotions, instinct and will sex consciousness, optimism, freedom from anxiety and tension, complexes and prejudice and respectability to new ideas, constructive outlook and healthy philosophy, of life.

The Nigeria Health profile FMOH (1987), Nigerian Fertility survey (1981-1982) ignited the poor state of health of the population. The infant mortality rate is as high as 100 to 160 per 1,000 live births in rural areas. This demonstrates that out of every 12 children who are born alive, one or more of them dies before reaching the first birthday. Childbirth is associated with significant loss of life among women in Nigeria; it has been estimated at 15 maternal deaths per 1,000 live births. It must observed that, it is not possible to make an accurate assessment of the health status of Nigerians, because of myriads factors involve in delimiting health status, and lack of systemic collection of basic health statistics on birth death and other health indicators on country wide basis. (A. 0. 0. Sarugbe 1991,) (Aina Solo, 2006), Olokp 2007.

On the pattern of ill health and its determinant, indicates that many deaths and serious illness are due to condition that are easily preventable or can be treated with simple remedies. The WHO (2007) statistic cited in patrician 2007, stated that due to increasing poverty in Nigeria have increased the emergence of diseases that have be eliminated in development countries.

"On maternal death Sunday punch 2008 Dr. Adetokubo Fabamwo maintained that it will cost Lagos State government $12 million a month to write off the cost of caesarean sections. He further maintained that, government of Lagos State equally subsidies the cost by 50 percent and spend just N6 million a month and save women who die giving life? Fabanwo maintained that the "Kano State government have adopted it and maternal mortality rates dropped by over 50 percent from 11,000 deaths per 100,000 women to about 4,000 deaths per 1000,000 women."

Furthermore, a report of John Amen (2008) published in Sunday punch admitted of lack of data on health matter:

"Nigeria lacks adequate data on physically challenged children, the federal government admitted. The dearth of data has reportedly been a major constraint to government efforts over the years to plan for the citizen's well-being. This was contained in "Nigeria's 3rd periodic report (2005 to 2008) on the implementation of the African charter on Human and people right." The above demonstrated the problem of predicting or getting adequate picture of the state of health of the people.

Aside from the state of health of Nigerians, many Nigerian shows I don't care attitude to their health status 2008 world Heart Day professor Wale Oke and professor Ayodele Omotoso called for legislation that would compare Nigerian to go for annual medical check-up to reduce the incidents of heart diseases in the country.

Professor Wale Oke further maintained that "hypertension is the risk factor and is no respect of class or any person." Africa is going through a period of disease transition and in next 15 years, the burden of non-communicable diseases will over-take communicable diseases." He further maintained that "many Nigerian show I don't care attitude about their health statues." According to him "When some people are informed about their health status they reject the result on religious grounds." The above help to climax the danger inherent getting the state of health of the people.

While scientist in developed countries especially in United States are having break-through in scientific investigation, Nigerian scientist are still lacking behind, the science of the forward March of human minds for injuries.

The US scientist have alerted the congress of cancer risk for cell phone users, the warning was given by David Carpenter, Director for Institute of Health and Environmental the university of Albany in testimony before the subcommittee of the US House of Representative committee on oversight and Reform. This situation was also supported by Ronald Herberman (2008) director of the university of Pittsburgh Cancer Research Centres, said that most "studies claiming that there is no link between cell phones and brain tumours are outdated, had methodical concern and did not include sufficient numbers of cell phone users. The above situation may impose health hazards for Nigerian society in years to come as cell phone use is still in its infancy.

It must be observed that the state of health does not run similar with federal government determination to promote national health policy of

social justice and equity and Nigerian.

Obtaining health service, she or he needs near utopian dream. This is because health indicators are difficult to measure. In a report of the punch 29 2008, the UN-Habitat warns of expanding slums in Nigerian and its health implication for the nation. "The united nations' agency, in charge of housing "UN-Habitat has warned that the growth rate of slums in the country in particular and Africa at large, posses serious health risk of diseases and environmental degradation.

The UN under secretary and executives director, Dr. Anna Tiban Juka estimated that Nigeria had the highest urban slum households in the world with figures varying between 60 and 70 percent.

Besides, the UN boss, blame the housing challenge on the makers, who considered housing provision as a nonproductive good that constituted a burden to rapid economic development. They further maintained that "policy makers assigned a low priority to housing in their national development strategies, housing is a critical factor in health care and modern economic development and that investment in housing supply development and access to good. Medical care, generates a higher multiplies effects to wider macro-economic and social system." She promised that her agency was "prepared to work with Nigerian government and other agencies to develop and implement programmes to achieve the recommendations of enhanced framework in the areas of refocusing housing policies and legislations on the poor, women and the vulnerable."

"The UN-Habitat can contribute significantly to providing technical and operational support for housing delivery through slum upgrading facility, innovative housing, financing mechanism, urban water supply, and sanitation and pro-poor planning and management of urban economy." She said other areas the agency could assist include, "human settlements. Planning development and management to tackle the chaotic problem of rapid Urbanisation through Rapid Urban profiling for sustainability." This may be in consonance to Millennium Development Goals, which also championed to deal with collective health and environmental sustainability of developing nations. The African version was, Rabat Declaration 2007, which also decried slow space and delay for African actualisation of Millennium Development Goals.

Health is a strategic factor in realizing human development and collective human resource planning and utilization. When health is taken away, human resource management will not contribute to corporate growth and productivity of the workforce to collective goals of the society.

3.3 Referral System in Nigerian Health Care Administration.

Referral System is a process by which a health worker transfers responsibility of care temporarily or permanently to another health professional or a social worker or to the community.

At the early part of Nigeria Health Care administration, it was "One way referral system" this system permits issuing of Letter or forms when patients are referred and no effort made to give relevant feedback about the patients to the referring centre. This does not allow effective management of patient, and "the outcome of patients' management is not known." According to K. S. Oyibite (1991) for many years in Nigeria, the "One-way referral system" has been and still is, in operation in many parts." The excerpt revealed that one-way referral system is still operational in some part of Nigeria until day. As primary Health Care is part of health care system, it needs a workable referral system to operate in all sector of health care. Integrated health care makes it more convenient for patients and clients to interact with health care professional teams. When services are integrated, it makes it easier for all people to receive treatment on the same day, say family of it children.

3.3.1 Two-Way Referral System

The two referrals system is an ideal way of development health care from the lowest of care to the highest. For example, care can be taken from village health worker to primary health centre to state general Hospital; except during emergency when patients can referral to level for immediate treatment.

The process involves completing an appropriate form in three. Two of the forms are sent with the patient. "The facility that manages the patient gives information about the treatment and the condition on one of these forms and returns it to the point of referral."

Effective referral system enhances follow-up treatment of patients at lower level. This also helps to relieve the pressure on the comprehensive health centre and the general hospital.

3.3.2 Forms of Referral System

Referral from the village health worker to health post. At the village's health worker level, patient can be referred to health post if he or she does not respond to treatment within 24 hours.

The district supervisor pays scheduled visits to the village. Patients are referred on the days as required. It may be necessary, to refer patient immediately to health post by health extension worker

3.3.3 Referral to Primary Health Centre

In Nigerian public health administration, a primary health centre is technically equipped to provide a standard level of care higher than village and health post to patients and clients. This sector is managed and administered by community Health office and health extension officer. These health team professionals are trained to manage aliments using standing orders. This would guide health workers on how to perform their professional roles, but if they cannot cope with the patient, they can refer the patient to next health facility.

3.3.4 Referral to Comprehensive Health centre

The comprehensive health centre is more competent, robust, technically sound, and equipped to handle more referral cases from lower health facility. More advanced approach to healthcare delivery is available at this level of healthcare. According to M. A. Y. Ojo (1991) "a more advanced approach to healthcare is available at the centre," and "more sophisticated facilities and equipment are provided such as, x-ray, laboratory, dental clients and beds for observation of patient before discharge or referral." This demonstrates that referral to comprehensive health centre are managed by doctors and other trained healthcare professionals, who copes with patients and clients in the community.

It must be observed that, some patients needing secondary care may be referred for more expert advice or consultation. This stage of referral is next to referral to state general hospital.

Referral to state General Hospitals, various state general hospitals across Nigerian health sector provides secondary care to people. Patients and clients referred are those "who need more detail examination to confirm diagnosis and treatment." The patients need prolong treatment and investigation of their health conditions.

Besides efficient and effective referral system, enable patients and customers to have regular appointment with healthcare team at primary or comprehensive healthcare to monitor their state of health. Furthermore, adequate referral system, enable patients to have periodic appointments with specialist in healthcare system, this may be with psychiatrist, social worker pediatrician, cardiologist etc. to enable patients recover from their aliment.

3.4 Advantages of Two-Way Referral System

There are many advantages of two-way referral system in healthcare delivery system in Nigeria.

(i) It promotes effective integration in healthcare service delivery system among tier of primary healthcare system in Nigeria.

(ii) It enhances effective in built in mechanism for supervision, monitoring and evaluation of healthcare system for the people. This help to promote social justice and equity in national health policy of Nigeria.

(iii) It helps to harness PHC resources both material and human to increases productivity, effectiveness and efficiency in handling competent healthcare system.

(iv) The two way-referral systems promote effective networking of primary, secondary and tertiary health services in Nigeria. This promotes availability and accessibility of healthcare services at community and state level. It provides effective linkage with the facility in healthcare service delivery.

(v) It promotes continuity of care and sustained consultation with chains of healthcare professionals in service delivery.

(vi) It provides relevant and critical information needed by patients and their wards for health worker dissemination to the final consumer (family of patients).

(vii) This will *enable* Health worker to update the nature of treatments provided in one health centre, *the* facilities available and give critical information on healthcare services to the local community.

3.5 Disadvantages of Two-Way Referral System

(i) Unnecessary bureaucracy at the level of facilities referred to may hamper treatment.

(ii) Distance and lack of means of good transport bad roads may influence the quickness to which referral services are delivered.

(iii) Cultural and custom of the people may make them attach to traditional method of visiting native doctors instead of going for referral letters in other tiers of healthcare sector.

Despite the disadvantages of two-way referral system, its advantages outweigh its demerits. The success of efficient and effective referral system will depends on the following factors.

(i) Efficient and strategic orientation of all health human resources to the two-way referral system. This will help to eliminate lack of information and know-how on part of health workers operating at primary healthcare level. In word of M.A.Y. Ojo (1991) "Some hospital based personnel should be aware of different categories and competence operating at primary healthcare level." Besides, referral system should be accepted by workers and workers should be oriented towards home-based record cards, instead of maintaining continuity of care.

(ii) There should be simple design of forms, which will be a systematic ways of recording competent information about clients and patient of healthcare system. This form should include a field back on patients to promote continuity of care.

(iii) There should be effective mobilization and community participation "community and local health team must be instructed to arrange self-help transport and other assistance needed for referral purpose and to actualize national health policy for all.

(iv) Village health workers, traditional birth attendants, and other professional health team at the primary health centre level, should be made aware of their limitations as regards, tiers in healthcare delivery system in Nigeria. They should refer patients immediately and appropriately whenever things surpass their power.

(v) There should be sound health education, social mobilization and participation to meet Alma-Ata Declaration and new Millennium Development Goals and Rabat Declaration of Human Development in Morocco 2007.

(vi) There should be effective commitment and advocacy from the political community and donor countries to provide support for tiers of Healthcare service to enhance referral porgrammes.

4.0 CONCLUSION

In this introduction, we have attempted to study the introductory aspects of health administration in Nigeria. We have seen the state of healthcare, referral system and its advantages and disadvantages.

5.0 SUMMARY

We have attempted to review the background of Health Administration in Nigeria and how it stared and how it has grown in this module, we looked at definition and conceptual clarification, primary care, Nature of health services, state of health of the population and reference system. This module helps to clarify basic concepts on health administration.

6.0 TUTOR-MARKED ASSIGNMENT

1) What is the background to Nigerian Healthcare system?
2) What are the advantages and disadvantages of Two-way reference system?

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UNIT 3 MEANING AND RELEVANCE OF HEALTH ADMINISTRATION

CONTENTS

1.0 Introduction
2.0 Objective
3.0 Main Content
    3.1 Definition and Meaning
    3.2 Relevance of Health Administration
    3.3 Relationship between Public Administration and Health Administration
    3.4 Comparism between Health Services Administration and Public Administration
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5.0 Summary
6.0 Tutor-Marked Assignment
7.0 References/Further Readings

1.0 INTRODUCTION

What is Health Service Administration? It must note that hospital administration or Health Services Administration involves considerably more than the positions of hospital or health service administrators. In fact, Physicians, Nurses and other health professionals and health service administration provide the administration of hospitals and other health service-S. Austin (1874) defined Health Service Administration as planning, directing, controlling and coordination the resources and procedure by which needs and demand for health and medical care and a healthful environment are fulfilled by provisions of special services to individual clients, organization and communities.

2.0 OBJECTIVE

At the end of this unit you should be able to:

- Understand the Relevance of Health Administration
- Find out the Relationship between Public Administration and Health Administration
- Engage in Comparism between Health Services Administration and Public Administration

3.0 MAIN CONTENT

3.1 Definition of Health Services Administration

What is Health Service Administration? It must note that hospital administration or Health Services Administration involves considerably more than the positions of hospital or health service administrators. In fact, Physicians, Nurses and other health professionals and health service administration provide the administration of hospitals and other health service-S. Austin (1874) defined Health Service Administration as planning, directing, controlling and coordination the resources and procedure by which needs and demand for health and medical care and a healthful environment are fulfilled by provisions of special services to individual clients, organization and communities.

Charles Austin (1983) in his contribution to the topic "What is Health Service Administration" posited that administrative leadership is an essential but neglected ingredient in the search for solutions to the serious problem of equity, quality and efficiency in delivery of Health and Medical care. He suggested that Health Service Administration could respond to the complex sets of demands, which are in conflict with one another. He maintained that there are various ways that hospital or Health Service Administration can respond to administrative efficiency of Healthcare Industry in one, or combination of the following concepts via:

(1) Super Clerk: Those who oversee a complex process of paper work designed to facilitate the activities of the professional within the hospital.
(2) Efficiency Experts: Adopting the role of one whose only purpose is to optimize the allocation of resources
(3) Magician: Bridging the gap between unlimited demands for services and scarce resources.
(4) Ombudsman: Spokesman for the clients or consumers of health services.
(5) Negotiator: Super arbitrator of the conflicts between special interests.
(6) Empire Builder Grabbing as big piece of action as possible.
(7) Philosophical king: The benevolent despot with ultimate policy authority and other possible roles, educations fireman, change agent, lawyer, and scope goat.

Charles Austin further posited that Health Service Administration could be viewed as an emerging profession. He however noted that profession entails ability to regulate practices and membership code of ethics; he however lamented that many cases, professional goals and codes, of

ethics, which originally were intended to *be* client serving to members of the profession. In this regard, he garnished that if this is to *be* avoided in the emerging profession of Health Service Administration, Straus "3RS" must continually guide members.

(1) Responsiveness to the needs and demand of ends Users of the health system.
(2) Responsibility for the functions of planning, organizing, controlling and coordinating service and
(3) Reconciliation of the vast array of knowledge attitudes, and skills that interact in the functioning of the hospital system.

For the profession to develop he suggested that formal education, directed experience, commitments, and ability, are all points of professional competence as well as active and effective relationships between clients, practitioners and educators. He further maintained that Health Service Administration must play important roles in *the* solution of problems of inequitable distribution and access, uneven, quality and inefficiency in the provision of health services.

Through effective administration, the health of total community can be promoted in a more equitable comprehensive high quality and efficiency manner.

Accordingly, we can conceptualize the concept Health Service Administration as the planning, organizing, directing, controlling and coordinating the resources and procedures by which needs and demands for health and medical care and healthful environment are fulfilled by the provision of specific services to individual client, organizations and communities."

This definition presupposes that Health Service Administration is a major force in Public Health Administration, Public Administration as system of governmental administration and health system. To those who believe that the solutions to Health care system problems lies only in the provision of more professional manpower or better financial, mechanisms. Austin (1994) maintained that without attentions to broader administrations matters, the problems will remain aggravated. He further posited administration would be that logical apparatus to clear vision, intelligent strategy to further hospital corporate goals and objectives.

3.2 Relevance of Health Service Administration

Health Administration enables Public Administration students to understand both Sectorial Allocation and the Constitutional provisions

on health care delivery system in Nigeria. For example, the 1979 and 1989 constitutions of Nigeria placed health care on the concurrent legislative list while external health relations, quarantine and the control of drugs and poison are in the exclusive legislative list. Beside the draft, constitution makes provision to right to free medical consultations in government medical institutions.

Besides, the study of Health Service Administration will expose the hypocrisy in the Sectorial allocations in Nigerian Public Health Administration. World health Organization (WHO) garnished that developing and developed countries should allocate not less than 5% of their budget to Health Sector. Nigeria allocates 2% of her budget to Health, while Kenya 7.1%, American 10.5%. This sectorial allocation enables students, Public Administrators, and even laymen to appreciate why the Health Sector cannot perform effectively.

Another relevance of the study of Health Service Administration is that it enables us to engage in comparative health analysis and administration across National boundary. For example, government expenditure on curative and preventive health care clearly comes into focus when we compare figures across National boundary. For example, Nigeria expends 70.7% on curative and health care and 29.3% on preventive healthcare. Kenya 88.5% on curative and 11.5% on preventive and the USA 82.4% on curative and 17.6% on preventive healthcare. (WHO 1989) The above figures have revealed the disparity in expenditure of aforementioned countries on curative and preventive healthcare system. Besides, the example above reveals that all the countries spend less on preventive healthcare than on the curative healthcare. This is not good enough for comparative studies, because 'Prevention' as the adage maintained 'is better than cure.'

Furthermore, the study of Health Administration will enable us to examine public policies on health sector and examine their formulation, implementation, execution and its evaluation E.g. health for all by year 2000 and National Health Insurance Scheme. (N.H.I.S.) The success or short comings.

Apart from the above, the study of Health Administration enables us to understand basic medical terminologies, basic concepts in health services and principles in health administration. The concepts like politics of healthcare, telemedicine, managed care leadership, communication and scientific management principles etc.

In another vein, the study of health administration will enable public administration students to appreciate paucity of trained health service administrator across national boundary. In December 1987, Intelligent

report 213 qualified Nigerian Health Service Administrator are the United States. 18 in Kuwait/Saudi Arabia, 14 in Canada, 12 in United Kingdom, 10 in African Countries, 4 in Germany, 2 in Switzerland and 113 untrained healthcare administrators in Nigeria and other 800 health administrative assistants in public and private or missionaries healthcare delivery organizations. This shows that there is acute need for health service administrator in Nigerian healthcare sector.

Aside from above, the study of health service administration will review the epitome and the danger inherent in politics of healthcare, delivery. Many celebrated authorities, Lass well, Dahl and Easton, have conceptualized politics. Politics is about the use of authority and influence in decision-making in affecting the distribution of resources of an organization. Easton refers to politics as the authoritative allocation of value in an organization. Values are the things human nature prize most; as long as the values are in short supply, according to the quest for it than politics will come to play of who is to get what, how and when. In hospital environment, the Doctors want call duty, allowance, pharmacist also wants call duty allowance, nurses want call duty, but Doctors call it shift duty allowance. The Doctors have, peopled the hospital administration, and this makes it possible for them to allocate all the values in the system. This is bordering in the politics of healthcare.

The study of Health Administration enable us to apply the issues of marketing and strategic management in the administration of hospital services to make the healthcare industry more profitable like other business ventures in the economy. There is need for effective and efficient management and marketing hospital services.

Besides, the study of Health Service Administration will enable us to appreciate the role of culture, religion, value and tradition in our public health administration. Despite the influence of modern medicine, average Nigerians still should allocate not less than 5% of their budget to Health Sector. Nigeria allocates 2% of her budget to Health, while Kenya 7.1%, American 10.5%. This sectorial allocation enables students, Public Administrators, and even laymen to appreciate why the Health Sector cannot perform effectively.

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healthcare.

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Besides, the study of Health Service Administration will enable us to appreciate the role of culture, religion, value and tradition in our public health administration. Despite the influence of modern medicine, average Nigerians still patronage shrines native doctors and the uses of traditional medicine still pervade the national psyche.

This is the significance of our social cultural milieu, which engulf average African man.

Moreover, the study of Health Service Administration will enable us to know various method of health financing. This is because; most of our public sector health organization depends on government budgetary allocation. This has made the sector dysfunctional. Some of the sources of healthcare financing include, community financing, user charges, commercialization of activities, special taxes, lotteries, external assistance, charitable appeals, investment and health insurance

Finally the study and analysis of health administration will enable us to distinguish between, public and private sector healthcare industries; and understand why public policy, the policy goal remove must be well articulated to emphasis, cost-saving potentials or provision of a more comprehensive and responsive mix of services.

Besides, this study will enable us to appreciate the administrative issue of competency, responsibility of healthcare system, issues of accountability of our health system and then agencies to the public at large. Healthy workforce can contribute to national development for the purpose of providing good.

In conclusion, the study of Health Service Administration will enable us appreciate the remove import of merit, pure and impure public goods, which entails that the government must be involved their provision otherwise the consumption of such services will be underutilized or over prized by profit driven capitalists.

3.3 Relationship between Public and Health Service Administration

Many students have queried the inclusion of Health Service Administration in the curriculum of Public Administration and my experience of teaching at the department of health administration, Nigerian medical school, many of our students there, have also asked me this fundamental question, 'what is the relationship between Public Administration and Health Administration? This section will enable me to attempt at the relationship between the two academic fields of study.

Before we go to conceptualize the public and health administration, it can be observed that both discipline share the same principles of scientific management, they both belong to the discipline of administration with the aim of directing and controlling both human and material resources towards the attainment of stated goals and objectives.

Public Administration entails the management of government activities through decision-making, policy formulation and implementation. Health Administration and healthcare systems are parts of government activities, which is within the purview of public administration.

To promote effective and efficient delivery of public health service to the target citizenry, Public Administration should attempt to monitor, how public agencies perform their health role for the entire citizens.

Besides, through extra-ministerial agencies e.g. NAFDAC, Drug law Enforcing Agencies, provision of specific services to individuals, clients, organization and communities are better taken care of. This is achieved through effective public administration.

Another valuable connection between public and health administration is the role of ecology in shaping administration and healthcare system across national boundary. Through the concept of ecology, public and health administrations are shaped by social cultural and economic values.

In order to appreciate healthcare system, public administration is used to the role ecology play in shaping the political economy. This is because government public policies and annual budget will affect the health administration, because there are big stakeholders in our healthcare system.

Furthermore, through the concept of bureaucracy, labour relation, conflict management and public personal administration, public and health services administration are related. These are some of the reasons

why health services administration is requirement for public administration.

In order vein, public administration, through sectorial allocation, National Policy recurrent/capital expenditure, preventive and curative, environmental health and public utility services reflect its import in health administration; it should be noted that ineffective performance of the health sector is linked to the public administration. Both health services student and public administration students need to study these disciplines in order to solve the problem of health care delivery system in Nigeria.

The major distinction lies while public administration is in holistic and all embracing, health administration is dualistic in nature, i.e. it comprises both public and private sector owners in health service delivery.

While the public hospitals may be there to provide essentials health services for the entire citizenry at a lower cost, the private hospital target profit as the yardstick for existence and have target market to serve, those that have the means to pay for the service. This is why in health administration, private hospitals operate well or better than the public owned hospitals.

3.4 Comparison between Health Services Administration and Public Administration

Public administration is a cooperative group effort that covers the three branches of government. We can also define Public Administration as an act of Public Policy Formulation and Implementation in order to achieve the predetermined goals and objectives of the government; and to meet provision of social, public and merit goals of the citizenry.

Health Administration has *been* defined by Austin (1974), as the Planning, Directing, Controlling, and Co-coordinating the resources and procedures by which needs and demands for health environment are fulfilled by provision of special services to individual, clients, organizations and communities.

Some scholars and practitioners in public and health administration have maintained that both disciplines concern the activities of the government and its regulatory schemes. Health administration is part of government concern in public administration in order to achieve health for all and promotion of social justice. In many higher schools, students of Public Administration are required to undergo course content in Health Service Administration and the students in Health Administration are required to

do the same. For example in University of Benin, the Department of Public Administration is in holistic control of all Health Service Administration Courses.

S/N	Public Administration	Health Service Administration
1	The goals pursued by public administration are non-economic; social political ends e.g. Law and order, political stability and	The goals pursue by public service administration, are non-political and partially economic. Health service Administration may be interested in profit maximization.
2	It is difficult to measure efficiency, effectiveness, and competency in public	Health service administration is dualistic, i.e. both public and Private administration Profitability and efficiency is easy to measure, because
3	In public sector organization, the word administration is used always.	In health administration, which embraces both public and private sector the word, management is often used.
4	Public administration is responsible and accountable to the public because it involves	Health administration may have collective goals *but* its activities are subject to public fund but aim at achieving corporate interest.
5	The major goals of public administration is to implement public Polices, satisfies collective interest arid	Health administration may have collective goals but its activities are subject to public fund but aim at achieving corporate interest.
6	Public administration is regulated by public law.	Public and private laws or land regulates health service.
7	The issues of mortality and probity in office, self-discipline are of major concern in public administration.	The issues of mortality and ethics exist in health administration but probity is less because it is both public and private sector ownership.
8	The external social-political environment exact great influence on public administration.	External social-political environment exact less pressure on health administration.

9	Public sector performance is difficult to measure because output is not often quantifiable	Health Service Administration Performance is not difficult to measure. It determine by coast benefits analysis.
10	The conceptual frame work or explanatory categories of public Administration is difficult form that health	Health service administration adopts a dysfunction conceptual or rhetorical approach from administration.
11	Public administration is excessively is bureaucratic, time is devoted to record keeping rules and	Health administration is less bureaucratic because of the services it renders to the clients and the public e.g. emergency service.
12	Public administration is political.	Health administration is less political. The activities are not under political interference.
13	Preparation for career in public administration is different because it has no professional bodyto regulate it	In health administration, career preparation is rigorous and ethics and professional bodies control it.

4.0 CONCLUSION

We have attempted the definition and basic the concepts in health administration, public administration, and comparison between health administration and public administration and the relevance in the study of Health service administration. These areas represent the basics of the study of health administration.

5.0 SUMMARY

At the end of this unit student are supposed to understand the meaning and relevance of health administration, relationship existing between public administration and health administration, their comparison the meaning of management and administration. These are the summary of this unit.

6.0 TUTOR-MARKED ASSIGNMENT

1. Examine the relevance of health administration in Nigeria?
2. What are the relationship between health administration and public administration?

3. Compare and contrast public and health administration?

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UNIT 4 CONTEMPORARY PRACTICE IN NIGERIAN HEALTH ADMINISTRATION

1.0 Introduction
2.0 Objectives
3.0 Main Content
    3.1 Evaluation of Patients and Visitors by Emergency Word Staff
    3.2 A Reciprocal Relationship
4.0 Conclusion
5.0 Summary
6.0 Tutor-Marked Assignment
7.0 References/Further Readings

1.0 INTRODUCTION

In modern healthcare administration team work is needed to enable patients and clientele to benefit from service delivery in hospitals. The therapeutic interpersonal relationship that develops between for example the nurse and the clients and between the doctors and the patient is an important factor for effective client change and growth. There are some principles and guideline for developing and maintaining relationships.

- The relationship is therapeutic rather than social
- The focus remains on the clients or patient's needs and problem rather than on health workers or trivial issues.
- The relationship is purposeful and goal directed.
- Relationship is objective time limited and open ended

A therapeutic relationship is decoyed to help clients solve problems, relating to health and well-being. This relationship, help to manage care, make meaningful decisions, achieve better healthcare delivery services, and enable patients learn coping strategies rein enforce self-worth and examine effectiveness and efficiency in the relationship.

The meeting between healthcare professional teams is not for mental gratification or for meritocracy. The nurse for example can be friendly with a patient/clients but the nurse is not there to patient's friend. This is because boundaries define healthcare professional teams and their roles, are significant in any relationship especially in therapeutic relationship. Trying to befriend patient may blur boundaries and confuse role of healthcare professionals. The healthcare professionals help the clients increase awareness of the limits and practical boundaries in hospital practice.

Healthcare professionals can only be therapeutic, if candy they remain objective. This refer to remaining free from bias, prejudice and personal identification in interacting with the clear and being able to process information based on facts subjective principles refers to emphases on one own feelings, attitudes opinion when interacting with clients when healthcare professional are subjective in relation to clients problem on situation they loss effectiveness in the relationship with conscious intents to remain objective, the healthcare professionals will see things realistically rather than identifying with patients or client or becoming overly and personally involved with clients issues.

Helping is therefore a process that arises to assisting another person help him or herself, choose a direction in life, fine purpose for existing, solve problem, work, play and love. It also increase individual and societal existence and production and collection living. (Holiday 2000 P 250)

2.0 OBJECTIVE

At the end of this unit students should be able to:

- Evaluation of Patients and Visitors by Emergency Word Staff
- Establish a Reciprocal Relationship between Patience and world attendance
- Understand the problem inherent in Nigerian health care system as regard emergency service.

3.0 MAIN CONTENT

3.1 Evaluation of Patients and Visitors by Emergency Word Staff

Moral evaluation has a direct effects health profession's diagnosis and treatment recommended. This is obvious in extreme cases, such as when a monarch on the governor, president or minister of health is attended by teams of highly qualified diagnosticians to insure a detailed and accurate diagnosis and has outstanding specialists to carry out treatment.

The data taken from observation of six hospital emergency service in two parts of the country one northeastern location and one western coast location several periods of time (spread over two or three months in each case) in the emergency department in each of the hospitals. In one hospital, they worked as intake clerks over

period of three months. They observed that, the emergency units workers were not wholly initialing interaction with patients.

The emergency unit serving is setting minimum of information is available about patients and their interactions with healthcare professionals. In many hospitals in Nigeria, emergency unit services enable us to appreciate negligence and inefficiency in our healthcare delivery system.

The evaluation of patients and visitors by emergency – ward staff may be conveniently thought of in two categories.

i) The application by the staff of the concept of social worth common's the larger society.
ii) Staff members concepts of their appropriate work role.

In this study, we are going to examine first the locus and focus of the first point before going through the second point.

In sociological perspective on health and illness, a critical perspective, Peter conard, 2012 observed that, "there is a popular myth (generated in part by some sociological writing) that person engaged in providing professional services, especially medical care, do not permit the commonly accepted concepts of social worth in our culture to affect their relationship to the clientele or patients. An on the sport description of any service profession – should disabuse us of this notion. There is no evidence that professional training succeeds in creating universalistic moral neutrality. (Becker 2009 pp. 250-255)

On empirical observation of how our healthcare is managed, we are on more safer ground to assume that those who engaged in dispensing professional services (or any other services) will apply the evaluations of social worth common to their culture and will modify their services with respect to those evaluations unless discouraged from doing so by the organizational arrangements under which they work. In private hospitals, some of such organizational arrangements do exist on emergency words. The rapid turnover and impersonality of the operation is in itself a protection for many patients who might be devalued if more were known about them.

In Public hospital at least, there is a rule that all patients representing themselves at the registration desk must be seen by a doctor, and clerks and nurses know that violation of this rule, if discovered, can get them into trouble. Despite this, some patients are occasionally refused registration, why some patient cut corners to get fast service by tipping money and gifts. Some have been refused registration, because they repugnant to clerks and nurse in our public healthcare system.

One woman concept of social worth held by emergency-ward personnel is that old people are more valuable than children. This is amplified most dramatically in the marked differences in efforts to rehabilitate young and old patients (Glaber and Strauss 2006. P 66). In the USA, welfare care, women with illigimate children to support do not deserve best care. Besides, persons of higher status in larger society are likely to be accorded more respectful treatment in the emergency ward just as they often are in other service or customer relationships and conversely those lower statuses are treated with less consideration.

The fact that higher status persons are more likely to make an effective complaint or even file a law suits may be an additional reason for such differential treatment.

Besides, staff members vary in the manner and degree to which they apply those cultural concepts of social worth in determining the quality of their service to the clientele. They use their positions to alter the nature of their service in term of patient differentiation.

Registration clerks can determine how large a patient would have to wait and what kind of treatment he or she is sent can occasionally prevent a person from seeing a doctor at all. Some patients have been categorized before they arrived at the hospital. Hospital categorization affects the priority and the kind of service given by healthcare professionals. Furthermore, some professional staff sees the bulk of patients as people undeserving of the services available to them. They sometime maintain that they need not tolerate any abuse or disobedience from patients or visitors. Patients and visitor may be issued orders which they are expected to obey. The staff can, and sometimes does, shout down patients and visitors and threaten them ejection from the hospital premises. The staff demands protection against possible law suits which are

classified as unjustifiable. Record clerks engage in argument with patients.

To when there is no need to be polite to the clienteles. Some uses, slays soldier go soldier comes, they sometimes refuses services are those who complain. From time to time, clients are referred as "garbage" "scum" 'lairs' deadbeats' people who "come out from the bush" by doctors, nurses, aides, clerks and even housekeepers who sweep the floor. Tribe, mode of dress word usage the manner which client dress can influence the kind of services healthcare teams can deliver. Some of the above variables turn staff against patients affects the quality of cure given.

3.2 Reciprocal Relationship

On one level, it is true to say that the staff's moral evaluation of a patient influences the kind of treatment he gets in the emergency room. But this causal explanation obscures important aspects of the network of interception of devalued or favoured categories and attributes of the patient reinforce each other in a reciprocal manner.

Take, for example, patients who are labeled as drunks. They are more consistently treated as underserving them any other category of patients. They are frequently treated or handled as if they were baggage when the police. The drunk are treated in jocular manner, they may be ignored for long period of time, in one hospital stay are placed in a room separate from most other patients. Emergency-ward personnel frequently comment how they hate to take care of drunks some look at the drunk that they do not deserve treatment.

The occasional challenges exist for the doctors. How to you know that the patient is drunk? Once the drunk label has been accepted the emergency-room staff – a more careful examination is not likely to be made unless some particular.

4.0 CONCLUSION

We have notice contemporary practice of health administration in Nigeria. We must note that, Nigerian health care system is quite difference from the American system where insurance and free medical care is available for the aged and less privileged class of the society.

5.0 SUMMARY

We can view this unit to review what happens in emergence ward, many patients have been killed for negligence at emergency ward of our hospitals. Care must be taken in managing health care system at emergency-wards in our hospitals

We have attempted to examine the problems in the practice of health administration in Nigerian health care system.

6.0 TUTOR-MARKED ASSIGNMENT

1) Examine the failure in emergency-wards practice in Nigerian hospitals

2) How would you improve the malpractice in Nigerian health care practice

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MODULE 2

Unit 1 Types and Structure of Health Care Institutions
Unit 2 Levels of Health Care Services in Nigeria
Unit 3 Hospital as an Organization
Unit 4 Hospital as a System
Unit 5 Hospital Management System

UNIT 1 TYPES AND STRUCTURE OF HEALTH CARE INSTITUTIONS

CONTENTS

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  3.2 The Hospitals as a Social Institution
  3.3 The Organization of the Hospital
  3.4 Government as an Institution of Health care delivery
4.0 Conclusion
5.0 Summary
6.0 Tutor Marked Assignment
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1.0 INTRODUCTION

Health care institutions consist of formal and informal organizations where preventive, social and clinical services are rendered to the members of the society. Each of the institutions has specific aims and objectives even though they all exist to promote health, to prevent the occurrence of diseases, to bring about a peaceful end for those suffering from terminal disease, and to treat human illness.

Most health care institutions form an arm of the government. Their social structure therefore follows the same pattern as other government institutions. The social system within the institution or organization is determined by the established procedures, which govern the relationships between individuals within the institutions. As in all other bureaucratic organizations, relationships within most health care institutions follow a pyramidal structure. There are master-servant relationships, and an individual's roles and status defines the position in the hierarchical structure. Health care institutions form a large social system, and within this system are other large sub-systems. The systems

vary from one country to another and even slightly within the same country.

This Unit will expose you to the types and structure of Health Care Institutions especially in Nigeria.

2.0 OBJECTIVES

At the end of this unit, the student will be able to:

- State and describe various types of Health Care Institutions
- Explain the organization of the hospital
- Discuss how the government is an institution of Health Care Delivery in Nigeria.

3.0 MAIN CONTENT

3.1 Types of Health Care Institutions

In most African Countries, there are at least five types of the health care institutions, closely intertwined but nevertheless distinct enough to be analyzed separately.

a. Private Hospitals

There are the private hospitals, which may or may not be profit-oriented. Some are individually owned while others belong to religious bodies. (e.g. the Catholic hospitals and the Seventh Day Adventist hospitals).

b. Drug companies and other suppliers

A second sub-system is the drug companies, medical equipment manufacturers and pharmacists. Pharmacies, which are important in our communities, may have drugs including antibiotics, analgesics, or steroids among others. in some African countries, all these drugs are accessible to people, even if they are contra-indicated. The role of the pharmacist is supposedly limited to dispensing doctor’s prescriptions and selling common, unrestricted, non-poisonous drugs (aspirin, panadol, etc.), but pharmacists often do more and in many instances take up the roles of a doctor, nurse and dispenser. Since they are more accessible than hospitals, their clients may be greater in number than those of the government hospitals. In Nigeria, the situation has tremendously improved as a result of the activities of National Agency for Food and Drug Administration and Control.

c. Traditional Medicine

A third sub-system is the less structured network of many different traditional folk and religious cults and organizations. They form an important pathway to health and they compete favourably with the government hospitals and primary health care facilities. Their role in providing psychological and social support to their patients account for their huge success in recruiting and retaining patients, especially those suffering from chronic diseases and psychosocial problems.

d. Public Health System

A fourth sub-system is public health. In this era of primary health care, health promotion and prevention of diseases are crucial to the success of any health care system. Public health system is the sub-system whose roles are mainly health promotion and prevention and control of diseases. In general, the personnel working in the public health system do not practice curative medicine. They protect, administer and perform community orientated services. Public health personnel detect diseases and if necessary they refer the sick to other medical personnel; they immunize to reduce the incidence of disease; inspect to prevent epidemics; educate people to have insight into the cause of diseases; make home visits to carry out surveillance on communicable diseases; visit public places to enforce the rules of hygiene; and notify the appropriate authority about the occurrence of certain diseases.

e. Curative Medicine

The fifth and largest sub-system is the world of large government hospitals, clinics and nursing homes. Their roles are mainly curative and they form a very complex bureaucratic organization that will be described in details.

3.2 The Hospitals as a Social Institution

Hospitals can be classified in many ways: by their types of service, by their type of management or control, by their type of financial support, physical size, and type of facilities, staff composition and numerous other features. Some are owned privately (by missions or individuals), while others belong to the government (Federal or State). All hospitals deal with people, but nevertheless they vary according to what kind of hospitals they are, the culture within which they operate, and the economic and social systems that support them. a hospital is an organization, which cannot be viewed as an entity in itself, within which a certain art is practiced, but must be seen as having contacts and overlaps with other organizations. It receives funds, patients and staff

from the society that support it, as well as instructions about how to use its resources. In return, it provides the society with the services of trained professionals. So the hospital and society are inter-dependent.

Although a hospital shares some basic attributes with any other large organization, it has its own distinctive traits, which place it in a special category for analysis:

1. A hospital is an organization which gives care and treatment
2. It deals with people and doesn't merely process inanimate objects
3. It operates within the context of the culture of the society, because the occurrence of disease and illness behaviour is influenced by the culture of the society
4. It is commonly expected to give priority to standards of service rather than to a consideration of cost-efficiency.
5. Demand for care tends to be urgent and in most cases treatment cannot be postponed.
6. Decisions must be made which have implication and
7. Authority, power and discretion are divided between the administrative structure and the professional (doctors, nurse, pharmacist, etc.) Hence there is interdependence and the need for co-ordination between all hospital employees.

3.3 The Organization of the Hospital

Nigeria, many successful attempts have been made to reframe the social organization of hospitals to improve their effectiveness. For instance, there have been efforts to decentralize decision making in order to make hospital services more responsive to patients' needs and to improve the relationship between the various categories of workers in the hospital.

Nevertheless, the social structure still remains bureaucratic. There is a hierarchy in which each employee is assigned a specific set of functions and authority over certain areas. At the top is a director, a medical doctor, who is responsible for seeing that assigned tasks are carried out, that the suitable personnel are available to perform the jobs that the organization remains in order, etc.

It is worthy of note that since the early 1980s there has been a radical or evolutionary change in the pattern of administration of hospitals in several African countries. Professional staffs, especially medical doctors and nurses, currently play a major role in the administration and management of hospitals and other health facilities. The hospital's organogram usually shows that the position of the chief medical director or medical superintendent, usually held by a medical doctor, is an executive position. In other words, the medical or superintendent is the

overall head of the hospital and is only accountable to the Hospital Board of Management.

The office of the hospital administrator is therefore under the direct supervision of the medical doctor. Furthermore, with the emergence of (Primary Health Care) in the early 1980s, the role of nurses and public health practitioners cannot be overemphasized. In many African countries, nurses are currently the backbone of primary health care programmes due to acute shortage of medical doctors. This is especially so in the rural areas where the majority of the people live. As part of their expanded roles, nurses perform the roles of managers and administrators of health facilities.

The implication of this is that nurses must be conscious of the effect of bureaucracy on the delivery of health services. As managers, nurses must be sensitive to the needs of their clients and their client's expectations about public health facilities. One such expectation is efficiency and accountability. Patients / client expect that they should spend as short a time as possible when they come for treatment, yet due to the effect of bureaucracy patients often spend countless hours before they receive treatment. Hence, many patients prefer to receive treatment from traditional healers who, they believe, will not take much of the time. This has a serious implication for achieving the objectives of PHC, because people may develop negative attitudes towards the use of PHC facilities.

The roles being played by public health practitioners, such as environmental health officers have also expanded tremendously. The control, prevention and eradication of are reckoned with.

3.4 Government as an Institution of Health Care Delivery

A government is responsible for the overall planning and organization of all the political affair of a country. Its functional capacity ranges over all issues, which can affect the members of the country as a group or as individuals – social, psychological, political, and physical problems.

These can be broken down into the following needs: governments often establish various departments or ministries, each specializing in answering a specific need though the responsibilities of these departments may overlap. As an example, let us examine the situation in Nigeria.

The Ministry of Health of the Federal Government of Nigeria, together with those of the states, is the chief provider of health services in Nigeria. Each State Ministry of Health is legally responsible to the

Federal Ministry of Health. As an institution of health care delivery, each ministry performs all or some of the following roles:

- Policy making
- Finance
- Planning and Organization
- Educating / Training
- Discipline of workers
- Recruitment of personnel
- International liaison
- Standardization of care

The Federal Minister of Health and one Commissioner of Health in each state are the political head of the health ministries. Next to the Minister in hierarchy is the Permanent Secretary who is a civil servant and responsible for the day-to-day running and organization of the health services. For administrative purpose, the Ministries of health at both federal and state levels are divided into Directorates (e.g. Directorate of Primary Health Care, Medical services, Nursing, Hospital Services, specialist or expert in the field (For example, the Directorate of Nursing should be headed by a nurse). One of the points being made here is that there are several professional, administrative and technical units being supervised by the Permanent Secretary, and that these units, referred to as Directorates, are being administered by the various directors. In each directorate, there is a vertical structure comprising of senior professional officers, principal nursing officers and senior nursing officers; and from one level to the other, there is a vertical relationship. An officer is expected to move from one level to a higher level through promotion.

The role of the Federal Ministry of Health can be divided into four parts:

- Policy making
- Liaising between hospitals and international bodies, e.g. W.H.O. and foreign governments.
- The provision of funds for manpower training and establishment of specialized training programmes and research (e.g. in medical schools and teaching hospitals)
- The provision of funds for different state ministries of health, either for capital projects (building of hospitals, medical schools and so on), current expenditure, or reimbursement for training programmes.

At present, because of the Nigerian Government’s commitment to decentralize health care though the expansion and improvement of primary health care services, the Federal Ministry established a College

of Health Technology in each state of the federation under the primary health care system. These training schools were established to increase the capacity of the government in providing primary health care services to meet the needs of both the urban and rural communities. However, it is important to note that one of the main reasons for establishing the college is to reduce the rural-urban differentials with regards to the availability of health workers in the rural areas.

The Federal Ministry of Health is not directly concerned with the running of the secondary and primary health care facilities; it is the responsibility of the state ministries and local government. Each state has a set of hospitals, which operate a referral system. They are organized to provide the three levels of care: primary, secondary and tertiary. The types of health facilities in this system are illustrated in Figure 4. However, tertiary hospitals are under the direct supervision of the Federal Ministry of Health.

Level of Health Care and Types of Health Facilities

4.0 CONCLUSION

Hospital is an organization which gives care and treatment which also deals with people and not merely processing machines and tools need to be resourced in terms of human, money and materials both in quality and quantity as the needs of the consumers are multifaceted which must be met in order to be relevant to the society where it operates.

5.0 SUMMARY

The students have been exposed to the types and structure of Health Care Institutions in Nigeria and what has made the institution different from other social institutions within the same society.

6.0 TUTOR MARKED ASSIGNMENTS

Enumerate and explain functions performed by the Federal Ministry of health Specialist/Teaching Hospital General/District Hospital Health Centers/Health Posts/Maternity Hospital/Mobile Stops.

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UNIT 2 LEVELS OF HEALTH CARE SERVICES IN NIGERIA

CONTENTS

1.0 Introduction
2.0 Objectives
3.0 Main Content
    3.1 Organization at Federal Level
    3.2 Organization at State Level
    3.3 Organization at Local Level
        3.3.1 Functions of Local Government
4.0 Conclusion
5.0 Summary
6.0 Tutor Marked Assignment
7.0 References/Further Readings

1.0 INTRODUCTION

This Unit will focus at the various levels of health care services in Nigeria, the functions of each level and how they inter-relate with each other. Health is a subject of concurrent list in the constitution of the Federal Republic of Nigeria as a result of its importance to the teeming population.

2.0 OBJECTIVES

At the end of this Unit, the learner should be able to:

- List the levels of health care services in Nigeria.
- Describe the functions of each level
- Explain the inter-relatedness of the levels.

3.0 MAIN CONTENT

3.1 Organization at Federal Level

The official "organs" of the health system at the Federal level consists of:

(a) The Federal Ministry of Health
(b) The National Council of Health

We shall talk of the organization and function of each one of them.

(a) The Federal Ministry of Health

The Federal Ministry of Health as headed by a Minister. It is a political appointment. Currently, the Federal Ministry of Health has 5 directorates / department. These include:

i. Department of Personnel Management
ii. Department of Finance and Supplies
iii. Department of Planning, Research and Statistics
iv. Department of Hospital Services.
v. Department of Primary Health Care and Disease control.

The following are the responsibilities of the Federal Ministry of Health

i. Take the necessary action to have a review of national health policy and its adoption by the Federal Government.

ii. Devise a broad strategy for giving effect to the national health policy through the implementation by Federal, State and Local Government in accordance with the provisions of the constitution.

iii. Submit for the approval of the Federal Government a broad financial plan for giving effect to the Federal component of the health strategy.

iv. Formulate national health legislation as required for the consideration of the Federal Government; 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 this national health policy.

v. Assess the country's health situation and trends, undertake the related epidemiological surveillance and report thereon to Government.

vi. Promote an informed public opinion on matters of health; Support State and through them Local Government in developing strategies and plans of action to give effect to this national health policy.

vii. Issue guidelines and principles to help states prepare, manage, monitor and evaluate their strategies and related technical programmes, services and institutions.

viii. Promote co-operation among scientific and professional groups as well as non-governmental organizations in order to attain the goals of this policy;
ix. Monitor and evaluate the implementation of this national policy on behalf of Government and report to it on the findings;

International Health

The Federal Ministry of Health shall set up an effective mechanism for the co-ordination of external cooperation in health and for monitoring the performance of the various activities. Within the overall foreign policy objectives, this national health policy shall be directed towards:-

i. Ensuring technical co-operation 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;

iv. Collaborating with United Nation agencies, Organization of African Unit. West African Health Community, and other International Agencies on bilateral and / or regional and global health care improvement strategies without sacrificing the initiatives of national, community, and existing institutional and other infrastructural arrangements;

v. Working closely with other developing countries, especially the neighbouring states 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 co-ordination of major intervention programmes for the control of communicable diseases.

(b) The National Council of Health

The National Council of Health is composed of the following members:

i. The Honourable Minister of Health (Chairman)
ii. The Honourable Commissioners for Health (States)

The following are the functions of the National Council of Health. The National Council on Health shall advise the government of the Federation with respect to:

i. The development of national guidelines.
ii. The implementation and administration of the national health policy; and
iii. Various technical matters on the organization, delivery, and distribution of health services.

The council shall be advised by the Technical committee.

Technical Committee

The Technical Committee of the National Council on Health shall be composed of:

i. The Federal and States Permanent Secretaries (M.O.H)
ii. The Directors of Federal Ministry of Health
iii. The Professional heads in the state Ministries of Health
iv. A representative of Armed Forces Medical Services;
v. Director of Health Services, Federal Capital Territory, Abuja.

Expert Panels

(a) The Technical committee shall set up as required, appropriate programme expert panels including the representatives of health related Ministries:

i. Agriculture, Rural Development and Water Resources
ii. Education
iii. Science and Technology
iv. Labour
v. Social Development, Youth and Sports
vi. Works and Housing
vii. National Planning
viii. Finance

(b) Health related bodies

i. National Institute of Medical Research
ii. Medical Schools
iii. Schools of allied health professionals
iv. Non-governmental organizations
v. Professional associations (Health) e.g. NMA, NANNM, PSN, among others.

3.2 State Level

At present there are 36 states and the Federal Capital Territory, Abuja and has many types of health administration. In all the states, the management sector for health lies with the Ministry of Health while in some states, Health management Board also participates in the management.

State Ministry of Health

Organization: The state Ministry of Health is headed by an Honourable Commissioner, while in Health Management Board, there is governing Board with an Executive Secretary. The Commissioner is the Political head of the Ministry while the Permanent Secretary is the administrative head. There are Directors manning the directorates assisted by Deputy and Assistant directors.

Functions: The State Ministries of Health directs and co-ordinates authority on health work within the State via:

i. Ensuring political commitment
ii. Ensuring economic support
iii. Winning over professional groups
iv. Public information and education
v. Financial and material resources provision
vi. Intersectoral action
vii. Coordination within the health sector
viii. Organizing primary health care in communities
ix. Federal system
x. Logistics system
xi. Health Manpower recruitment and retaining
xii. Priority health programmes.
xiii. Health technology.

3.3 Local Level

There are 774 Local Government Areas in Nigeria with various health facilities operating under the hinges of primary health care. The Local Government Headquarters coordinates the activities of the health facilities providing manpower, funds, logistics and control.

The Local Government is headed by elected Chairmen during political era with council members. Supervisory councillors are also appointed to oversee various aspects of Local Government activities including Health and Social Services. The health department is always headed by a Primary Health Care coordinator.

3.3.1 Functions of the Local Government

- Provision and maintenance of essential elements of primary health care: environmental sanitation; health education

- Design and implement strategies to discharge the responsibilities assigned to them under constitution and to meet the health needs of the local community under the general guidance, support and technical supervision of state health Ministries.

- Motivation of the community to elicit the support of formal and informal leaders

- Local strategy for Health activities.

Examine this illustration, which provides an overview of health care delivery system at the three levels of health care i.e. primary, secondary and tertiary levels.

As you know a full range of primary health care (first level contact of individual, family and community health system) are being rendered through the agency of primary health centers.

Secondary Health Care is being provided through the establishment of cottage, General Hospitals where all basic specialty services are being made available.

Tertiary care is being provided at Teaching and Specialist Hospitals where super specialty services including sophisticated diagnosis, specialized therapeutic and reliabilitative services are available.

4.0 CONCLUSION

The health of the population of the Country determines the strength and the future of that country hence the understanding of the levels of health care services in Nigeria is crucial to the learners especially with reference to the adage that says “health is wealth” as a healthy Nation is a wealthy Nation.

5.0 SUMMARY

The learner has been exposed to the three levels of health care services in Nigeria their functions and interrelatedness.

6.0 TUTOR MARKED ASSIGNMENTS

1. List and explain the levels of health care delivery system in Nigeria.
2. Why is not possible for each level to operate in isolation?

7.0 REFERENCES/FURTHER READINGS

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UNIT 3 HOSPITAL AS AN ORGANIZATION

CONTENTS

1.0 Introduction
2.0 Objectives
3.0 Main Content
    3.1 Hospital as an organization
    3.2 Problems of Hospital as an organization
4.0 Conclusion
5.0 Summary
6.0 Tutor Marked Assignment
7.0 References/Further Readings

1.0 INTRODUCTION

This Unit will expose you to hospital as an organization being a system with several components with specialized individuals and the problems faced by this social organization which it has to strife to solve on daily basis.

2.0 OBJECTIVES

At the end of this Unit, the learner should be able to:

- Explain why hospital is an organization
- List four (4) problems of the hospital as an organization
- Discuss (5) characteristics of a hospital

3.0 MAIN CONTENT

3.1 The Hospital as an Organization

This is a social component, and a system made up of people with specialized technology. It has certain characteristics, which differentiate it from other forms of organization. We can describe the hospital as a socio-technical and problem solving system whose main objective is to provide effective health care services (personalized and specialized care irrespective of the fact that the individual can afford to pay or not). As an organization, it formally defines the roles of its members constrained only by its own socio-technical limitations which are related to its own society/societal demands. Hospital prescribes the demand of its members, the relationship which is task oriented, impersonal authority oriented.

The hospital defines the roles of its members, the hospital is also different when we talk of the levels of cadres and skills of its participants. Here are people with extreme different skills, diverse background and all of them must work together to achieve the goals of the hospital, people having general and specialized skills.

Professionals have strong demand for personal independence in their work and they have an aversion to organizational regimentation (they want to be independent in their thinking and functions). However, the hospital cannot function effectively without a good deal of compliance with its members with the existing rules and regulations in the hospital of practice. These rules and regulations may be in to the tenets of the professional callings even though the hospital requires that one obeys the rules and regulations you must not compromise patient's care.

3.2 Problems of Hospital as an Organization

Apart from the above distinguished characteristics, hospitals do face some problems which the hospital must address and resolve if it is going to be an effective organization. The following problems must be addressed by the hospital in order to be an effective organization. There are seven problems the hospital must address if it has to survive as an organization viz.

1) Organizational Adaptation

This is the ability of the hospital to adapt itself to the external world and carry on an effective interchange with that world at all times. This may include the ability to respond successfully to relevant changes in its environment, to obtain resources and personnel, maintain advantageous relationship with its community and generally to influence its environment in the ways to benefit the system and its members.

2) Organizational Allocation

This problem deals with the ability of the hospital to deploy, allocate and utilize the available resources which include facilities, fund and personnel in the most appropriate manner. To handle related problems of access to an information among the participants, also to ensure participation among the concerned in decision making process and question of allocation of tasks and functions among departments, groups and members.

3) Problem of Co-ordination

The ability to articulate, interrelate and regulate the activities of various participants. To continually coordinate in time and space in many diverse and interrelated activities of the different members. How does

the hospital coordinates the activities of the doctors, nurses, accountant, laundry etc. to contribute to the health care, if the hospital fails to do this, it fails to function as an organization.

4) Organizational Integration

This deal with the ability of the hospital to integrate itself (unite itself). This will include all necessary functions associated with the problem of integrating the individual members into the organization and securing the cooperation. It also includes integrating all parts. Also, development of common organizational values and shared norms, attitudes and mutual understanding must be integrated. Each members need to be socialized into the life of the organization.

5) Organization Strain

This deals with the ability to resolve or minimize and manage the tensions and conflicts which may arise within the organization which must be addressed by the hospital. If it must be effective particularly frictions and confrontations among the key groups. The key groups that are always having frictions are doctors and nurses and others. The hospital must also look at the strain among highly interdependent groups and members and among unequal status participants (Nurses and cleaners, professional and non-professionals) the hospital must try to manage stress and strain throughout the system, hospital can set up grievance committees.

6) Organizational Output

The hospital must possess the ability to reach and maintain high levels of output if it is going to be an effective organization in terms of quality, quantity, acceptability and cost.

The hospital deals with patient-care and provision of health services to the community, in order to attain the high level of quality, quantity, acceptability and cost, there must be qualified staff, enough staff, needs of the community must be met and at affordable cost. The problem of output will also involve the ability to maximize the efficient and reliable performance by all department, groups and members. This assumes that a system of personal goal achievement and job satisfaction on the part of the members is entrenched.

7) Organizational Maintenance

This is the ability of the hospital to preserve its identity and integrity as a distinct and unified problem – solving system or to maintain itself and its basic character and viability in the face of changes which are

constantly occurring in its environment. The hospital must look for a way of maintaining itself.

4.0 CONCLUSION

The hospital has distinguished characteristics which make it unique, the hospital has its own socio-technical personnels that delivers qualitative service. The hospital prescribes the demands of its members, the relationship which is task oriented, impersonal and authority oriented. But despite all these characteristics, hospital has its own inherent problems which it should always strife to find solution to.

5.0 SUMMARY

The unit has presented to the learners a hospital as an organization and Problems encountered by this unique social institution.

6.0 TUTOR MARKED ASSIGNMENT

1. List and discuss five (5) problems faced by the hospital as an organization.
2. What is the relevance of hospital as an organization to man?

7.0 REFERENCES/FURTHER READINGS

Akinsola, H.A (1993) A to Z of Community Health and Social Medicine in Medical and Nursing Practice

UNIT 4 HOSPITAL AS A SYSTEM

CONTENTS

1.0 Introduction
2.0 Objectives
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    3.2 Hospital as a system
    3.3 Types of Systems
    3.4 Basic Systems Concepts of relevance to Hospital Organization
4.0 Conclusion
5.0 Summary
6.0 Tutor Marked Assignment
7.0 References/Further Readings

1.0 INTRODUCTION

Scholars concerned with the administration of complex organizations began to view an organization as a system in the late 1950s. To understand a phenomenon we must recognize that the whole is greater than the sum of the parts. In other words, the systems view point challenges the reductionist approach where the individual part is the level of analysis and emphasizes that "it the whole, the combination and interrelationships of parts that will provide the greatest insight" Mitchel, 1978).

2.0 OBJECTIVES

At the end of this Unit, the learners should be able to:

- Explain what a System is
- List the types of Systems
- List the basic system concepts relevant to hospital

3.0 MAIN CONTENT

3.1 Definitions

There are several definitions of the term 'systems'. Some of these are provided below:

1) Hall and Fegen (1956) defined a system as ' a set of objects together with relationships between the objects and between their attributes'.

2) To Flagle, Huggins and Roy (1960), a system is ‘an integral assembly if interacting elements designed to carry out cooperatively a predetermined function’.

3) Griffiths (1964) defined a system simply ‘as a complex of elements in interaction’.

4) Choforas (1965) viewed a system as ‘a group of interdependent elements acting together to accomplish a predetermined purpose’.

5) According to Berrien (1968), a system is ‘a set of components interacting with each other and a boundary which possesses the property of filtering both the kind and rate of inputs and outputs to and from the system’.

6) A system can be defined ‘as a complex of elements standing in interaction’ (Bertalanffy, 1968).

7) Rapoport (1968) viewed a system as:

   1) Something consisting of a set of (finite or infinite) entities;
   2) Among which a set of relations is specified, so that,
   3) Deductions are possible from some relations to others or from the relations among the entities to the behaviour or history of the system.

8) Blendinger (1969) sees a system as ‘an organized ‘something’ that has direction to it and some degree of internal unity. The structure of organization of an orderly whole which clearly shows the interrelationships of the parts to each other and to the whole itself’.

9) According to Immegart and Pilecki (1973) a system is ‘an entity composed of (1) a number of parts, (2) the relationships of these parts, and (3) the attributes of both the parts and the relationships’.

10) Kast and Rozenzweig (1979) viewed a system as ‘an organized, unitary whole composed of two or more interdependent parts, components, or sub-systems and delineated by identifiable boundaries from its environmental suprasystem’.

11) Sherlekar (1984) defined a system as ‘an organized complex whole, combination of things or parts forming a complex or Unitary whole’.

3.2 Hospital as a System

From the foregoing definitions, two basic threads serve as a common denominator. These are that a system comprises:

(a) 'Elements' or 'parts' or 'objects' or 'components' and
(b) The use of the term 'interdependent', 'interrelated' or relationships, which indicates that the parts and their properties are 'tied together in time and space. However, the general system theory is concerned with the study of the system as whole. It holds that to understand the whole, begin with the whole and not with the components.

Buffa (1976) has identified five points that convey the essence of the systems approach.

These are:

1. Defining the problem in systematic terms originally.
2. Taking the system as a whole as the starting point.
3. Representing the complex interactions among the components.
4. Recognizing the need for compromise and trade-off among competing criteria and values.
5. Predicting the performance of the system as a whole prior to the creation of the system.

A systems approach to hospital administration attempts to view the school as a unified, purposeful organization, or as a system composed of interrelated parts. It maintains that instead of dealing separately with the various parts, hospital administrators should look at the system as a whole. This is due to the belief that the activity of any part of the hospital system goes on to affect that of every other part.

3.3 Types of System

All systems can be divided into two classes: These are natural and manmade or designed systems. Natural systems refer to a collection of connected, coordinated, naturally occurring objects. For example, the solar system comprising the sun and the planets that revolves around it. The man-made systems consist of many sub-classes. Lee (1970) has identified four of them as procedural, physical, social and conceptual.

By procedural systems, Lee meant a coordinated set of consistent principles, rules and procedures which may, or must, be followed to resolve or solve problems or perform some tasks. For example, Mathematics may be regarded as a collection of self-consistent,

coordinated principles, rules and procedures. It consists, among other things, of the means of calculating solutions to specific problems by means of entering specific numerical values into generalized procedural formulas. Legal systems are also procedural systems.

Man-made physical Systems are coordinated and connected assemblies organized collections of physical elements intended and designed to serve a common purpose. For example, the braking system, or the clutch system of a car.

Social systems are organized and coordinated groups of people working together to serve mutual interests and perhaps to achieve a common purpose. In health administration, is primarily concerned with social systems such as the hospital.

Finally, the Conceptual System is a class of a consistent theory, or coordinated body of facts, principles and hypotheses by which some aspect of reality may be ordered, explained or understood e.g., the Newtonian system.

3.4 Basic System Concepts of Relevance to Hospital Organizations

Several concepts have been offered by system theorists, some of which are useful for the understanding of hospital administrator. A number of these relevant concepts are highlighted and discussed below:

Components: Refer to the parts - the smallest meaningful units that interact with each other to fulfill the purposes of the system.

Boundary*:* Is more or less arbitrary demarcation of units that are included within and that are excluded from the educational system. It is the boundary that separates the system from its environment and filters the inputs to and outputs from the system.

Environment: Refers to everything (physical and social factors) external to the system (i.e., its boundary) that has the potential to affect all or part of the organization. Every system, sub-system or supra system has an environment.

Inputs: Those messages or stimuli that trigger off the internal components of a system to perform those activities for which the system was designed. Such inputs may take the form of people, materials, money, and / or information. Inputs are all elements that enter the system across its boundary. Inputs cause or enable the components to interact or affect the ways in which the components interact in fulfilling

the system's purpose(s). Although inputs can be relatively diverse or uniform, Buckley classified them as being only two types, energy and information:

(a) **Energy Inputs:** Physical materials or forces are imported to the system and enable the components to move and therefore to interact physically. The energy inputs to hospitals as systems include fuel, electricity, air and sunlight entering from the environment and the caloric energy the people bring (from the foods and beverages they infest) that enables them to move about and work.

(b) **Information Inputs:** Signals that enter the system and indicate to the components how or when they are to interact. Information inputs to hospital include students' actions and statements, community members' comments, legislative mandates, Ministry of Health or Health Management Board's directives, and all messages that affect the **interactions among components.**

Outputs: Refer to all that the system produces, either by design or accidentally. That is to say that outputs can be intentional or unintentional. A system's output always entails altering the inputs.

Open Systems: Have relatively highly permeable boundaries.
Consequently, they receive inputs and provide outputs.

Closed Systems: Have relatively rigid, impermeable boundaries; as such there are very few inputs / outputs - i.e., few exchanges of energy and information with the environment points out that no social system as being relatively closed or open.

Subsystem: Refers to a system that exists within a larger system. All systems, except the very smallest, are composed of sub-systems, if the hospital is taken as a system, then administrative and support services units/departments and wards can be considered as its sub-systems.

Supra system: A larger system of which a particular system is a part. For example; a hospital can be considered as a system, existing within a larger system, hospital district / General hospital. In this case, the hospital is a sub-system with respect to the district, and the district is a supra system with respect to the Teaching hospital.

Equilibrium: The tendency of a system to achieve a state of balance or stability among the many forces or factors operating upon the system or within it. Chin distinguishes between two different types of equilibrium, namely; stationary equilibrium and dynamic equilibrium. A stationary

equilibrium exists when there is a fixed point or level of balance to which the system returns after a disturbance. A dynamic equilibrium (also referred to as a steady state) occurs when the equilibrium shifts to a new position of balance after disturbance.

Disequilibrium: A state of instability or imbalance in which some components of the system overload others.

Entropy: Related to the concept of organizational equilibrium. It is the tendency of organizations overtime to move towards randomness, chaos, disorder, lack of patterning, disorganization or 'death'; that is, the tendency towards a decrease in order and an increase in disorder within an organization.

Negative Entropy: The tendency of an organization to combat 'death' or disorganization (entropy). It is also referred to as negative entropy.

Equifinality: Refers to 'a property of a system which permits different results from similar inputs and similar results from alternate inputs'. In other words, it is a condition where identical output conditions appear to be derived from different initial inputs, and identical inputs appear to achieve different results. The application of the concept to organizations suggests at least three ideas.

1. The initial inputs to an organization do not determine the extent to which a goal will be realized; that is, organizations such as the hospital may have differing levels of inputs in terms of human and fiscal resources, teaching methods, facilities and have similar goal achievement (outputs).
2. Organizational outputs may vary widely, even-through the inputs are 'equal'.
3. There is no 'best way' to achieve a given organizational goal; rather, there may be a number of acceptable alternatives ways.

Lipham and Hoeh (1974)0 point out that the principle of planning, organizing, simulating, coordinating and evaluating. Any one or a combination of these activities may lead to equally desirable outcomes.
Feedback: The process through which the organization learns. It is the input from the environment to the system, telling it how it is doing as a result of its output to the environment. In other words, feedback refers to response to output which enables a system to modify its subsequent functioning. Granger (1971) simply refers to it as 'a return communication or reaction to information processing behaviour'. Silver (1983) put it more lucidly when he states that feedback is the process which entails drawing some of the system's outputs back into the system

as information inputs, so that possible discrepancies between intended outputs and actual outputs can be sensed.

Feedback may be either positive or negative. Positive feedback is information that there is no discrepancy, that the outputs are those intended. It serves to reinforce the system's action. Negative feedback is in opposition to a system's action and stimulates the system to corrective activity in order to adapt to change - that is, to maintain a steady state in order to be able to fulfill the system's purpose.

Synergy: That the whole is greater than the sum of its parts. In hospital administration, this implies that as the separate departments within the hospital or hospital board or Ministry of Health cooperate and interact, they become more effective, efficient and productive than if they had acted in isolation.

Flow: A term sometimes used to refer to both inputs and outputs. For example, a system such as the hospital has flows of information, energy, material, students and other resources (including human). These enter the system from the environment as inputs and exit the system as outputs (services, educated persons).

Throughput: Also referred to as the 'black box' or 'transformation process', or 'conversion process', it is the processing of information energy and resources available to social or open systems.

4.0 CONCLUSION

Hospital is such a complex system that a better understanding of this by the hospital administrators and even the society will help the hospital to meet its purpose. Hospital is essential to man in order to promote health, prevent illness, treat disease and rehabilitate in order to prolong life.

5.0 SUMMARY

The Unit has presented the hospital a system, the complexity of the hospital, various types of system were discussed and basic systems concepts of relevance to hospital organizations.

6.0 TUTOR MARKED ASSIGNMENTS

Why is Hospital a social system organization?

7.0 REFERENCES / FURTHER READINGS

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UNIT 5 HOSPITAL MANAGEMENT SYSTEM

CONTENTS

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1.0 INTRODUCTION

This Unit will expose you to Hospital Management System where a typical multiple Hospital System (Medinous Hospital Management System (HMS)) will be presented to you for proper understanding.

2.0 OBJECTIVES

At the end of this Unit, you will be able to:

- Discuss a typical Hospital Management System.

3.0 MAIN CONTENTS

3.1 Hospital Management System

Medinous Hospital Management System is powerful, flexible and easy to use and was designed and developed to deliver real conceivable benefits to hospitals and clinics. And more importantly it is backed by reliable and dependable Medinous support.

Medinous Hospital Management System - HMS - Solution for Hospitals

Medinous is a Hospital Management System - HMS designed for multispecialty hospitals to cover a wide range of Hospital administration and management processes. It is an integrated client server application that uses Visual basic as the front-end GUI builder and Oracle as the database.

3.1.1 Registration

The Registration module is an integrated patient management system, which captures complete and relevant patient information. The system automates the patient administration functions to have better and efficient patient care process.

- Patient Registration Details
- Inpatient and Outpatient Registration
- Medical Alerts Details
- Appointment Scheduling (Patient / Doctor wise)
- Doctor’s Schedule Summary
- Doctors Daily Schedule List
- Patient Visit History
- Medical Record Movements
- Appointments for Radiology tests and Operation Theatre
- Patient Visit Slip
- Sponsorship Details

It provides for enquiries about the patient, the patient’s location, admission, and appointment and discharge details. Furthermore, this system even takes care of package deals for a cost. Medical Record keeps an abstract of clinical data about patients. It allows easy records on patients.

3.1.2 Billing

The Patient Billing module handles all types of billing for long-term care. This module facilitates cashier and billing operations for different categories of patients like Outpatient, Inpatient and Referral. It provides automatic posting of charges related to different services like bed charges, lab tests conducted medicines issued, consultant's fee, food, beverage and telephone charges etc. This module provides for credit partly billing and can be seamlessly integrated with the Financial Accounting Module. The billing module is extensively flexible by which each of your billing plans can be configured to automatically accept or deny. The system is tuned to capture room and bed charges along with ancillary charges based on the sponsorship category. The Billing Screens is used for In-patient and Outpatient Billing and Invoicing.

Furthermore, the charges for various services rendered can be recorded through service module and this can be used for billing purposes.

- Payment Modes / Details
- Sponsorship Conditions Details
- Patient Billing Details
- Package Installment
- Approval from Sponsor
- Company Sponsorship Details
- Package Registration
- Sponsor Verification
- Retroactive Processing
- User-defined Billing Cycles
- Automatic Room and Board Charges
- Recurring Ancillary Charge Capability
- Auto-generated Codes and Billing Criteria
- Provision for Pre-billing
- Extensive Third-party Billing

The system supports multiple reports utilizing various print options with user-defined Parameters.

3.1.3 Financial Accounting

The Financial Accounting Module deals with Cash/Bank, Receipt/Payments, Journal Voucher and General Ledger etc. Books like Cashbook, Bankbook and Ledger book can be generated. This modules generates reports like Trail Balance, Balance Sheet and Profit and Loss statement.

The Financial Accounting screens describe about the Account Payable, Account Receivable and General Ledger. Also describe the activities related to IP, OP, Bank related activities and provision to clearing the Supplier Invoice and keep track of the Account Receivable and Revenue related activities. The services that are covered by the sponsor companies, Insurance Agencies, Family Accounts, Individual Accounts, sponsorship details of the patient, Health Care Insurance are recorded in the system.

3.1.4 Fixed Assets

The fixed Assets Module deals with all the activities that are related to the Fixed Assets part of financial accounting. This included the activities that are related to identifying an item and then allocating depreciation, managing its movement, Maintenance, Revaluation.

3.1.5 Payroll

The payment and Personnel module deals with pay (and deduction) calculation, printing of certificates, and PF statements, gratuity statement and provides a monthly analysis. Maintenance of employee bio-data, attendance/ overtime details. It also reports on an encasements etc. The personal and payroll department is responsible employee relationship appointing the staff, maintaining the employee database, fixing allowance and entitlements, leave sanctions, loan termination process, maintenance of hospital document details, tenancy contracts and vehicle registration etc.

3.1.6 Outpatient Management

The outpatient module serves as an entry point to schedule an appointment with the Doctor or consultant Doctor for medical consultations and diagnosis. This module support better and timely consultation decision by providing instant access to comprehensive patients visits are divided into new, follow-up and review. This module also handles report of laboratory tests and other examinations. External Doctors visit to in patients can be on". Some patients may avail only the hospital facilities like lab, radiology, nuclear, physiotherapy and so on.

- Medical Alert Details
- Consultation Duty Roster
- Diagnosis Details
- Triage Details
- Patient's Appointments
- Daily/Weekly Schedule Summary
- Appointment Scheduling/Rescheduling

- Outpatient Medical observation Details
- Investigation/Treatment History
- Clinical Services Details
- Group/Packages Registration Facility
- Common Billing Clinical Services
- Doctor's Diagnosis Statistics

Furthermore, Confidentiality of Doctors observation, previous History of patients visits, online Request for investigations and so on, are the special features in Doctors observe system calculates the cost for the services rendered to the patient and reflects in appropriately resulting in smooth billing process.

3.1.7 Inpatient Management

The inpatient module is designed to take care of the activities and functions pertain management. These modules automate the day-to-day administrative activities and provide other modules, which leads to a better patient care. It provides comprehensive admission of patients and ward management: availability of beds, estimation, Agreement collection of advance, planned admission, emergency admission and so on. The inpatient deals with ward management: shifting from one ward to the other, bed available administration of drugs, nursing notes, charge slip and so on.

- Admission cost estimation
- Admission Approval
- Admission request
- Doctor Transfer Details
- Nursing Notes
- IP Medical Observation
- Pending Drug Request
- Surgery Scheduling Details
- Discharge Notification Summary
- Expected Date and Time of Discharge

The module tracks every visit made by the patient and caters to follow up visits of patient multiple appointments.

3.1.8 Pharmacy

Pharmacy module deals with the automation of general workflow and administration made of a pharmacy. The pharmacy module is equipped with bar coding facility, which makes medical items to the patient more efficient. This module deals with the activities such as:

- Enquiry
- Quotation
- Purchase order
- Online approval
- Pharmacy drug configuration
- Pharmacy stored configuration
- Drug issues to patients and billing
- Unit dosage facility
- Supplier information
- Maintenance of drug inventory
- Automatic reorder level setting
- Purchase Requisitions
- Purchase order
- Online request for stock from various sub-stores
- Online Stock transfer
- Maintenance of stock at different sub-stores
- Return of items nearing expiry
- Destruction of expired items
- Physical stock verification and adjustment
- Goods receipt
- Stock Transfer (inter store stock transfer)
- Stock Adjustment
- Stock in Hand reports

In addition the online prescription facility assists and facilitates the physicians to the prescription details and as well reflects the medication billing details in the billing module.

3.1.9 General Stores

General stores and inventory module deals with purchase of items, issue of items, main automatic reorder level setting, online request for stock from various sub-stores, online maintenance of stock at different sub stores, physical stock verification and adjustment, supplier etc.

3.1.10 Laboratory

The laboratory module automates the investigation request and the process involved results to the concerned department/doctor of the hospital. Laboratory module starts online request from doctors and also allows laboratory personnel to generate request module supports to perform various tests under the following disciplines: biochemistry hematology, microbiology, serology, Neurology and radiology. Tests are grouped under and sample type (specimen). Based on the request the user can input the sample number. Results can be entered based on the

sample type either to one test or the test result requires approval, the supervisor has to approve the result and it is concerned doctors.

- Sample Result Entry
- Test Association Details
- Specimen Association Details
- Antibiotic Details
- Result Range for Test
- Investigation Request
- Bulk Sample Request
- Sample Details
- Samples Received from External Laboratory
- Samples Dispatch to External Reference Laboratory
- Investigation and Treatment History

Test report can be made confidential. Tests can be performed only after the billing is exempted when the case is declared as urgent. In addition, this module facilitates referral patients.

3.1.11 Radiology

Radiology module caters to services such as X-ray, Scanning, Ultra sound etc. A scheduled resource is possible. The system stores all the result details of various tests and makes the Test Results. These Tests are carried out both for Inpatient and Outpatient. The system details (like patient number, Test report like X-ray, Scanning details) and for each generates a unique number for the image.

Investigations can be done only after the billing is done. This rule is exempted when though as urgent.

3.1.12 Nuclear Medicine

The main function of this module is to conduct the various Tests and make a report of the Results and a unique number is generated for each image. The tests are carried out in Outpatient. Appointments have to be fixed by the Patient before the test. The conduct analyses the result and makes a report based on the findings.

3.1.13 Physiotherapy

This module facilitates tracking the services given to patients depending on recommendations. Physiotherapy sessions are carried out both for Inpatient and Outpatient has to be fixed by the patient for these sessions.

All the appointments to the Physiotherapy will be through the consultant. There are appointments.

3.1.14 Dental

Dental module caters to the service rendered by the dentists. Treatment and follow-up tracked using this module. Progress readings can be recorded through this module.

3.1.15 Service

The service module deals with all the services available in the hospital and the charges are stored through this module. There are various services that are available in the hospital.

Service master: This master gives the details about package details, Group details.

Room Type master: This gives the details about Room Type (Ex: Private, Semi-private, Suite etc.) and their charges.

Consultation Charge master: This gives the details about Doctor and the charges follow-up, Review and Call-on.

Revenue Type master: This gives the predetermined charges for various service giver Ambulance, Anesthetists Fee, Baby Cot etc.).

3.1.16 User Manager

The User Manager module basically deals with security through controlling the access available in the application. Any user associated with a user group can access only those that the user group has rights. It also deals with the System Related Activity like User Monitor Group Master, User Master and view the User Group Lookup of employee database company documents, User defined error message, Generating Daily Statistical Summary.

4.0 CONCLUSION

No doubt Medinous Hospital Management System is a solution for hospitals as it is designed for multispecialty hospitals to cover a wide range of Hospital administration and management processes.

5.0 SUMMARY

The learner has now learnt the Hospital Management System, a detailed of what Hospital system should be and when fully operational especially in the teaching hospitals, the service delivery will be easier, accountability can be guaranteed and it will be obvious if some parts of the system are not measuring up to the standards.

6.0 TUTOR – MARKED ASSIGNMENTS

State and explain ten function of Nuclear medicine

7.0 REFERENCES / FURTHER READINGS

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MODULE 3 PRINCIPLES AND CONCEPTS IN HEALTH CARE PROGRAMMES

Unit 1 Application of Principles and Concepts in Various Health Programmes
Unit 2 Factors Affecting the Organization and Administration of Health Services
Unit 3 Health Economics
Unit 4 Basic Economic Concepts
Unit 5 Managing Conflict In Hospital

UNIT 1 APPLICATION OF PRINCIPLES AND CONCEPTS IN VARIOUS HEALTH PROGRAMMES

CONTENTS

1.0 Introduction
2.0 Objectives
3.0 Main Content
- 3.1 Hospital Objectives
- 3.2 Measure of health states
- 3.3 Health profiles
- 3.4 Case management
- 3.5 Valuation in healthcare

4.0 Conclusion
5.0 Summary
6.0 Tutor-Marked Assignment
7.0 References/Further Readings

1.0 INTRODUCTION

There are lots of principles that are applied in health administration in Nigeria Division of labor, specialization, discipline, unity of command, unity of direction, remuneration, centralization and hierarchy. These are administrative principles that influence management and administration of healthcare administration.

The US department of Health (DOH 2007 d) policy for tackling health inequalities. Which requires local service provider to work in partnership to address the wider determinants? This brings about partnership as yardsticks for applying the principles in health administration (David Matthew 2009. P. 55).

The reality of philosophy of health and policy are principle in health administration. The principle of social health of post modernism of one size fit all policy that characterized of post war creation of universal health and welfare provision. Lyanard argues that huge national schemes or grand narratives have failed to help the people they were created to help. He cites example of housing and poverty as a social problem, not to devoid of healthcare system.

Another principle that can be applied in healthcare administration is doctrine of partnership in healthcare administration. In primary health care partnership is necessary is healthcare is to reach the grassroot. Some people term it as partnership and collaboration in healthcare delivery. Some authority have seen partnership, as equal commitment, the state of being a partner, or ne one of a pair as the side in a game sharing essential knowledge, skills and experience healthcare professionals. In Nigeria, there is public/private partnership in healthcare administration. The government alone cannot with collaboration with vested interest in health care administration partnership a principle accepted in healthcare administration in Nigeria.

In partnership, there is trust and confidence in accountability, respect for specialist and expertise joint working team and showing of rested interest and appropriate governance structures.

2.0 OBJECTIVES

At the end of this unit student should be able to:

- Measure health status
- Understand Health profiles
- Engage in Valuation of healthcare

3.0 MAIN CONTENT

3.1 Hospital Objectives

Certain principle of health were there, it could be discovered and health service professionals should be experts in their work, if they learn how to apple principle of objective are universally accepted as fundamental or primary truths consciously recognized and adhered to. Principle of hospital objectives work successfully everywhere irrespective of environment, culture and institutional framework. This help managers, doctors and administrators to make sound and useful decisions to attain defined goals and objectives of health service administration.

Rationale of Objective principles of health administrations

The principles of hospital objectives have the following functions.

i) It helps to guide the action of administrators, healthcare professional in hospital.

ii) It helps healthcare practitioner and academician to generate techniques for understanding and treating different administrative situations and environment.

iii) They enable us interprets the aims and objectives of hospitals and all other healthcare industries.

iv) It enables client and ends use of healthcare facilities to form the basis to guide the use of discretion of power of healthcare providers.

v) It enables clients and patients and their relatives to know the legal basis of hospital. Hospitals and healthcare institutions are legal entity. It can sue and be sued.

vi) It enable us to diagnose several groups to whom professionals can reason by own an obligation including:
   i. Patients/clients
   ii. Patients/client's relatives
   iii. Follow professionals
   iv. Employees
   v. The general public
   vi. Themselves and their dependents

   It must be observed that fairness and truthfulness combine informing dilemma for professionals (Carn well 2009)

   The above rationale are there to enable us appreciate the objective principles of hospitals.

Hospitals are extremely complex organizations producing a wide range of services. There are major difficulties in defining the output of hospitals. In addition, some hospitals are run on a for profit basis while others fall into not for profit category. However, just because a hospital is run a profit basis, it does not follow that the objective is to maximize those profits. Many hospitals compete in market, as in the USN or in a quasi – market, as in British NHS. In either case, the hospital's objectives will determine its competitive strategy.

Many models of hospital behavior have been developed over three decades ago, new house (2000) put forward a model to describe the behavior of non-profit hospitals. In it he assumes that the hospital's objective was to maximize both quality and quantity of services provided, subject to a limit on the size of the hospital deficit. The arguments for including quality in the maximand follows from the premise that as administrators of hospitals.

3.2 Measurement of Health Status

This presents difficulties because health is multi-dimensional and value-judgment are required about the quality of patients lives. Different individual may value apparently similar health status differently. An outlets many take a more serious views of sprained ankle them a TV critic.

In medicine we are often interested with improvements in health status. Some patients are more seriously ill than others before treatment begins. Ideally a value-added approach should be used when comparing treatment outcomes. This is one of the different disadvantages of crude hospital 'league table' in US, which compare death rates from different causes. We need to know the health status of patients before they are treated, if we are to come to conclusion about the effectiveness of health care procedures and services. Before we examine measurement procedures, it is important we understand the main types of scale in use and drawn backs.

Ordinal Scales

These scales are designed to rank health status. This is done by comparing whether one health status is better than another, but do not try to decide how much better one state is better state than another. We can use medical statistics, categories Viz: relieved unrelieved and dead. This kind of scale has some drawn backs, for example, suppose treatment A, cost N2,000 while treatment B (for the same condition) cost N6,000. We find that treatment B produce a more highly ranked state of health than treatment A. Since we cannot judge whether it is better how much better the value for money. This is a problem, because if the budget is limited using treatment B will mean that fewer patients can be treated. We need to have a more informative measurement scales to make this sort of decision. The majorities of developments take the form of cardinal scales and do not help us to decide how to allocate funds between varieties of services for maximum benefit Few would be willing to completely sacrifice middle-ranked services until all those in need of top-ranked services had been dealt with.

Cardinal scales

There are two types of cardinal interval and ratio. Temperature is measured on an interval scale. If two numbers on the scale are a certain distance apart this will indicate the same ever the two numbers are on the scale for example, a jump from 20^{o}c to 30^{o}c is a 10 degree rise in temperature wherever the two numbers are on the scale.

Measures of health status

Economists, clinician and others have attempted to use a variety of techniques to measure health status and to identify the value added by health services.

Clinical measures are one of the simplest approaches in the sense that they are often single dimension. For example, the measurement of lung capacity before and after treatment might be thought to give evidence about the impact of treatment for lung disease, while the measurement of cholesterol senile might be thought to give evidence about the impact of drug treatment or patient compliance following the advice of the doctor. This may follow cyclical processes, because clinician frequently require a range of measures of symptoms over an appropriate time period before coming to any conclusion in the diagnostic and treatment process.

Clinical Measures require an understanding of single or multiple disease processes and frequently diagnoses will have the status of hypotheses with considerable levels of uncertainty which are matched by similar uncertainty about progress.

Functional Measures can be described as multi-attribute measure and may include clinical indicators and other indicators related to activities of daily life or other capabilities which are regarded as important for the individuals or groups being measured. Some measures are specific to a particular disease groups while others are generic and designed to be used across wide range of conditions.

Wilkin et al (2009) have pointed to the need for precision in the use of language when we talk about human function. They make an important and widely supported distinction between impairment, disability and handicap.

- Impairment is used to refer to any disturbance or interference with the normal structure and functioning of the body, including mental functions. This might normally be assessed by one or more clinical measures.

- Disability is the loss or reduction of functional ability and activity consequent on impairment. This would be measured by a functional measure.

- Handicap is the value attached individual's status when this departs from the norm-this must be related to some notion of social status or social functioning. Such an assessment and the implications for policy of action are likely to be a matter of competing values and may be very difficult to agree. (David Perkins 2006) we must that a particular impairment in terms of the norms for an individual of a particular age and gender will result in either a significant disability or handicap. For example, long sight is a clear impairment experienced by a large proportion of the middle-aged population which is corrected by spectacles and for many does not result in significant disability or handicap.

  Besides, functional measures focus on disability and typically look at what are called activities of daily living (ADL) basic ADL measure look at bathing dressing, toileting, transfer, continence and feeding (Maltioney and bath 2006) instrumental ADL measures look at activities in terms such as stopping, cooking, housekeeping, laundering, use of transport managing money, managing meditation, use of telephone etc. (Mobulu, Mumen 2009) while it can be seen that these indices do not apply universally, they do provide some means of assessing the impact of impairment and action to remedy the resulting disability.

3.3 Health Profiles

We should understand that health profile is an attempt to provide a consistent set of descript for a condition which can be used in the description of changes in health status.

One of the best-known profile is the sickness impact profile (SIP) which has 12 dimension and 136 items (Berger 2004) while this is thought to be a methodologically send instrument.

Example of health profile
McEwan 1983
The profile measures 13 dimension the dimension are:

1) Physical mobility
2) Pain
3) Sleep
4) Energy
5) Social isolation

6) Emotional reaction
7) Employment
8) Household work
9) Social life
10) Sex life
11) House life
12) Holidays
13) Interest and hobbies

Such profile can be used to assess health status overtime. It may be difficult to determine whether these changes are attributable to a particular intervention or whether they would have occurred anyway due to the natural history of the disease or other intervening factors. There are a number of serious problems which can arise in the administration of these profiles which limit their reliability and need to be guarded against.

- A doctor may carry forward impression of a patient's function from one rating to next to make the ratings consistent.

- The rater may upgrade the score of a patient who is thought to be complainer.

- Imprecision may occur if different raters use different frame of reference.

Other services of bias may occur where the process of judgement is inconsistence.

Besides, if we can prevent these sources of bias which reduce the reliability of functional measures we are still faced with the difficulty of handling different dimensions such as pain and quality of life in a single measure. There is no obvious way of scaling such variable although on or two attempts have been made.

3.4 Valuation in Healthcare

Healthcare purchasers, whether individuals, insurance companies or public authorities inevitably make value judgement s in their decision about what services to buy and what services, and potential benefits, must be forgone. This is any assumption, because not everybody can make value judgment. In the rural areas where healthcare facilities are few or not available, how effective is the village patients and clients about to value their judgment. However, they are a number of questions which need to be asked of a health care intervention:

- For whose benefit is the intervention being carried out? Is it individual procedure for the benefit of a single patient, a preventive measure with individual and collective benefits, or a health programme targeted at a community or similar group?

- Is the procedure worth doing? Is it possible to use resources which could be consumed in another way that is more effective or more worthwhile?

In principle, questions to do with clinical effectiveness are open to scientific investigation using random controlled trials and other similar methods. The question which ask whether there is a better use for the resources or whether a clinical procedure is worth doing imply that we can value the benefits which arise from the treatment or the programme and then make a decision based on the comparative value of two or more procedures and programmes. For instance a number of purchasing authorities have decided that while it is clinically possible to remove which individually voluntarily purchased, it is not priority for scare public funds since there is no contract for such a service it is not available in local trust hospitals.

4.0 CONCLUSION

Hospital is far from healthcare provider despite the vast resources which hospital consume. Other healthcare provides, also applies the above principle in dispensing their functions. Hospital also apply fundamental principle or unusual principles this includes responsibility, which demonstrates that body of professionals in healthcare institutions exercising power and authority must be responsible within power delegated. This also show that people exercising delegated power or administrative discretions must work according to power delegated. Humanitarian principle in hospital administration will see patients and clients help to govern relationship existing in healthcare system. Appreciation of collective worth care professionals delivering the goods and services.

Justice implies rigidity in implementing rules and regulation without victimization. This means, application of administration discretion uniformally without fear or favour; fairness and equality of all before establish rules and regulation healthcare system.

Finally, we must also examine prudential principle in application of principle in health administration. Prudential enable health workers to anticipate, calculate, regulate, interpret and control both material and human resources in healthcare institutions. Economy entails that healthcare professionals avoid wastage of resources both human and

material. With economic miseries facing many healthcare institutions, managers and administrators should minimize waste of resources in reaching defined goals and objectives of healthcare institutions. (Mumen Lugard 2010 p 52)

No matter the sectorial nature of administration economy principles entails how well organization and its management is able to use available scarce resources in achieving goal of the establishment.

5.0 SUMMARY

In this section, we attempted to examine the application of various health principles, concepts, in various healthcare programmes. There is dare needs of marketing principles and idea of customers in application to health care programme. Institutions to clients and their customer's (patients clients and their relatives) and know their problems, complaints and address it in their health programme customers are always right, but patients are treated with idealize out cast in hospitals. If we apply legal principle also, healthcare providers will understand their services provided it is negligible can attract law suits when healthcare providers know this, and customers discriminate that they are the king and can determine which programme to patronize, health care delivering will work better.

Correct application health care principles will bring sanity into health administration in Nigeria and grant soccer to the entire populance.

6.0 TUTOR-MARKED ASSIGNMENT

1. What is health profile?
2. How does health profile related to health statistics

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UNIT 2 FACTORS AFFECTING THE ORGANISATION AND ADMINISTRATION OF HEALTH SERVICES

CONTENTS

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1.0 INTRODUCTION

Tele Medicare is essentially the use of information and biomedicine technology to support, facilitate or improve collaboration and delivery of healthcare services among geographically dispatch parties including patients and physicians (Mendel 2009)

2.0 OBJECTIVES

At the end of this unit student should be able to:

- Understand the Problem in the practice of Tele-Media Technology
- Relate Tele-medicine to health care and medicare
- Understand the problem of health care delivery in Nigeria.

3.0 MAIN CONTENT

3.1 Tele-Medicare Technology

Healthcare organization have become increasingly aware of and knowledge about telemedicine in recent years. In effect many organs have exhibited considerable interest in adopting telemedicine technology to suggest practices of the organ, as manifested by a fast growing number of telemedicine program establishes around the world.

The ultimate success of telemedicine requires an adoption organ to address both technological and managerial challenges effectively.

Most previous telemedicine research has concentrated on technology develop a few should have examined issues relating to technology adoption especially individual line. For instance, Mairinger et al surveyed individual physician in different European regions or countries about their perception toward telemedicine Gschwendtnen. However, most the these handful of studies have concentrated on individual technology adoption and acceptance thus offering limited if any discussion of technology that take place at the organ level. Adoption of telemedicine technology in many organizations has been driven by legitimate motivations including service improvement, patient make extension and organic performance and competitiveness enhancement. However not all programme drives are pragmatic or sustainable. In effect healthcare organization can and do adopt telemedicine technology without proper motives or due consideration. As hill Sheng 2009, commented, the adoption of telemedicine technology by a healthcare organization may result from compromises between physicians and management or proceed without due consideration of important decision factors.

Technology adoption has been an important issue for is research and practice. May previous studies have built their theoretical perused along Regions innovation adoption theory which centennially states that observed adoption are largely promoted attributes that have been communicated to potential adopts. This theory encompasses an innovation (technology) emphasis and has primarily arisen to explain or predict innovation where adoption takes place.

In Nigeria, telemedicine is not in practice because experts are not available and technological backwardness. This make telemedicine not practiced.

3.2 Healthcare and Medicare

Nigerian medical care system is highly structured – for the benefit of those who control it and of some of those who work in it. It is highly fragmented, the responsibilities, the level of control so manifold, the communication and coordination between its parts so haphazard that – except for euphemisms pluralistic, and pragmatic – the system almost defiles brief description. The various level of care is primary, secondary and tertiary.

At first level patients with relatively minor systems or who is worried about his or her health may seek care in a number of different ways.

Self-care, often with meditation available without prescription, taking "Igbo" (locally prepared herb sustained) going to local seller or go to family members for care, this situation have serious problem for health service administration, as this provides problem for secondary ties in health care delivery system.

Illness affects people social relationships, self-image and behavior. According to Freidson (2009) when a physician diagnoses diseases a human's condition as illness, he changes the man's behavior by diagnosis, a social state is added to bio physiological state assigning the meaning of illness to disease. This demonstrates the role of sickness to work illness behavior TalcqH Parsons (1951) cite by Mumen Lugard (2009) argued that in order to prevent the potentially descriptive consequences of illness on a group or society, there exists a set of shared cultural rules (norms) called the "sick role" The sick role legitimizes the derivation.

According to Parsons, the sick role exemplifies that sick person is exception from normal social responsibilities.

It must be observed that Nigerian medical profession in great crisis, our society invests a great amount of its social and economic resources in medical care, has some of the world finest physicians, hospitals, and medical schools, is plagued by deadly infectious diseases.

Healthcare crisis exists, another problem, is how this problem can be addressed.

Medical cost have risen exponentially, in three or more decades the amount Nigerians spend annually on medicare increased from 4 percent to nearly 10 percent of the nation's gross national product. 2010, the total cost was over N200 billion. Indeed, medical costs have the leading cost of personal bankruptcy in Nigeria, including poverty in Nigeria.

The increasing specialization of medicine has made primary care medicine scarce. Less than core out of former doctor can be defined as primary care physicians, general and family practitioners and some physicians and obstetrician – gynecologist. In many rural and inner-city areas, the only primary care available is in hospital emergency rooms, where waiters are long, treatment are often impersonal, and continuity of care minimal (and the cost of service delivery very high).

Although it is difficult to measure the quality and medical care, a few standard measures are helpful. Life expectancy, the number of years can be expected to live, is at least a crude measure of a nation's health. According to United Nations data, Nigeria ranks one of the countries

with lowest life expectancy for males and females. Infant mortality is high, and taken to mean infant death in the first year, is one of our best indicators of health and medicare (particularly prenatal care) The US for example ranks fifteenth in infant mortality, behind such countries as Sweden, Finland, Canada, the German democratic Republic and the United Kingdom. Austria and China has the highest Longevity of life in the world. (United Nation Demographic Year Book 2009)

Our medical system is organized to deliver medical medical care" actually "sick care" rather than" health care medical care is that part of the system which deals with individuals who are sick or who think they may be sick. health care is that part of the system which deals with the promotion and protection of health, including environment protection, the protection of the individual in the workplace, the prevention of accidents (and) the provision of pure food and water (Sidel and Sidel 2006)

Very few of our resource are invested in health care that is, in prevention of disease and illness. Yet, with the disease in chronic disease prevention is becoming ever more cost-effective than medicare"

Besides, Nigeria government spends more in curative medicine that promotional than prevention medicine. There is also, little public accountability in medicine. Recent health insurance schemes, health system agencies, is designed to coordinate medical service the review of quality and care of medic care and malpractices and use of fake drugs like NDLA has filled recently bringing drug barrooms to book. We must observe that the problem of health care administration are many, we need to examine other problems relating to service delivery.

3.3 Problem of Health Service Delivery

Medical care in Nigeria is enormous and complex industry, involving thousands of organizations, the expenditure of billions of naira each year, and the employment of millions of workers. It is widely acknowledge that the Nigerian health care crisis is primarily one of organization, administration and accountability (Rochelle David 2006) medical costs and health care crisis exist, there is, considerable disagreement as the cause of this crisis and how, these crisis can be dealt with. One thing is obsidians, problem of service delivery is manifesting as a hydria headed demon, whose influence is real. In an article published why Col. Oboh in institute of health services administration journal vol. 3 2004, addressed the issues of Health care and medical care and how and why medical services are organized and distributed the way they are in Nigeria. The author find a serious coupled with a set of economic and political priorities that has produced a medical care

system unresponsive to health needs of many of its citizens. The questions that need to be asked it, why this should be in a country that invests so much money in medical care more than her counterpart in West African sub-region remains a central question in the article throughout the journal.

Besides, medical care system is highly structured for the benefit of those who control it and of some of those who work in it – in another sense it is fragmented, the responsibilities so diffused, the levels of control manifold, the communication and coordination between its parts so haphazard, that – except for the euphemisms, "Pluralistic" and "pragmatic" – the system almost defiles brief description. They are many government hospitals where directors divert drugs to their private hospitals.

Consumer crisis the crisis felt by consumers of health services is the failure of the preventive system to deliver adequate health care at any price. Though not limited to poor people, because medical care is fragmented and isolated from the social economic and environmental causes of pathology, people are experimented on and used as teaching material. The doctor's priorities come first. And the patients and hospitals are totally an accountable and unresponsive to the needs of the users of service. People experience long waits in over – crowded doctor's waiting rooms.

Another related crisis is providers crisis.

Those who provide and pay for healthcare face a different crisis – the breakdown of the old systems of financing. The hospitals find themselves near collapse at cross skyrocket and financing fails to keep up. This threatened not only the institutions themselves but also the multimillion-naira drug and hospital supply companies who spend on the hospital as a retail outlet for their products. At the same time that the hospital weeps because of "inadequate" funds the providers of funds groan under the weight of the hospitals. The health insurance scheme looked like the way out, but its implementation is real problem at this, its infancy development.

4.0 CONCLUSION

There are many factors affecting the organization and administration of health service. These factors include the use of telemedicine, the problem of interpretation of medic and healthcare, problem on health care service provider's crisis. Readers are expected to generate factors that influence the administration and organization of health service in Nigeria.

5.0 SUMMARY

We have been able to examine of the factors affecting organization and administration of health service administration. These includes: problems and practice of tele-medicine, healthcare and medical care, crisis of end users and healthcare providers and so on.

6.0 TUTOR-MARKED ASSIGNMENT

1. What are the factors influencing health administrations in Nigeria?
2. What are the advantages of Telemedicine?
3. Critically examine the problems influencing organization and practice of health care services in Nigeria.

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UNIT 3 HEALTH ECONOMICS

CONTENTS

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1.0 INTRODUCTION

This unit explores the contribution that the discipline of managerial economics can make to the management of health services. According to Mansfield (2003) Managerial economics attempts to bridge the gap between the purely analytical problems that intrigue many economic theorists and the day-to-day decisions that managers must face. Hirschey and Pappas (2007) add, managerial economics helps managers to recognize how economic forces affect organizations and describes the economic consequences of managerial behaviour. The scope of this section is different from that of the many excellent texts on health economics for example Economics, medicine and healthcare (1992) and key issues in Health Economics (1994) both by Mooney: where he defines health economics as the discipline of economic applied to the topic of health. Clearly the study of managerial economics in a health services context cannot be carried out independently of the study of health, economics. However, the emphasis is managerial economics and reference to problems encountered in the management of health care.

Health economics is a branch of economics concerned with issues related to efficiency, effectiveness, value and behavior in the production and consumption of health and health care. In broad terms, health economists study the functioning of the health care systems as well as health-affecting behaviors such as smoking.

A seminal 1963 article by Kenneth Arrow, often credited with giving rise to the health economics as a discipline, drew conceptual distinctions between health and other goods.[1] Factors that distinguish health economics from other areas include extensive government intervention, intractable uncertainty in several dimensions, asymmetric information, barriers to entry, externalities and the presence of a third-party agent.[2]

In healthcare, the third-party agent is the physician, who makes purchasing decisions (e.g., whether to order a lab test, prescribe a medication, perform a surgery, etc.) while being insulated from the price of the product or service.

Health economists evaluate multiple types of financial information: costs, charges and expenditures.

Uncertainty is intrinsic to health, both in patient outcomes and financial concerns. The knowledge gap that exists between a physician and a patient creates a situation of distinct advantage for the physician, which is called asymmetric information.

Externalities arise frequently when considering health and health care, notably in the context of infectious disease. For example, making an effort to avoid catching the common cold affects people other than the decision maker.[3][4][5][6]

Economics is the science of scarcity. The application of health Economics reflects a universal desire to obtain **maximum Value for money** by ensuring not just the clinical effectiveness, but also the cost-effectiveness of healthcare provision.

Achieving 'value for money' implies either a desire to achieve a predetermined objective at least cost or a desire to maximize the benefit to the population of patients served from a limited amount of resources. This requires services to be evaluated for **'cost-effectiveness'.**

An associated concept is that of **efficiency,** which measures how well resources are used in order to achieve a desired outcome.

Opportunity cost represents an invaluable mode of thought in health economics, as it makes clear the explicit trade-offs that underlie resource use in the health services. The true cost of using scarce healthcare resources in one manner is their unavailability to fund alternative beneficial services.

All economic evaluations have a common structure which involves explicit measurement of inputs **('costs')** and outcomes **('benefits').**
Health economics can help to inform and improve decision making through the systematic and objective application of **'applied common sense'.**

Such 'applied common sense', which symmetrically balances costs and benefits, represents a valuable mode of thinking for **Decision-makers,**

irrespective of whether a formal economic evaluation is undertaken Supported by Sanofi-Aventis (2004)

Economics is the science of scarcity. It analyses how choices are structured and prioritized to maximize welfare within constrained resources (Box 1). We all use economics on a daily basis ('do I buy the cheaper car, or pay a bit more for the nicer one?') as we work within our own resource constraints (our desires say, 'Buy the nicer one'; our resources say, 'Buy the cheaper one'). By comparing the costs and benefits arising from the purchase of the competing cars, we are able to optimize our decision-making. If we routinely use such economic techniques in our private lives, then surely it is not too great a 'leap of faith' to apply them in our lives as health professionals? This is the basis of health economics. It is universally acknowledged that the technical ability of healthcare systems to provide care (the wide array of new and expensive health technologies available) far exceeds the ability of any healthcare system to afford all such technologies. Once healthcare decision-makers have accepted the need for choice, they must inform that choice by prioritizing competing interventions through the analysis of their costs and benefits. However, it is important to recognize that healthcare exhibits a range of special characteristics that will fundamentally affect such analyses. Health economics reflects a universal desire to obtain maximum value for money by ensuring not just the clinical effectiveness, but also the cost-effectiveness of healthcare provision.

Cost-effectiveness

Health economics is dominated by a simple theoretical concept, that of cost-effectiveness (this is explored in greater detail in *what is cost-effectiveness?*).1 In general, the concept of cost-effectiveness implies either a desire to achieve a predetermined objective at least cost or a desire to maximize the benefit to the population of patients served from a limited amount of resources. To achieve this aim, we use the tools of economic evaluation to select the most cost-effective options from a range of healthcare alternatives. An associated concept is that of efficiency.

Efficiency

Efficiency evaluates how well resources are used to achieve a desired outcome. It has a number of different aspects.

Allocative efficiency measures the extent to which resources are allocated to the groups or individuals who can benefit most. For example, the benefits of statin treatment provided to high-risk patients (for example, patients who have already had a heart attack) are far in excess of the benefits that arise when they are prescribed to low-risk

patients. Allocative efficiency therefore requires the high-risk patients to be targeted as a priority (primary prevention), resulting in an improved level of health associated with statin treatment.

Technical efficiency measures either the extent to which resources are combined to achieve maximum outcome, or alternatively the minimum amounts of resources that are combined to achieve a given outcome (for example, identifying the least expensive way to effectively heal a peptic ulcer). The prescribing of unnecessarily long courses of drugs or unnecessarily expensive drugs implies the existence of technical inefficiency.

Defining and measuring 'health Outcomes'

Defining and measuring health outcomes is fraught with difficulties, but such measures are the essential bedrock of health-economic health economics, a social system that studies the supply and demand of health care resources and the effect of health services on a population.

Health Economics this division of economics focused on evaluating scarcity in health care systems in different economies. Health economics seeks to identify problem areas in a health care system and propose solutions for pressing issues by evaluating all possible causes and solutions.

The field of economics, is a field of application, deals with the use of scarce resources to satisfy human wants and needs whether in public or private sector, organizations have to be managed and decisions have to be made about how best to use the resources available. This applies to the delivery of health care from other field where managerial is applied are the personal life-and-death decisions, and access to service is often considered to be a basic human right irrespective of ability to pay.

In traditional managerial economics, it is implicitly assumed that output quality, in other words, that it works. Consumers have rights, they can return faulty goods and demand for refunds. In Nigerian political economy, faculty goods can easily be returned and paid with military or police assistance. Sellers of services and goods are rarely obliged to refund money.

In health care, it is the case that many treatments are unproven (Lewis 2006) and (Goelter 2006) point out diagnostic dilatation and curettage (D and C) operations on young women, although quite commonly carried out, are of unproven value. There is lack of evaluation studies of many common treatments. In addition even when the results of studies are available, there are problem with which both the dissemination of the result.

(Hailes and Jones 2008) and the extent to which the clinicians are willing to change their preferred treatment regimes. In United Kingdom for example, the department of Health is encouraging the move towards evidence-based medicine, where decisions about interventions will be more firmly based on research evidence about their effectiveness (Appleby 2000).

Nigerian healthcare lacked effective evidence-based medicine. It is based on if symptom persist see your physician. This serviced with trial and error medicine rather than evidence-based U.K and U.S standard practice.

It must be observed that, in Healthcare, it not the consumer who demands the treatment but the doctors, acting as the agent of the patient. This agency relationship is not exclusive to health care but it does raise special problems in demands and resource allocation studies. In this section, or unit, we are going to consider the nature of healthcare and health and the special problems facing, health administration as regards health economics application, measuring output and efficiency, assessing health status, appraisal of health programmes how healthcare is financed and basic economic questions as it influences decisions in health service administration.

2.0 OBJECTIVES

The central objectives of this unit are examining the effectiveness in the use of health economics in making decision in healthcare administration in hospital. The objectives include the followings:

- To show how economic concepts and techniques assist in the understanding and resolution of critical problems in the delivery of health services.

- To introduce the key economic questions which have to be addressed by all enterprises whether public or private in healthcare services.
- To introduce some of the special problems which arise due to the particular character of health and health care?

- To demonstrate health administration is a multi-dimensional discipline.

- To show how basic economic questions relate to hard choices which have to be made every day by patients, clinicians, administrators, managers and politicians?

- It illustrates various approaches to difficult decisions about the content of healthcare, the pattern of services, and the distribution of those services in conditions of scarcity.

- To introduce some of the issues in the theory and practice of rationing in healthcare administration.

- To demonstrate that future trends can influence health administration, for example the idea of customers needs and rights in influencing healthcare administration.

3.0 MAIN CONTENT

3.1 Definition of Health Economics

As viewed from the introduction, health economics has been defined by various scholars. Health economics as a discipline of economics applied to health, it is managerial economics applied to the topic of health. It is the disciplines that enable us to deal with problems encountered in the management of healthcare. It can also be defined as a discipline that enables students and managers in healthcare, to recognize economic forces and consequences of managerial behaviour.

Relevance of Health Economics

There are many relevance of health economics. They are itemized as follows:

(i) Health-economics enable us to formulate basic economic questions as regards, definition of health, costs of poor health, demand for healthcare, and its supply, and the requirement health services.

(ii) It helps us to deal with some basic economic question, concepts and techniques, like scarcity, opportunity cost, economic choices and how decisions in healthcare are made.

(iii) Enable healthcare specialists to address the issues of measurement and valuation in healthcare, e.g. Health profile, health status measurement and scale measurement.

(iv) It promotes both appraisal of health delivery, it deals with issues of productivity, efficiency, economy and inefficiency in healthcare administration.

(v) It helps us to analyse special problems and trends in character and changes healthcare administration.

(vi) It helps us to analyse government policy to the people. For example, it helps to address why government policy for healthcare for all Nigerian by the year 2000 failed.

(vii) It helps students and scholars to address the issue of comparative healthcare, a study that enables to do cross national healthcare. This also reveals that Nigerian government is a copy-cat in healthcare administration. British and American healthcare must be copied wholesale without discrimination.

(viii) It enables us to demonstrate the relationship between the resource inputs and the service outputs produced in healthcare administration.

(ix) It enable us to examine the measurement of outputs in healthcare services and know the standard deviations whether it exists in our healthcare management.

(x) Finally, health economics is a discipline and branch of specialization in public health administration that is yet to be properly studied in Nigeria. We use this opportunity to sensitize that health administration should be given its pride of place in Nigeria.

3.2 Basic Economic Questions and Concepts

There are some basic economic questions that may crop up in health administration.

(i) For example, have health managers/administrator failed to plan and budget effectively for the financial year?

(ii) Is the hospitals being run inefficiently and not making the best use of its resources.

(iii) Has the hospital failed to obtain enough contracts or fund, if so, why?

(iv) Why are expensive facilities lying unused when they are waiting lists for treatments?

(v) Is the NHS system, in health administration effective in Nigeria.

(vi) What are the consequences and costs of this situation for patients.

(vii) Is NHS is underfunded?

(viii) How many people died in hospitals due to health professionals negligence?

We must observe that the first five questions are concerned with the demand for and supply of services the way the services are being planned and organized, the characteristics of the market in which the hospital is operating the efficiency or otherwise of the resources use and the pricing and marketing of the services. These questions can be addressed using the ideas and the techniques of health economics.

The last, vi, vii and viii are question which can be addressed only by using value judgments. They are outside the scope of conventional or positive economics which does not tackle problems which require interpersonal comparisons of welfare (Buchanan 2000). Positive economics attempts to establish cause and effect in a scientific manner. Hypotheses are formulated and these are then checked against observed facts.

By contrast, normative economics is concerned with establishing the means by which socially desirable outcomes can be achieved. It is prescriptive. It suggests what 'aught' to be. The questions of whether the distribution of incomes and output is equitable are normative since there is no universal agreement about what is fair. Question as per health consequences for patients are also normative because they require value-judgments.

It could be viewed that all economic question about the allocation of resources in healthcare normative, since the final outcome is generally some change in the health status of patients. Nevertheless, administrators operating the service on day-to-day basis are more likely to concentrate on intermediate and easily measurable outputs such as the number of patients treated and will therefore treat such questions as problems of positive economics. This problem, of whether questions about resource allocation in healthcare are normative or positive, may heat the root of some of the conflicts between health service managers and clinicians.

Question vii and viii are clearly normative for example, the question of whether the service is underfunded or not requires us to consider what the level of funding ought to be; bearing in mind that if more public funds are devoted to healthcare, there will be less available for education and other public services.

Similarly, a question such as question vii which ask of fairness requires us to make judgments about what is fair and what is not. According to Friedman (2009) 'fairness' like 'needs' is in the eyes of the beholder. If

all are to have 'fair shares' someone or some group of people must decide what shares are fair and they must be able to impose their decisions on others.

We must observe that, in Nigeria, nevertheless, one of the basic principles of NHS and many other public healthcare systems is that treatment should be provided on the basis of needs rather than on the basis of funds are available; and that equity should be one of the objectives of the service. This type of issue would not be central to most treatment health-economics but in healthcare it is important issue of equity in healthcare has been given credence by Mooney (2000, 2004.)

The fundamental principles underlying the national health policy of Nigerian government aside from the above, was base on IDSS, declaration to "achieve health for all Nigerians based on national philosophy of social justice and equity. A health system based on primary healthcare adopted as the means of achieving the goal.

3.3 Health Administration and Health Economics

There are several areas where health administration is related to health economics. There are both disciplines in social science and behavioural sciences. Health economics is branch of discipline in broad science of Economics. They both interwove in the sense of finding answers to numerous questions concerning healthcare, funding, utility and service delivery. Economics enable us to address issues, of price, demand for health care, issues of scarcity and choice, efficiency in health management, demand and supply, economic analysis of production in healthcare administration.

Besides, the issue of market structures, buyers and sellers in healthcare system market failure and government intervention in healthcare delivery, public/private sectors in healthcare provision in financing healthcare. Health administration and health economics have a lot in common for health administration to get its footage.

Furthermore, health administration and health economics enable government to evaluate mental health of the people, and their abilities to address issues of equity, fairness and justice in governance.

3.4 Demands for Healthcare

The demand for healthcare services will depend on the individual's and society's demand for health and on the perception of the link between healthcare and health improved healthcare service provides benefits to individuals and society as a whole. The process of providing healthcare

may have trickle down effects on the well-being of mankind which will promote economic and social development. The progress in the struggle for more meaningful development indices focused on social indicators like poverty, inequality and health. This gave rise to freedom in choice and functioning, emphasis on health and education, this life-sustaining basic human need, and food, shelter and health are trickle down effects on demand for healthcare. Demand for good healthcare can go a long way in promoting development in any political society. (Michael Todara 2010)

3.5 Healthcare and Economics

Economics is the study of the way in which choices are made about how best to use scarce resources to satisfy human wants. Because resources are scarce, and the means of satisfying them are remote, objective conflict and choices must be made about which needs are met immediately which are met eventually and which are not met at all.

The application of economics to healthcare raises special difficulties not found when considering, for example the care market. As noted in the first unit, it is difficult to define and measure, the benefits of healthcare and it is often difficult to assess and not restricted to just their patient and many (but not all) would argue that individuals have a right to healthcare irrespective of their ability to pay for it. In Nigerian system, you need to pay for all treatment no matter what, but in United Kingdom, there is more preference for concern for equity of provision of healthcare than in Nigeria and USA.

Further view of health help to address methods by which production and delivery of services are organized. But all healthcare systems face the same basic economic question.

(i) Which goods and services are to be produced?
(ii) How many resources should be allocated to different specialists?
(iii) How to produce the goods and services
(iv) Who receives the goods and services? Whatever the methods of finance, organisation and delivery, healthcare systems have being facing some problems of ever-increasing demands and the rising costs globally.

In private market healthcare system, shortage is easily resolved. The poor and the wretched of the earth cannot afford the high cost and go without or rely on whatever safety net the state provide. In a state funded by national insurance or taxation, some form of rationing is inevitable (although it may not be called rationing).

4.0 CONCLUSION

We have attempted to conceptualize health economics, examine its relevance, and some basic economic questions that confront end-users of healthcare services, health administration and health economics healthcare and economics. We must observe that, within a health service, or health-related organisation, people whose job description includes the word 'manager'/'administrators' are responsible for the raising of many different types of departments, sections or units. Some managers are responsible for the day-to-day running of the section, others, more serious, may be more concerned with long term planning. However, they face the same problem how best to use scarce resource to meet organizational goals and objectives or sets of objectives. Choice must be made.

A decision to use resources for the purpose. These days, administrators/ manager are required to be accountable, they have to be able to provide justification for their decisions. The problem of making best use of scarce resources is the problem with which economics is mainly conceived. Many of the models and techniques can be used to describe and analyse problems in a healthcare context and those models and techniques are better to be dealt with. We can also examine how market forces allocate healthcare resources and how market failure, promotes government intervention in health system.

5.0 SUMMARY

We are able to notice that health economics is very vital in administering healthcare administration or management.

We can summarise the units as follows:

- Definition of health economics
- Relevance and objective of studying health economics
- Some basic economic questions and how to deal with them and
- Healthcare and economics.

We have noticed that within healthcare service or other healthcare related organisation, decision about how best to utilize scarce resources remained the hydra-headed problems to be given its pride of place.

6.0 TUTOR-MARKED ASSIGNMENT

(1) Examine the relevance of health economics to healthcare managers

(2) How effective is the use of health economics in solving healthcare problems?

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UNIT 4 BASIC ECONOMIC CONCEPTS

CONTENTS

1.0 Introduction
2.0 Objectives
3.0 Main Content
    3.1 Scarcity and Choice
    3.2 Opportunity Cost
    3.3 Economic Choices
    3.4 Measurement and Valuation in Healthcare
4.0 Conclusion
5.0 Summary
6.0 Tutor-Marked Assignment
7.0 Reference/Further Reading

1.0 INTRODUCTION

Before we move further to examine basic economic concepts, I think it is necessary we define the meaning of concepts. Concepts are words that describe and characterize any phenomenon under investigation. It is an abstract that represents, symbolized and describes a class or a range of phenomena with distinctive characteristics. Concepts help to convey perceptions, word views and information about class of words under review.

If concepts are to be useful in any scientific inquiry, it must be able to define clearly, and unambiguously what it meant to deal with or describe.

Schattschneither (2006) maintained that people who cannot define the object of their study do not know what they want or what they are looking for and if they do not know what they are looking for, how can they tell when they have found it. Therefore, we should be able to address the meaning of concepts before looking it in economic terms. We have operational and conceptual clarification of concepts. The conceptual definitions help to explain inclusive ideas under review.

For purchaser and providers in public health services a critical feature of everyday life is that there are never sufficient resources to meet legitimate needs, and sometimes not enough to meet serious needs. For example, patient in Abuja attending an Accident and Emergency Centre and requiring impatient admission for investigation or treatment will frequently require transfer to another hospital because there are no available beds in the hospital concerned.

Similarly, doctors deciding whether to discharge a patient will need to take into account the clinical and social needs of the patient but also the alternatives demands being made upon a bed by patients whose needs may be considered more urgent (Ann Clewer 2006).

The purpose of this is to show that many of the fundamental questions with which patients, clinicians, managers, and politicians are concerned are basic economic questions. These questions are at the heart of the hard decisions which have to be made every day and which underpin important plans about the future pattern of services and the use of resources.

2.0 OBJECTIVES

- To show how basic economic questions relate to hard decision or choices which have to be made every day by patients, clinicians, managers and politicians.

- To illustrate various approaches to difficult decisions about the content of healthcare, the pattern of services, and the distribution of those services in conditions of scarcity.

- To introduce some of the issues in the theory and practice of rationing in health care.

- To demonstrate that the opportunity cost of using scarce resources in one way is measured by the loss incurred by not using those resources for some other purpose.

- It helps us to find out what goods and services are to be produced.

3.0 MAIN CONTENT

3.1 Scarcity and Choice

The fundamental problem faced by consumers and providers is that while human wants are unlimited, the supply of resources available to satisfy those wants is finite. This means that the choices must be made by consumers, or their representatives, about which services to buy out of their limited resources. This problem is difficult enough without considering the needs for consumers to plan for possible needs in the future and for providers to plan so that they can meet those needs when they arise.

The resources available for producing goods and services are generally classified into three types Land, which refers to all resources such as farmland, urban land, oil, minerals and water. Labour, a measure of human resources and expertise available to be used in production of goods and services, and capital goods such as buildings and equipment used in the process of production. Besides, Economists talk of human capital, which relates to labour skills. If a health authority or a hospital sends staff on a training programme, the aim is to increase the stock of human capital available for the production of goods and services.

There is a fourth factor of production, is associated with private sector administration. This is called entrepreneurship, and it is referred as the skills and talent needed to make a success of creating and running a business.

Entrepreneurs see new opportunities and take risks by using resources to bring new products to the market place. If they are successful, they make profit, if unsuccessful they will make losses.

The new public management, which emerged after privatizing and commercialization of public enterprise in Nigeria implies a shift from administration to management by which is meant a more from implementation and interpretation of predetermined rules and instructions to a more entrepreneurial or active management style. (Galiate Jones 2008).

Further, resources are available to varying extents and at different costs. It cannot be assumed that they will be available for purchase when they are needed so consumers and providers need to plan ahead with some care. For example, the director of Divine Hospital Ikoyi will want to be clear about whether it will be possible to recruit pediatric nurses in the next five years and whether he or she should contribute to a training programme to secure that supply. The same hospital director might want to extend the hospital site and will be interested in the availability and price of land and the views of the appropriate planning authorities for such a development.

While the hospital budget may be healthy, it may be that these basic resources are not available for purchase, are very expensive because they are short supply or

3.2 Opportunity Cost

Opportunity cost is an alternative forgone in order to satisfy other wants. Hard choices involve employing a limited resource so that it is used to achieve the best possible result. For example, using a skilled doctor for a

routine operation might not be the best use of that resource of the doctor can be used for a more complex activity. Using an expensive acute hospital bed for an elderly patient may not be the best use of that bed if there is a less expensive bed in a nursing home which can be used instead with no detriment to the patient using a resource for one purpose usually means that it is not available for another purpose.

Economics refer this, as the opportunity cost. The opportunity cost of using scarce resources in one way is measured by the loss incurred by not using those resources for some other purpose. For example, given a limited budget, the decision to increase resources devoted to orthopedic surgery may mean that fewer resources can be given maternity services. The cost is therefore those maternity services. The cost is therefore those maternity services which cannot be provided because the money has been provided because the money has been sacrificed for other things. More contentiously, the opportunity cost of introducing a hospital computerized accounting system might be the operating schedules cannot be refurbished within the particular time period covered by the budget.

Viewed from the above, we can say that opportunity cost can be defined as the cost of using resources in one way as the highest-valued alternative that must be sacrificed. In cost-benefit studies, the opportunity cost of using a hospital building for one specialty is measured by the highest-valued alternative use to which the building could be put. (Ann Clearer 2009)

3.3 Economic Choices

Economic definition of choice

Besides above conceptual clarification of economic choices, some basic problems to be resolved by any society are:

(i) What goods and services should be produced (and how much of each).
(ii) How are they to be produced?
(iii) To whom should the goods be allocated. The above represents questions that hospital managers, clinicians, ministers and consumers have to deal with healthcare administration, in modern state.

We must observe that, since resources are decisions have to be made about how many hip replacements to be carry, how many cataract operations, whether drugs or surgery should be used to treat certain condition, and of course, which patient should be treated first. It may be

that some treatments are not provided at all. Each stake holder will have to balance their own particular interests with the broader objective to provide the best possible pattern of services within the available resources.

Within the public sector, a fourth and important question is how are decisions to be made? Some countries like Britain and Holland, including Nigeria, regard internal market mechanism within public sector is the best framework in which these decisions should be made it provides a series of incentives for efficiency and effectiveness. However, whatever the overall framework, decisions about how best to use the given resources have to be made. We must note that economic techniques of marginal analysis and economic appraisal can be of great assistance in determining the optimal pattern of resource use.

4.0 CONCLUSION

This unit has introduced three key management problems using the languages and concepts of health economics:

i) What goods and services should be produced?
ii) How should they be produced?
iii) To whom should they be distributed and on what ground?

We have pointed to the question of opportunity cost recognizing that the use of resources in service precludes the use of those same resources which is forgone. We have pointed to the issue of health gain as a widely aspiration of purchasers and providers in healthcare. We have raised questions about the allocation of services and procedures under conditions of scarcity pointing to the utilitarian basis of much health thinking but recognizing the limits of this approach.

5.0 SUMMARY

We have analyse some of economic principles and concepts that influence healthcare administration. We analyse opportunity cost, scarcity and choice, economic choices and conclusion. Health gain has gained prominence in health management and health policy. Health gain is a improvement in health. In private sector, firms combine scarce resources in order to add value to their inputs. Similarly, we can view the job of managers and clinicians in hospitals as being to combine scarce resources in order to produce health gain in patient treated District sanitary health officer, who purchase services on behalf of the residence population. The general health gain for the entire population can be measured by life expectancy, infant mortality rates and death

rates from health disease and cancer in different age groups, and quality adjusted life. (Hunter 2004).

6.0 TUTOR-MARKED ASSIGNMENT

(i) Relate how economic concepts influence our understanding of health administration.

(ii) a. What is health gain?
b. Why study health economics

(iii) Write short notes on these terms:
a. Opportunity cost
b. Scarcity
c. Choice
d. Health gain

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UNIT 5 MANAGING CONFLICT IN HOSPITAL

CONTENT

1.0 Introduction
2.0 Objectives
30 Main Content
- 3.1 Introduction
- 3.2 Causes of Conflict among the Hospital Workers
- 3.3 Resolution of Conflicts

4.0 Conclusion
5.0 Summary
6.0 Tutor -Marked Assignment
7.0 References/Further Readings

1.0 INTRODUCTION

The concept of conflict, being an outcome of behaviour, is an integral part of human life. Whenever there is interaction there is conflict. Conflict can be defined as a disagreement between two or more individuals or groups, with each individual or group trying to gain acceptance of its views or objectives over others. Because people differ in their attitudes, values and goals, conflict among them becomes unavoidable. Management is concerned not so much with eliminating conflict which would be impossible, but to contain and manage it for organizational and individual benefits. This unit will delve into conflicts among the major players in the health care services in Nigeria and its implications.

2.0 OBJECTIVES

At the end of this unit, the learner should be able to:

- Professionals.
- Identify the causes of conflict among the major Health.
- Discuss the possible and/or resolutions of these conflicts.

3.0 MAIN CONTENT

3.1 Introduction

Any time two persons come together, there is a potential for conflict. The potential is there because each individual has his own unique way of perceiving or seeing situations and understanding information. As a result, when perceptions and understanding of situations or information

differ, conflict occurs. Conflict within a work sitting is a natural phenomenon and can be expected. Without conflicts, there would be complete agreement at all times. Under these conflict circumstances, persons would think alike and much like robots. Conflict only grows in intensity when ignored; therefore, conflict can be effectively managed by confronting it positively.

3.2 Causes of Conflict among the Hospital Workers

In today's health care environment conflict abounds because individuals and groups have their own opinions about how to handle the many challenges that lie ahead as a new health care system emerges. Conflicts exist between health care organizations and the society as persons ask for health services in particular quantity and at a level of quality that varies from what can be delivered. Changing demographics and limited finances have stimulated professional groups to vie for the consumer's attention.

Conflicts are occurring between the private and public sectors as federal and state governments attempt to determine what their appropriate role is in financing and delivering health care. As resources have become scarcer, health care organizations are encountering increased internal conflicts, where personnel and/or work units compete for their fair share.

With hospital environment laden with conflicts and stress, relationships and interactions among colleagues are potentially more liable. There may be conflicts because of given information or set of facts, emotions, perceptions about a situation that occurred in the workplace or the values held by other hospital workers.

Learning about conflict can also be differentiated by gender. Many women were socialized into believing that they were not suited to the vagaries of conflict. Being angry was not considered an acceptable response and when differences occurred, women were supposed to either avoid or accommodate. Learning this message can cause women to feel fearful, powerless and immobilized when confronted with conflict situations. There can be conflicts related to disagreements over goals and objectives of the organization or the policy of the management especially the conflicts may arise over the means to reach those goals and objectives or the policies.

When there are opinions from one health provider group to the management in order to subjugate other professionals, conflict results. It ought to be facts and not opinions as facts are generally indisputable resulting in agreements while opinions are highly personal and

subjective and may provide for criticisms and disagreements. These conflicts are often results of personality clashes. People with widely differing characteristics and attitudes are bound to have views and aims that are inconsistent with the views and aims of others.

Health service delivery sector is an organization which is an interlocking network of groups, departments, sections or work teams, there can be conflicts within one group and another. These conflicts are not so much personal in nature, as they are due to factors inherent in the organizational structure especially conflicts between line and staff.

There can be conflicts as a result of inconsistent rewards and differing performance criteria for different units and groups. Different functional groups within the health sector may come into conflict with each other because of their different specific objectives. There are some fundamental differences among different units of the organization both in the structure and process and thus each unit develops its own organizational subculture.

Conflicts may be between the day shift and night shift workers who might blame each other for anything that goes wrong from missing tools to maintenance problems or particular duties not performed which may have adverse effects on the client/patients. Behavioural aspects of conflicts: These conflicts arise out of human thoughts and feelings, emotions and attitudes, values and perceptions. This conflict can arise by a simple misunderstanding or an error in communication.

A misunderstood message can create viewpoints about various issues. Role ambiguity can also lead to conflict. A role is a set of activities associated with a certain position in the organization or in the society. If the work activities am ill-defined, then the person who is carrying out these activities will not behave as others expect him to because his role is not clearly defined. This will create conflict, especially between this individual and those people who depend upon his activities.

3.3 Resolution of Conflicts

Except in very few situation in which the conflict may lead to competition and creativity so that those situations the conflict can be encouraged, in all other cases where conflict is destructive in nature it should be resolved once it has developed but all efforts should be made to prevent it from developing. Some of the ways to prevent and resolve conflicts are:

- Goals should be clearly defined and the role and contribution of each unit towards the organizational goals must be clearly defined. All units and the individuals in these units must be aware of the importance of their role and such importance must be fully recognized.
- The compensation system should be such that it does not create individual competition effort and should reflect the degree of
- Interdependence among units wherever necessary. Trust and open the communication among them would be. Individuals and unties should be encouraged to communicate openly with each other so that they can all understand each other, understand each other's problems and help each other when necessary.
- Properly coordinated activities reduce conflict so there must be adequate coordination of the activities of the units/departments. Generally, conflicts may be resolved by either or combination of Denial or withdrawal, suppression or smoothing over, power or dominance, compromise or negotiation and collaboration.

4.0 CONCLUSION

In today's health-care environment, conflict abounds as the individuals in the health industry have their own opinions about how to handle the many challenges that lie ahead as a new health-care system emerges.

5.0 SUMMARY

In this just concluded unit, you learnt about various means of conflict in the health care delivery system and the likely ways of resolving these conflicts but it is important to know that conflicts abound in any organization and managers should know how to contain conflicts.

6.0 TUTOR MARKED ASSIGNMENT

1. Why should there be conflicts among the professionals in health industry in Nigeria?
2. If there is intra-professional conflict in your department, how will you resolve it?

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MODULE 4 NIGERIAN HEALTH CARE POLICY

Unit 1 Public-Private-Partnership in the Health Service Administration
Unit 2 National Health Declaration
Unit 3 Fundamental Principles Underlying the National Health Policy
Unit 4 National Health Care System
Unit 5 National Health Strategy
Unit 6 National Health System Management

UNIT 1 PUBLIC-PRIVATE-PARTNERSHIP IN THE HEALTH SERVICE ADMINISTRATION

CONTENTS

1.0 Introduction
2.0 Objectives
3.0 Main Content
- 3.1 Characteristics of PPP
- 3.2 Desirability of PPP in the Health Sector
- 3.3 Possible Areas of PPP in Health Services
- 3.4 Key Concerns
- 3.5 Accountability
- 3.6 Equity
- 3.7 Management of PPP
- 3.8 Stress Management and Mental Health
- 3.9 Mental Ill Health
- 3.10 Case Management
- 3.11 Implication for Practice
- 3.12 Social Worker and Human Behaviour
- 3.13 Nature of Stress
- 3.14 Sources of Stress
- 3.15 Effect of Stress
- 3.16 Health and Stress
- 3.17 Job Burnout
- 3.18 Coping Strategies
- 3.19 Behaviour Modification
- 3.20 Models of Stress and Coping

4.0 Conclusion
5.0 Summary
6.0 Tutor Marked Assignment
7.0 References/Further Readings

1.0 INTRODUCTION

A Public Private Partnership (PPP) is a partnership between the public and private sector for the purpose of delivering a project or service, which was traditionally provided by the public sector. It could be more accurately described as public sector programmes with private sector participation. Also, any collaboration between public, bodies, such as Federal, State and local authority governments, and private companies tends to be referred to as public-private partnership (PPP).

2.0 OBJECTIVES

The objectives of public-private partnerships in health services, according to WHO that are the advocate of PPP, are to:

- Ensure an efficient competitive process and a fair balance in the division of responsibilities between the public and private sectors.
- Improve product quality or regulation.
- Encourage industry to abide by the Health for All principles.
- Facilitate universal access to essential health services and drugs.
- Accelerate Research and Development in the field of vaccines, diagnostic and drugs for neglected diseases.
- Prevent premature mortality, morbidity and disability by giving special attention to policies and behavioural change.
- Encourage industry to develop products in ways that are less harmful to workers and the environment.
- Acquire knowledge and expertise from the commercial sector.

- Enhance corporate image among typically hostile constituencies.

3.0 MAIN CONTENT

3.1 Characteristics of PPP

The term public private partnerships covers a wide variety of ventures involving a diversity of arrangements, varying with regard to participants, legal status, governance, management, policy-setting prerogatives, contributions and operational roles and the degree of risk allocation between the two parties.

PPP range from small, single-product collaborations with industry to large entities hosted in United. Nations Agencies or private not-for-private organizations. Public private partnerships can take many forms. A public private partnership is a co-operative venture for the provision of infrastructure or services, built on the expertise of each partner that

best meets clearly defined public needs, through the most appropriate allocation of resources, risks, and rewards.

The private sector's immense resources make it an irresistible yet potentially overpowering 'partner for public health initiatives. The economic power of this group is extraordinary. In fact, the five largest multinationals have revenues more than double the combined gross domestic's product of the poorest WOO countries

In a public private partnership, the public sector maintains an oversight and quality assessment role while the private sector is more closely involved in actual delivery of the service or project. Public-Private Partnerships can be categorized based on the extent of public and private sector involvement. All partnerships have a unique risk/reward allocation. PPP is a variation of privatization in which elements of a service previously run solely by the public sector are provided through a partnership between the government and one or more private sector companies. Unlike a full privatization scheme, in which the new venture is expected to function like any other private business, the government continues to participants in some way.

3.2 Desirability of PPP in the Health Sector

The shift towards public-private partnerships on health is the result of increased global integration due:

- The scope and pace of goods moving across borders
- The lack of geographical boundaries for infectious diseases.
- The increased possibility for rapid communication (Internet).
- The spread of ideas
- Worldwide products and marketing.

Other reasons include where:

- The public sector wishes to buy comprehensive change of service improvement programme that is beyond its own capabilities.

- The public sector needs specialist skills honed across a range of customers.

- The public sector wishes radically to reconfigure a service to align units from across different organizations.

- There is a need to obtain contributions from private/commercial entities and civil society to improve the health of the poor by combining the different skills and resources of various

organizations in innovative ways.

- Public agencies will clearly benefit from working in collaboration with the private sector or areas where the public sector lacks expertise and experience, e.g. in product development, production process development, manufacturing, marketing and distribution.

- In bringing the public and private sector together, the management skills and financial acumen of the business community will create better value for money for taxpayers.

Public private partnerships are increasingly seen as the only viable means to solve intractable social and health problems, such as poverty and disease eradication, new drug research, access to medicines and improving drug quality.

However, there are areas, such as public health policy-making and regulatory approval, where the concept of partnership with for-profit enterprise is not appropriate.

3.3 Possible Areas of PPP in Health Services

Many Public-private partnerships have successfully been executed in international, national and local levels such as:

(i) International Health issues such as Roll Back Malaria, Safe Injection Global

(ii) Network, and Stop TB (all of which have secretariat in WHO); Global

(iii) Alliance for Vaccines and Immunization (GAVI), which has its secretariat at UNICEF.

(iv) Product development, production process development, manufacturing, marketing and distribution like HIV/AIDS drugs, Medicines for Malaria, etc.

(v) Strengthening of health services, e.g. the Gates Foundation/Merck Botswana Comprehensive HIV/AIDS partnership.

(vi) Health Insurance Scheme like the NHIS.

(vii) Atypical PPP example would be a hospital building financed and constructed by a private developer and then leased to the hospital authority. The private developer then act as landlord, providing

housekeeping and other nonmedical services while the hospital itself provides medical services.

(viii) In U. K., two main areas are covered:

(a) Private Finance Initiative (PFI). This provides a way of funding major capital investment without immediate recourse to public purse. Contractor's pay for the construction costs of new buildings and then rent the finished project back to the public sector. This allows the government to get new hospitals, schools and prisons without raising taxes. Contracts typically last for 30 years.

(b) NHS Local Improvement Finance Trusts (NHS LIFT). This aims to develop a new market for investment in primary care and community based facilities and services.

(ix) Six major PFI projects have been completed within the UK NHS, with a further 17 hospitals and other facilities under construction and a further 45 in the pipeline.

3.4 Key Concerns

Partnerships present a number of key concerns: Representation/legitimacy:

Those designed to benefit from such public-private partnerships rarely sit on these projects' Boards of Directors. They are also usually uninvolved in the planning or agenda setting.

3.5 Accountability

Who is actually accountable for the outcomes of such partnership? Is it shareholders, board members, or donors?

To whom are public-private partnerships accountable?

3.6 Equity

Public-private partnerships may also undermine equity within and between countries. Many public-private partnerships address specific infectious diseases, not health delivery systems. The huge amounts of money pumped into some initiatives can also lead to a further shift in the public health agenda.

Many of the current public-private partnerships are nothing but corporate sponsorship in cash or in kind or negotiations for favourable drug prices: others are semiprivate discussions between public

institutions or high-level political figures and big corporations; others are publicly subsidized research collaborations. (In business language, some of the PPPs are actually called 'strategic sponsorship' or lobby activities).

Health has become an economic asset and is no longer primary seen as a basic human right.

Concerns have also been raised about:

- Conflicts of interest over the role of industry partners.
- Donations in kind, such as drug donations, which often require relatively high national inputs including costs associated with guaranteeing distribution networks, storing drugs at ports and airports, and training health workers.
- The exclusion of poor countries with large populations, unpopular governments or poor infrastructure from public-private partnership programmes.
- The circumvention of mechanisms designed to ensure that developing countries have a say in the policies that will affect their populations.

Advantages

It enables public services and infrastructure to be provided in the most economically efficient manner by allowing each sector to do what it does best.

It provides an effective tool in meeting public needs, improving the quality of services, and more cost effective.

It can be an essential tool in challenging economic times as it provides a continued or improved level of service, at reduced costs. And equally important, partnerships can provide the capital needed for construction of major facilities. Successful partnerships can lead to happy employees through career growth as private companies spend two to three times more on training and personnel development than their public sector counterparts do.

Public-private partnerships enabled the construction of state-of-the-art faculties, while using efficient operations to hold down costs to ratepayers and provide a way of meeting those "un-funded mandates" from the government.

Disadvantages of PPP

According to Canadian Health Coalition Reality Checks, all is not well with PPP:

(i) PPP do not "save governments money and in fact may cost more as government can finance the cost of services at a lower cost than the private sector."

(ii) PPP do not improve care or provide better service.

(iii) PPP are not a neutral financing mechanism it is a source of borrowing which has to be repaid! Either out of the public purse or by giving the private sector a concession (e.g. allowing the company to charge user fees).

(iv) PPP have enormous implications for public life and profound constitutional and democratic implications because by entering into a public-private partnership, government loses control over the provision of services.

(v) PPP in hospitals, clinics and health insurance have all been abysmal failure in the United States. Public-Private Partnerships promote unfairness and exploitation. It is not a partnership it is an oxymoron.

(vi) The public pays while the private sector profits. That's not a partnership.

(vii) The principal reason for governments entering into public-private partnerships is to avoid debt and thereby relegate its social responsibility for public service.

(viii) The cost of service will increase to pay for the private partner's profit.

3.7 Management of PPP

For public-private, partnership to be effective, the framework of operation must be properly established and this include:

(i) Establishing strong, enforceable, accountable and transparent guidelines must be a condition -V for the acceptance of industry partnerships and industry sponsorship, without which the relationships will undermine and destroy the public organization's role, responsibility and reputation.

(ii) Ensuring that the partnership is governed by bodies that are widely representative but with adequate decision-making power so as to reflect the achievement of the purpose of the partnership.

(iii) Ensuring that the governing body maintains a mechanism for the participation of constituencies that might otherwise lack material resources needed in order to participate.

(iv) Establishing clear goal, roles, responsibilities and decision-making structure and the means of monitoring and enforcing decisions should be taken into consideration.

(v) Establishing systems of communication whereby information about decision-making structure, funding, resource allocation and result is regularly conveyed to all concerned.

Conclusion

If the purpose of public-private partnerships is carefully considered and well-articulated, it will yield a lot of dividend, especially in countries like Nigeria. The rural population is almost 80% of the Nigerian population and social services like health need to reach the entire population in the rural areas.

A well-articulated public-private partnership therefore will facilities healthcare delivery service getting to the rural populace quicker, easier and more efficient and sustainable than just leaving to the government to handle in the traditional public service way.

3.8 Stress Management and Mental Health

Service lies at the very hub of economic activity of any society, for example, in a political economy, government services play a critical role in providing a stable environment for investment and economic growth. Service Such as public education, health care delivery, well-maintained public goods and services, good drinking water, 'Clean air and public safety are necessary for any nation's economy to service and people to prosper. (James Fitzsimmons 2003) services are deeds processes and performance (Valarie Mary 1996) service is an activity or Series of activities of more or less tangible nature that normally, but necessarily take place in interaction between customer and service employees and or physical resources or goods and service providers which are provided as solution to customer problems Christian (Grenroos 1990).

Many authorities consider the service sector to include all economic

activities whose output is not physical product or instruction, is generally consumed at the time it is produced, and provides added value in forms (such as occurrence amusement, timeliness, comfort and health). Intangible concerns of its first purchaser (James Brainee 1987) Based on the above conceptualization of service, Paul Dlsor (2000) maintained that services precise definition on goods and services should distinguished on the basis of their attributes.

A good is a tangible physical object or product that can create and transferred. It has an existence overtime and thus can be created and use latter. A service is intangible and perishable, it is an occurrence or process that can *be* created and used simultaneously or nearly simultaneously

While customer cannot retain the actual service after it is produces, the effect of the services can be retained (Earl Sasser 1778). This is more of that reasons, James Fitzsimmons (2000) opined that a service is a time Perishable, intangible experience performed for a customer acting to the role of a co-provider's health service administration is the act aid, science of providing healthcare service in *the* hospital environment to satisfy the customers.

The idea of patient can be used in hospital environment. Patients connote an individual who is not well, but customers may cover any individual who deserves hospital service. The concept of service administration or management should be applicable to all-service organization; for example, hospital administrator could learn something about their business from the restaurant and hotel trade.

Professional service such as consulting, law and medical, have special problems because the professional is trained to provide a. specific clinical service but not knowledgeable in business management. For effective management and treatment of stress and mental-ill health in hospital, attempt should *be* made to defined service and provide it. Coping with deaf require more than just a signs. This indicates that if we must deal with stress and mental ill health, we must be more effective than just treating the patients.

3.9 Mental ill Health

Many of the major mental illness in particular schizophrenia become evident in late adolescence and early adulthood. These who suffer from schizophrenia can be grouped into three broad categories.

1. Treated successfully with full recovery.
2. Partial recovery with reasonably normal life.

3. Little or no recovery with repeated hospitalization when an individual suffer from an illness like schizophrenia, what factors might produce a favourable prognosis?

Lekman and Cancecro (1985) have identified four factors that suggest the premise for recovery:

i. Sudden rather than gradual onset.
ii. Onset that occurs at a letter age.
iii. Good social work environment before the onset of the disorder.
iv. Informal support system within the patient family. The question to ask is what leads a person to develop a serious mental illness like schizophrenia?

Most of the evidence points to heredity as the major explanation (Rie Dr et at 1994) studies have shown that relatives of a person with schizophrenia have an increased risk for developing schizophrenia, and the closer the relationship the higher the risk. This demonstrates that association and closer relationship will promote higher risk in genetic inter-relationlessness.

Many researchers now look to the influence of neurochemical factors in diagnosing the cases of schizophrenia and other mood disorder are accompanied by changes in neurotransmitter activity in the brain. Most of the drugs that are effective in controlling the symptoms of schizophrenia act to restrain dopamine activity in the brain. Therefore, excess dopamine activity in the brain, is believed to be excessively or likely cause of schizophrenia. Most recently, research (Davis et at 1991) has linked schizophrenia to excessively high dopamine activity in sub cortical areas of the brain but abnormally low dopamine activity in the prefrontal cortex area.

3.10 Case Management

Case method and better tracking are keys to providing better case for persons with serious mental illness. Case management and tracking systems are new concepts in the struggle to provide mental illness. This refers to the process of 'managing' a case linking individuals with needed services and coordinating existing services. In many cases, past efforts at case management failed because social workers were given extremely large caseloads and could not do the necessary advocacy work that would coordinate needed service.

When a client is discharged from the hospital, staffs transmit key data to the community mental health centres. The centre can watch for the client and begin treatment based on client's individual history. This

tracking system can provide data to flag client who may need attention. This system tracking is used in the United States.

In 68 Reference Hospital Yaba, tracking is also used when the family of schizophrenia is asked to report to hospital as soon as the patients change attitudes. In the United States, for example, a report can be pointed that lists all existing clients at each mental home or health centre and identifies of those clients who have been seen for 40 days. Other reports can include a list of clients discharged from hospital and referenced to community mental health centres with clients identified who never show up at the centres. This also helps to identify the clients missing needed treatment and services.

3.11 Implication for Practice

Assessment of clients with mental illness, social workers are often called upon to provide accessory services with mental illness. Depression is one of the most serious cases of mental ill health. Understanding the multifaceted aspects of mental illness is critical to designing and coordinating services. Some of the factors that social workers might want to consider in assessing the clients and their social situation are as follows: (adapted from the national institute of mental health 1991) USA.

- Physical Health Status.
- Physical Functioning.
- Ability to perform activities for daily living.
- Extent of bodily pain.
- Quality of sleep.
- Level of energy and fatigue.
- Quality of life.
- Access to resources and opportunities.
- Fulfillment of life roles and tasks
- Overall well-being or life satisfaction
- Family and *peer* relationship.
- Ability to maintain and develop relationship with others.
- Ability to maintain and develop relationship with family members.
- Extent of family's burden.
- Rehabilitation status.
- Social skills.
- Vocational status.
- Independent living skills.

Although not complete, the preceding assessment list gives some ideas of the complexity involved in working with people with mental illness. Understanding and helping some clients involves assessing multiple aspects of the social environment.

3.12 Social Worker and Human Behaviour

The field of social work has historically assumed that social problem such as school shooting; mental ill health and stress cannot be understood by limiting analysis to inner life of the person and their relationship with family and needs. Events of this nature and not isolated in errors of socialization processes or error of intricate individual, and the environment that influences the behaviour of the individual. Human behaviour takes place in a diverse array of physical, psychological and social contents people confront biological, psychological and social demand that requires effective human responses. The ability to respond effectively to these demands on individual, families and groups is known as adaptation. Understanding the process of adaption is vital to the practice of any human service profession in the field of social work human behaviour and the social environment and the social environment is the curriculum area that provides the foundation of knowledge needed for a basic understanding on human adaptation.

The study of adaptation in social work focus on identifying concepts that can help practitioner behaviour to understand people and their demands, and what the constraints imposes on them by their environments. The place of environment in person behaviour is relevant to social work. Social work unlike many other human service professionals sees social adaptation as one of its social life, people must adapt to many occurrences and situations personal relationships changes in work schedules and living habits.

Human behaviour in social work is often viewed as the adaptation of people to resources and circumstances; resources are an important component of many practice perspectives in social work. Allowing the availability of resources allows for correction in adaptation through creation of services to enhance adaptation and identification of strength in people or their social networks so that condolence can be changed to enhance the use of these available resources (Levine & Perkin 1999). The social worker must learn to study and understand human behaviour and the factors that promote its changes.

3.13 Nature of Stress

Stress may be viewed as a burden placed on the individuals. As the definition may look simple, what places burden on the individual in his

or her environment; stress is devastating and could be dangerous to the individual, groups, workforce and organizational productivity. As observed by Sonan Luke (2006), the stress phenomenon as it referred today is a new as regard to humanity far back 1970s. The use of the word stress is as common as the use of "food" and "exercise." Stress in terms of physical coronal can be traced back to the Stone Age as a survival mechanism, what was once designed as a means of survival is now associated with the development of disease and illness which claims the lives of millions of people.

Research now indicates that between 70 and 80% of all disease and illness is stress related, most notably heart disease, cancer, the common cold, migraine headaches work some cases of female infertility, hypertension and mental illness are stress induced. National Health Statistics 1988 USA provide a host of health factor to be reckon within death. It contemporary true stress is based on various perspectives of human conditions in Eastern philosophies stress is considered to be an absence of inner peace. In western culture, stress can be described as a loss of control.

Serge Kahili (2000) defined stress as any change experienced by the individual. This definition may be rather general but it is quite correct. Psychologically stress is defined as a state of anxiety produced when events and responsibilities exceeds one's coping abilities. Physiologically speaking, stress is defined as the rate of wear and tear on the body.
Style (2003) defined stress-as the non-specific response of the body to any demand placed upon it to adapt style observed that whether a situation was perceived as good e.g. physiological response or Arsenal promotion or loss of job. Hellriegu Scocum (1989) maintained that the distinction between work and non-work stressors is not always clear. But maintained that the one source of stress lays possible conflicts between work and family demands. Managers therefore, must understand that much of the stress felt by employee may stem from stressors in their personal lives or life stressor. Studues Stongill and Kahn (2001) indicates that job stress and life stress are often related in that high stress are often related in that high stress in one area can reduce a person's ability to cope with stress on the other.

Medical science conceptualization emphasize that stress is the body general response to any demand made on it.

3.14 Sources of Stress

There are many sources of stress and stressors. These includes time and pressure of deadlines, work and load work over load, work under load

inadequate trained subordinates, long working hours, attending makings, demands of, work on private and social life. Demands of work on the relationship with family individual workers belief conflicting with organization, taking work home, lack of power and influence, the amount of travel and traffic jam experience in world of work, doing job more than the level of competence, incompetent boss and dictatorial boss. These represent the sources of stress.

3.15 Effect of Stress

Work related stressor has both positive and negative effects. However, research work on stress has focused on the negative effects. This focus seems well directed because the cost of stress related illness in Nigeria. In western industrialized countries work today are lost from stress related illness as they lost from other industrial stages.

The effects of work stress occur in three major areas, physiological, emotional and behavioural. Examples of the effects of excessive stress in these three areas are as follows:

i. Physiological effects of stress includes blood pressure, increase heart rate sweating, lot and could spells breathing difficulties, muscular tension, increased gastrointestinal disorders.
ii. Emotional effects of stress include anger, anxiety, depression, lower self-esteem, poorer intellectual functioning, including inability to concentrate and make decisions nervousness, irritability, presentation of supervisors and job dissatisfaction.
iii. Behavioural effects of stress includes decrease performance, absenteeism, higher accident rates, higher alcohol and other drug abuse, impulsive behaviour, and difficulties in communication.

3.16 Health and Stress

Considerable research links heart disease other major health problems commonly associated with stress include alcohol and other drug abuse, physical ailments like back pain and a variety of mental problems. Medical researcher has recently discovered possible links between stress and cancer. Stress relates illness ness place a considerable burden on people and organization, but it is possible to measure of the organizational costs associated with stress related diseases for example, recent research studies on stress from national safety council in America, national institute of health service administration of Nigeria 1999, revealed the following:

- The total cost of work related accidents in United States is currently about 832, billion for year. It is estimated that 75 85

percent of all industrial accidents are caused by an inability to cope with emotional distress.

- Heart disease, which is related to stress, causes an annual loss of more than 135 million workdays.

- Stress related headaches are leading cause of lost work time in US industry.

- More than 60% of long-term employee disability is related to psychological or psychosomatic made worse by stress.

3.17 Job Burnout

Job burnout refers to the adverse effects of working conditions where stressors seem unavoidable and sources of satisfaction or relief seem unavailable (Hellicbrum slocum 1999) job burnout commonly results in a state of physical, emotional and mental exhaustion. Only recently has job burnout come to be recognized as a major work stress problem. Burnout seems to be most common among professionals who must deal with other people, client's subordinates, peers on the job. The professionals who may be most vulnerable to job burnout include accountants, lawyers' managers, nurses and police officers social workers and teachers.

Timothy Matthew 2003 while realizable statistics are not available, it has been estimated that about 20% owners, managers, professional and technical people in the U. S. suffer from job burnout, (Mullin Lariere 2000).

Individuals who experience job burnout seem to have some common characteristics. Three characteristics is particular seem to be associated with a high probability of burnout.

- Burnout candidate's experience a great deal of stress as a result job related stressors.
- Burnout candidates tend to be idealistic and for self-motivating achievers.
- Burnout candidates tend to seek unattainable goals. (Moss John 2003.)

The burnout syndrome represents an interaction of certain individual characteristics and the job situation. Individual who suffer from burnout tend to have unrealistic expectations concerning their work and their ability to accomplish desired goals, given the nature of the situation in which they find themselves job burnout is nothing that -.happen

overnight the entire process typically takes place a great deal of time. The path to job burnout is related to stress.

3.18 Coping Strategies

Many articles in newspaper and popular magazines suggest various ways of coping with stress. The pervasive of these articles for example Health Service Administration June Edition 2003 illustrates prevalence of stress in Nigeria hospital. The obvious shallowness of some of the techniques proposed in these articles should not blind readers to ***the*** benefits of understanding stress better and the use of reasonable thoughtful methods to reduce stress.

Bessie Y. Margiuis (1996) maintained that stress management by individuals and organization usually is designed to

- Eliminate or control sources of stress
- Make individual more resistant to stress or better able to cope with stress.

Method used by individuals to cope with stress include therapy exercise, planning ahead, proper diet, adequate sleep, meditation and relaxation and recreational activities woodman (2000) maintained that managers in an organization will find that being able to identify stressors at work and pin point their effects on themselves and their subordinate is a useful skill. Effective managers he maintained must recognize the systems of too much stress on employee's changes in personality, work habits or behaviour pattern.

- Cognitive Restructuring: Scholars in stress management concept that it is the circumstances that is stressful, but the perception or the interpretation of the circumstance, when perception is negative it becomes both mental and physical liability, perception can become distorted and magnified entirely out of proportion and their seriousness. This is referred as cognitive dissertations, and may turn everybody problems into a gigantic monster (Brian Seaward 2002).

Attempt have been made to deal with "stress monster" from all angles, including decreasing or manipulating sensory, information and teaching people to control the stress response by employing various relaxation techniques cognition is the mental process that includes an assortment of thinking and reasoning skills.

Many coping skills or techniques go with many names, cognitive restructuring, cognitive appraisal, cognitive retaining cognitive therapy, and altitude adjustment. Despite the above normative, in the concepts, they suggest the same approach, to favourable alter the

currencies, frame to a less threatening perception, from a negative, self defecting attitude to a positive one, which may then allow the initiation of the steps towards a peaceful resolution.

The seed of cognitive therapy took root in 1962 with the r able work of Albert Ellis in which he referred to as rational emotive therapy (RET) The premise of Ellis, is work was that stress related behaviour are initiated by perception and that of self defecting perception can be changed. He maintained that all stimuli sent to the brain go through a process of interpretation when enough stimulation is interpreted as threatening, it becomes a critical mass of negative thought Ellis was of the opinion that a critical mass of perceived stress arises, it dim the ability to think rationally. As a result, self-defeating attitude becomes reinforce day after day, year after year, through internal dialogue that is scripted by the tone of these irrational thought processes. Ellis become convinced that people could be educated and trained to favourably alter negative or stress related perception (irrational thought) into positives attitudes, which in turn would decrease the intensity of perceived stress. The term cognitive restructure was carried by Meichenbaum (1995) to describe a coping technique for patients diagnosed with stress related disorders.

This coping style aimed to modify internal self-dialogue by turning into the conservation within the mind. The practice of cognitive restructuring was an important in what Medichenbaum referred to as stress inoculation, a process to build up positive thoughts when negatively perceived events are encountered. Work by Banadura in 1977 and Beck 1976 supported the concept of cognitive change of perceptions as a means to effectively deal with stress.

These are some of the steps to initiate cognitive restructuring. A simple four-stage process introduced by the field of behavioural medicine by Roger Allen (1984) is a model for implementing changes in life style behaviour through cognition to promote health. The following model explains how cognitive restructuring can be implemented as coping techniques to reduce stress.

This is through the process of awareness creation, stressors are identified and acknowledged, and this includes writing down what patient, frustrations and worries. Another awareness process is to identify why these situation and events are stressors and the emotional attitudes associated with it. The last step is that, primary appraisal is given the main stressor and the acknowledgement of the feelings associated with it. This also includes appraisal of the situation, adoption and substitution and evaluation.

Another cognitive restructuring includes, initiating relaxation techniques, five relaxation techniques, five turn expectation and giving oneself positive affirmation. In final session, cognitive restructuring means changing a perception from a negative one, making it less stressful. This process is also called reappraisal, re-labeling, refraining and attitude adjustment. Ellis planted this seed of coping in rational emotive therapy (RED. The cognitive restructuring strategy enable social worker to deal with patient having stress related illness.

3.21 Behaviour Modification

Behaviour is a component of personality one school of thought in psycho-logy states that personality is made up of three factors values, abstract constructs of importance, attitudes, perception derived from values and behaviour. Conscious and unconscious actions based on attitude and perceptions (Kreitner 290). Behaviours are considered to be any action, direct or indirect, that is based on conscious or unconscious thought. Behaviours are thought to be physical manifestations of an attitude based on a specific value. For example, clapping your hands at the end of a concert is a behaviour influenced by your perception that the music you heard sounded pleasant. The music in turn, can symbolize a value of freedom, or creativity. In terms of well-being, behaviours can be considered either healthy promoting or health impeding behaviours deleterious to one's health are often targeted for change.

Besides, values are abstract constructs are adopt early in life by emulating figures of authority, including our parents, ground parents, older brothers teachers and other influenced people; we seek have and affection from.
These are intangible concepts such as love, honesty, freedom, joy, pleasure education, privacy and creativity. They are made tangible through objects that symbolize their value. Value may consist of morals and ethics. Milton Rock each (1972) suggests that individual has a hierarchy of approximately, two dozens values, a handful of values that are 'core' value and terminal value. Personal value system is not static it can change.

Furthermore, attitudes are beliefs based on values. Attitudes are beliefs, perceptions, and feeling based on specific values. Attitude can be positive or negative. Negative attitudes are associated with stress. In behaviour modification, the process includes, awareness, desire to change cognitive restructuring behavioural substitution and evaluation. At awareness stage, individual suffering from stress is made to aware of the desire to change his or her behaviour for better. These stress-producing habits are made to have less effect if the individual modify his or her behaviour.

At other stage individual should desire to change them behaviour for good, without the desire to alter behaviour it becomes difficult for the individual to cope with stress. This also includes the use of assertive of - assertiveness and assertiveness skill. Assertiveness is the ability to be comfortably strong-wilted about one's own thought feelings, and actions, and either inhabited or aggressive in actions for betterment of oneself. Assertiveness carries with it the recognition of legitimate personal rights. This has been described by many therapists, Davis, Eshelmann and McKay (1988) to involve the following:

1. To say no and not feel guilty.
2. To change your mind to form a response to a comment or a question.
3. To take your time to form a response to a comment or question.
4. To ask for assistance with instruction or for directions.
5. To ask for what you want.
6. To experience and express your feelings.
7. To feel positive about yourself under any condition.
8. To make mistake without feeling or guilty.
9. To own your own option and convention.
10. To promote unfair treatment or criticism.
11. To change one's behaviour, there must first be recognition that current behaviour is undesirable not many in fact be stress promoting.

Once awareness and the will to change occurs, then alternative behaviours, can be derived and implement There are many ways to change behaviour all have a common format called behaviour modification model. This progression of stages includes denial that behavior contributes to poor health or that one practice an undesirable behaviour them.

i. Awareness of the undesirable behaviour.
ii. Desire, to change.
iii. Cognitive restructuring a conscious attempt to change.
iv. Behavioural substitution and
v. Evaluation of result in term of stress, behaviour modification, includes, assertiveness, the practice assertiveness. The practice of assertiveness skills to increase self-esteem.

The above attempt to summaries the use of behaviour modification as tool for managing stress in the work place.

3.22 Models of Stress and Coping

Stress is another major concept that plays a fundamental role in understanding many forms of human adaptation. Monet and Lazarus (1977), P 3) have pointed out that stress represents "any event in which environmental demands, internal demands, or both tax or exceed *the* adaptive resources of in individual, social system, or tissue system." However, stress has been defined and used in *different* ways, depending on the aims of theories (Weiten, 2000). This complex concept was first studied by Hans Selye (1936; 1956; 1982), a Canadian scientist who spent his entire career researching the body's physical responses to stress. His model of the body's responses to stress is known as the general adaptation syndrome (GAS). Professor Selye identified three stages that are associated with this syndrome: the alarm stage, the resistance stage, and the exhaustion stage. *In* the alarm, sympathetic nervous system is activated, which increase the heart needed to combat the challenges to the body's adaptive processes. This response has also *been* characterized as the fight-or-flight response (Weiten, 2000).1 The second stage the resistance phase, involves the body trying to resist the stress when it persists over a period of time.

During this phase, it appears as if the individual is doing fine. However, the person's bodily defenses are actually beginning to erode (Duffy & Wong, 1996). In the final stage, exhaustion is reached. Exhaustion occurs because the body's resources for combating stress are limited. After the exhaustion is reached, arousal decreases and so does one's capacity for resistance, which results in disease as an adaptation to the biological threat or challenge (Weiten, 2000). (See Table 1.1)

Other theorists have focused primarily on psychological and emotional responses4o stress when under stress people typically confront two problems. "One is to manage the internal stress, anxiety, tension, depression, anger, restlessness, difficulty in concentrating, sleeplessness, and fatigue and the associated thought content, self-doubt and self-blame" (Levine & Perkins, 1997, pp. 215-216). Thus is first problem requires what has been termed a form of emotion-focused coping (Folkman & Lazarus, 1980). The second problem involves what a person should do in response to the stress or stressors. This kind of response is generally termed problem-focused coping. Problem-focused strategies seek to deal directly with the source of the stress, while emotion-focused coping seeks to reduce one's emotional responses to the stress. People use both of these types of coping in stressful situations and can vary in the amounts and types employed (Heller et al., 1984).

As social workers, we are interested in understanding all forms of stress experienced by people that place them at risk for developing poor

adaptations, poor health, and other negative life outcomes. These forms of stress include factors in the physical and social environments of people that are sources of stress. Poverty, social class, sexism, racism, and unemployment are examples of factors in a person's 'environment that are known human stressors. These factors are often highly correlated with a person's position or location in the social structure. In addition, factors such as high population density, air pollution, heat, noise, and toxic chemicals are recognized by environmental psychologists as major contributors to stress (Heller et al., 1984; Wapner et al., 1997).

Barbara Dohrenwend (1978) has developed a model of stress that takes into account both person and environment. She assumes that what determines how people respond to stress are moderating factors such as one's personal characteristics and one's social resources. "A moderating factor is considered to be operative when, if in its presence, the relationship of stress to illness (mental or physical) is weaker than in its absence (Duffy & Wong, 1996, p. 99).

In the Dohrenwend model, having sufficient psychological and situational mediators is what reduces a person's vulnerability to stress and risk of developing health impairments (Dohrenwend, 1998). Crisis theory is compatible with the model of stress developed by Barbara Dohrenwend. In crisis theory, differences in outcome from stressors are a function of the environmental supports and psychological mediators available to the person who is coping. Figure 1.2 shows an illustration of Barbara Dohrenwend's (1978) model of how psychosocial stress induces psychopathology and clarifies for readers the potential role psychological and situational mediators can play in this process.

Crisis theory originated with the work of Eric Lindemann (1944). He is known for his follow-up of the relatives of victims of a tragic nightclub fire in Boston at the Coconut Grove Dance Hall in 1941. Lindemann learned from his study of the survivors' grief responses that the survivors had to change by detaching in some manner from the relationships they had previously had with the deceased and starting new attachments. Those who did not adapt developed some form of disabling mental disorder. Crisis refers in this context to "any rapid change or encounter that provides an individual with a "no exit' challenge, no choice but to alter his or her conduct in some manner" (Levine & Perkins, 1997, p. 207).

Gerald Caplan, Lindemann's colleague at Harvard School of Public Health, recognized that not just loss events involving extreme stress placed people at risk for developing serious mental disorders. From his research, he concluded that normative life changes are also capable of producing symptoms of psychopathology. His definition of crisis

includes any significant change in a person's life situation. Such a change becomes a crisis when internal adjustment or external adaptation is beyond the person's capacity. His research inspired a growing field of inquiry presently known as life events research. As a result of this body of research, we now know that change associated with non-extreme events in life also contributes to stress and can place persons at risk for developing serve mental disturbance (Dohrenwend, 1998; Gotlib & Wheaton, 1997). The word crisis comes from a Greek root word meaning "to decide." In some contexts, it refers to a point in a disease or disorder process that is "decisive" for recovery or death (Levine & Perkins, 1977). In a more general sense, it refers to a critical turning point in the progress of some type of process in which a decisive change for better or worse is approaching.

To some extent, this is the meaning adopted by Erikson in his theory of psychosocial crisis. For Erikson, a crisis is considered a challenge or turning point at which there are opportunities for individuals to choose between polarities associated with key developmental tasks such as trust or mistrust (Newman & Newman, 1999). In crisis theory, winning the lottery is viewed as a challenge to the person's previous state of adaptation. Accepting a new job or becoming the boss also involves changes that require new adaptations that tax personal and social resources. To understand these challenges, social workers are expected to have a theoretical and an empirical understanding of crisis theory and of life changes resulting from normal developmental process.

4.0 CONCLUSIONS

We have gone through this module where we examine public private partnership in health care, stress management and mental health. These above influence the productivity of the public. The new health insurance scheme is yet to be effective because some scions of the people are not covered.

5.0 SUMMARY

We can summarise here some basic nugget of facts as follows:

- Public private partnership is a new drive to enhance efficiency in health care delivery.
- Public partnership is a policy to enhance grassroot development.
- To understand stress and its coping strategy.
- Social workers and health professionals behavior and its effects on health care system in Nigeria.

6.0 TUTOR MARKED ASSIGNMENT

1. What is public private partnership in health care deliver in Nigeria?
2. Why is it impossible to control public private partnership?
3. How can workers cope with stress in Nigeria?

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UNIT 2 NATIONAL HEALTH DECLARATION

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1.0 INTRODUCTION

The national health policy and strategy is decoyed to achieve health by year 2000 and beyond for Nigerians.

It is now generally acknowledged that it is possible to improve considerably the importance of health sector to the overall national development by increasing the efficacy and effectiveness of Ministry of Health in the performance of their jobs A pre-requisite for such an enhancement is that the country should have a well-articulated health policy, and that the health officials at every level of the health care system should be conversant with the stated goals and objectives they are trying to achieve.

This marked a distinctive epoch, in Nigerians having National health care policy that is all embracing, including leaders, ministries of health throughout Nigeria. The principal aim of policy is to provide the Federal, state, local government health institutions and their functionaries and other health related organizations, a formal framework for appropriate national direction in development in Nigeria.

Fragmented efforts have for many years characterized the approach to health care delivery in Nigeria We must observe that reforms in health care in before this policy directive have been helpful in solving immediate problems, but usually proved inadequate to achieve long-term goals. The health status of the nation will only improve when a holistic approach in adapted to the system. The national health policy is a validation of the government's readiness to establish a national health system based on primary health care, where numbers of fundamental

changes are taking place e.g. altitudinal health behavioral, technological and managerial changes.

2.0 OBJECTIVES

- To examine the central missions and objectives of Nigerian health policy and strategy
- To trace the historical trends in health care delivery in Nigeria.
- Understand the principles which underlined the health care policy and strategy.

3.0 MAIN CONTENT

3.1 National Health Declaration

The Federal, State and local government of Nigeria hereby commit themselves and all the citizens by year 2000 and beyond that is a level of health for all that will permit them to lead socially and economically productive lives at the highest possible level.

All government of Federation are convinced that the health of the people contributes to better quality of lives and to sustained economic growth of the country as a whole.

That the people of Nigeria have the right to participate individually and collectively in the planning and implementation of their health care.

That primary healthcare is the key to achieve the goal health care for all the people of Nigeria.

Primary healthcare is essential health care based on practical on scientifically sound and socially acceptable methods and technology made universally acceptable to individual and family in the community through their participation and the amount they can afford. It is also based on self-reliance and social development.

All governments and the people are determined to formulate strategies and plans of actions to lunch and sustain primary health care in accordance with this national health policy.
The Federal government undertakes:

To provide policy guidance and strategic support to state in their efforts at establishing health systems that is primary health care and is accessible to all

To co-ordinate state efforts in order to ensure a coherent, nationwide health system.

To provide incentives in selected health fields to the best of its economic ability to promote this endeavor and

In collaboration with the state government, to undertake the overall responsibility for monitoring and evaluating and implementing of the health strategies.

3.2 Evolution of Health Development in Nigeria

The health services of Nigeria have evolved through a series of historical developments including a succession of polices and plans which had been introduced by previous administrations. The health services are judged to be unsatisfactory and inadequate in meeting the needs of Nigerian

Background. This unit has been prepared against the historical background of the growth and the present state of the health services. The public health services in Nigeria originated in the British Army Medical services, with integration of the Army with colonial government during colonial era, government offered to treat the local servants and their relatives, and eventually, the local population living close by government stations.

The colonial Medical service developed and was duty bound to provide free medical treatment to the Army and government and colonial service officers. Medical treatment which the government initially provided for its officials was extended or made available to the local population only as incidental service. Various religious bodies and private agencies established hospitals, dispensaries and maternity centers in different parts of the country.

The first attempt to at planning ahead for the development of health services in Nigeria took place in 1946, as part of the excise which produced the overall ten-year plan for development and welfare (1946-56) COVERING all aspects of government activities in the country. Science Nigeria was still a colonial territory, the proponents of this plan were mainly expatriate officials. It included 24 major schemes designed to extend the work of existing government departments but it was not an integrated development plan in the current sense of the word. These schemes were not properly coordinated nor were they related to any overall economic target. It was however realistic, modest, and well thought out plan for its time and purpose, and it served as the basis for subsequent health plans.

In 1960 when Nigeria became independent health polices has been enunciated in various forms, either in the national development plan or as government decisions on specific health problems.

(a) The health component of the 2nd National Development plan 1970-1974, identified and aimed at correcting some of the deficiencies in the health services.

(b) In the 3rd Development Plan 1975-1980, there was a delicate attempt to draw up a comprehensive national health policy dealing with such issues as health manpower development, the provision of comprehensive health care services scheme, diseases control, efficient utilization of health resources, medical research health planning and management

(c) The health policy content of the 4th National Development Plan is reflected in national health care policy and strategy.

3.3 The state of Health Services

The health services as currently organized show major defects which are widely reorganized:

(a) The coverage is inadequate. It is estimated that no more than 35% of the population has access to modern health care services. Rural communities and the urban poor are not well served,

(b) The orientation of the services is inappropriate with a disproportionately high investment on curative services to the detriment of preventive services.

(c) The management of the services often shows major weakness resulting in wastage and inefficiency, as shown by the failure to meet targets and goals, with several different levels of governments, voluntary organizations and other agencies providing the various inputs are poorly coordinated.

(d) The involvement of the community is minimal at critical point in decision making process. Because the communities are not well informed on matters affecting their health, they are often unable to make rational decisions and choices.

(e) The lack of basic health statistics is a major constraint at all stages of planning, monitoring and evaluation of health services.

(f) The financial resources allocated to health sectors or services, especially some priority areas, are inadequate to permit them to function effectively.

(g) The basic infrastructure and logistic supports are often defective owing to inadequate maintenance of buildings medical equipment and vehicles, unreliable supply of water and electricity, and the poor management of drugs, vaccines, and supply system

(h) These lists may not be accurate summary of the broad range of defects in health services, there are also encouraging cases in which dynamic health administrators, professional persons and lay members of the communities have corrected these faults within their areas. Such successful programmes provide useful models of what can be done with limited resources in spite of various constraints.

3.4 The State of Health of the People

It is not possible quessttimate an accurate assessment of the health status of Nigerians. This is because there is no system of collecting basic health statistics on births, deaths, the occurrence of major diseases and other health indicators on a country-wide basis. The best available estimates are obtained from a few centres where such data are collected, from sample surveys, from institutional records and from special studies.

(a) The limited health statistics indicate the general poor state of health of the population:

Crude Death Rate:	16 per 1000 population
Crude Birth Rate:	50 per 1000 population
Childhood Mortality Rate:	144 per 1000 children Aged 1-4 years
Infant Mortality Rate:	85 per 1000 live births
Life Expectancy at Birth:	50 years.

Sources: Nigeria fertility Survey 1981 – 82
World Demography Record.

(b) Some experts estimate that the infant mortality rate may be as high as 100 to 160 per 1000 live births in rural areas. Whichever figure is accepted, it means that out of every 12 children who are born alive, one or more of them dies before reaching the first birthday. This rate is ten times as high as in some developed countries; it is much higher than in some other developing countries which have a similar level of socio-economic

development as in Nigeria. Children in the age group 1 to 4 years similarly die at a rate countries. In some parts of the country, 25% or more of children die before their fifth birthday. Childbirth, which should mostly be a normal process with minimal loss of life, is associated with a significant mortality among Nigerian women.

Patterns of ill health and their determinants: Most of the deaths and serious illnesses which occur among Nigerians are due to conditions which are easily preventable or which can be treated with simple remedies. Communicable diseases, especially those which are associated with inadequate environmental sanitation and poor personal hygiene predominate and often compounded by malnutrition. Lack of timely and appropriate care often increases the risk of serious complications in the course of minor ailments. The current high rates of morbidity and mortality can be substantially reduced by a more rational application of available resources, even at this time of financial stringencies.

4.0 CONCLUSIONS

The National health care policy in Nigeria is designed to provide health for all Nigeria through egalitarian principle in quality and easy access to health facilities.

The death rate and infant mortality rate is consequence on short comings in health care policy in Nigeria.

5.0 SUMMARIES

In this unit student should be able to grape the following point:

i. Examine the failure for health for all by the year 2000
ii. Understand the basis philosophy behind the declaration of health statues of Nigeria and other variables influencing health care deliver

6.0 TUTOR MARKED ASSIGNMENT

1. What are the reasons for health care policy in Nigeria?
2. Examine the reason for the failure of vision 2000 on health care

7.0 REFERENCES/FURTHER READINGS

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UNIT 3 FUNDAMENTAL PRINCIPLES UNDERLYING THE NATIONAL HEALTH POLICY

CONTENTS

1.0 Introduction
2.0 Objectives
3.0 Main Content
    3.1 The National Philosophy of Health Policy
    3.2 Mode of Operation of National Healthcare Policy
    3.3 Implications
4.0 Conclusion
5.0 Summary
6.0 Tutor Marked Assignment
7.0 References/Further Readings

1.0 INTRODUCTION

In this unit we are going to be introduced to the basic principle underlying the national healthcare policy, these includes that Nigeria is a free democratic society blessed with egalitarian principle and economy bases on self-reliance and opportunities for all citizens

2.0 OBJECTIVES

(a) A free and democratic society;
(b) A just and egalitarian society;
(c) A united, strong and self-reliant nation;
(d) A great and dynamic economy;
(e) A land of bright and full opportunities for all citizens.

3.0 MAIN CONTENT

3.1 The National Philosophy of Health Policy

The national 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:

(a) A free and democratic society;
(b) A just and egalitarian society;
(c) A united, strong and self-reliant nation;
(d) A great and dynamic economy;
(e) 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.

The National Health Policy has been formulated in the context of those national goals and philosophy. Since health development contributes to and results from socio-economic development, the sectors shall be mutually supportive and together contribute to the ultimate goals of the nation. Health development shall be seen not solely in humanitarian terms but as an essential component of the package of social and economic development as well as being an instrument of social justice and national security.
Primary Health Care as defined in the Alma Ata Declaration shall be the key to the development of the National Health Policy:-

3.2 Mode of Operation of National Healthcare Policy

"Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community and through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process."

3.3 Implications

The adoption of the primary health care approach has a number of implications:

a. The various governments of the Federation have responsibilities for the health of the people which shall be fulfilled by the provision of adequate health and social services. The citizens shall have the right and duty to participate individually and collectively in the planning and implementation of these services.

b. Health care shall be accorded higher priority in the allocation of the nation's resources than hitherto.

c. Health resources shall be equitably distributed giving preference to those at greater risk to their health and the under-served communities as a means of social justice and concern.

d. Information on health shall be disseminated to all individuals and communities to enable them to have greater responsibility for their health.

e. Self-reliance shall be encouraged among individuals, communities and on a national scale.

f. Emphasis shall be placed on preventive and promotive measures which shall be integrated with treatment and rehabilitation in a multi-disciplinary and multi-sartorial approach.

g. All social and economic sectors shall cooperate in the effort to promote the health of the population.

h. That primary health care shall be "scientifically sound" implies that all health practices and technologies, both orthodox and traditional shall be evaluated to determine their efficacy, safety and appropriateness.

4.0 CONCLUSION

This unit deal with health care system and constitutional background to help healthcare policy system of coordination in level of healthcare and community participation it also give us the impression of federal ministry of health stand point in healthcare system and its implementation.

5.0 SUMMARY

The Nigeria healthcare system includes the three levels of government. Federal, State and local government, including private sector in healthcare delivery sectors.

The Exclusive legislative list external health relations belong to the federal ministry of health.

6.0 TUTOR MARKED ASSIGNMENT

1. Defined primary health care.
2. Explain the following terms
   - reference system,
   - tertiary healthcare

7.0 REFERENCES/FURTHER READINGS

Akinsola, H.A 1993. A to Z of Community Health and Social Medicine in Medical and Nursing Practice with Special reference to Nigeria. Ibadan: 3 AM Communications.

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UNIT 4 NATIONAL HEALTH CARE SYSTEM

CONTENTS

1.0 Introduction
2.0 Objectives
3.0 Main Content
    3.1 Constitutional Background
    3.2 Public/Private Partnership
    3.3 System of Co-ordination
    3.4 Community Involvement
    3.5 Level of care
4.0 Conclusion
5.0 Summary
6.0 Tutor Marked Assignment
7.0 Reference/Further Reading

1.0 INTRODUCTION

Federal, State and Local Government shall support in a coordinated manner a three-tier system of health care. Essential features of the system shall be its comprehensive nature, multi-sectorial inputs, community involvement and collaboration with non-governmental providers of health care.

2.0 OBJECTIVES

The objectives of this unit are as follows:

- Understand how federal, state and local government support for health care delivery.
- To understand we operate three tired health care system.
- Examine the constitutional basis of healthcare delivery.
- Understand constitutional basis of public private partnership in healthcare system in Nigeria.

3.0 MAIN CONTENT

3.1 Constitutional Background

(a) In the Constitution of 1979, health is on the concurrent list of responsibilities with the exception of the external health relations, quarantine and the control of drugs and poisons which are exclusively the responsibility of the Federal Government. The Constitution also assigns specific responsibilities to the Local Governments (Fourth Schedule to the Constitution);

(b) The national healthcare system is built on the basis of the three-tier responsibilities of the Federal, State and Local Governments;

(c) Schedules of responsibilities which are to be assigned to the Federal, State and Local Governments respectively shall be prepared for approval by the Federal Ministry of Health.

3.2 Voluntary Agencies and the Private Sector

(a) A variety of non-governmental agencies, especially religious bodies, provide health care including both durative and preventive services.
(b) Private practitioners also provide care although the services are mainly concentrated in urban areas;
(c) Health care is also provided by public and private companies to staff members and their families.

3.3 System of Co-ordination

(a) In discharging the responsibilities assigned under the constitution, the Federal, State and Local Governments shall co-ordinate their efforts in order to provide the citizens with effective health services at all levels

(b) Governments of the Federation shall work closely with voluntary agencies, private practitioners and other non-governmental agencies which provide health care to ensure that the services provided by these other agencies are coordinated with those of governments and are in line with the overall national health policy.

(c) Mechanisms shall be established to ensure that all sectors related to health and all aspects of national and community development, in particular, agriculture, animal husbandry, rural development, food, industry, education and communications are involved and their health related activities are coordinated.

3.4 Community Involvement

(a) Governments of the Federation shall devise appropriate mechanisms for involving the communities in the planning and implementation of health services.

(b) Such mechanisms shall provide for appropriate consultations at the community level with regard to local health services on the basis of increasing self-reliance. The traditional system and

community organizations (cultural and religious associations) shall be fully utilized in reaching the people.

(c) The State and Federal Ministries of Health shall consult accredited groups and associations which represent the various interests within society, including the various professional associations.

3.5 Levels of Care

(a) National Health Care System shall be developed at three levels viz:

Primary Health Care

i. Primary Health Care shall provide general health services of preventive, curative, promotive and rehabilitative nature to the population as the entry point of the health care system. The provision of care at this level is largely the responsibility of Local Governments with the support of State Ministries of Health and within the overall national health and within the overall national health policy. Private medical practitioners shall also provide health care at this level.

ii. Nothing that traditional medicine is widely used, that there is no uniform system of traditional medicine in the country but that there are wide variations with each variant being strongly bound to the local culture and beliefs, the local health authorities shall, where applicable, seek the collaboration of the traditional practitioners in promoting their health programmes such as nutrition, environmental sanitation, personal hygiene, family planning and immunizations. Traditional health practitioners shall be trained to improve their skills and to ensure their cooperation in making use of the referral system dealing with high risk patients. Governments of the Federation shall seek to gain a better understanding of traditional health practices, and support research activities to evaluate them. Practices and technologies of proven value shall be adapted into the health care system and those that are harmful shall be discouraged.

(b) Secondary Health Care: The Secondary healthcare level shall provide specialized services to patients referred from the primary health care level through out-patient and in-patient services of hospitals for general medical, surgical, pediatric patients and community health services. It shall also serve as administrative headquarters supervising health care activities of the peripheral

units. Secondary health care shall be available at the district, division and zonal levels of laboratory, diagnostic, blood bank, rehabilitation, and physiotherapy shall be provided.

(c) Tertiary Health Care: Tertiary health care, which consists of highly specialized services, shall be provided by teaching hospitals and other special hospitals which provide care for specific diseases, conditions of specific groups of persons – e.g. orthopedic, eye, and psychiatric, maternity and pediatric hospitals. Care should be taken to ensure that these are evenly distributed geographically. Appropriate supporting services shall be incorporated into the development of these tertiary facilities to provide effective referral services. Selected centres shall be encouraged to develop special expertise in the advanced modern technology thereby serving as a resource for evaluating and adapting these new developments in the context of local needs and opportunities.

(d) Referral System: In order to ensure that the primary health care services are appropriately supported by an efficient referral system, Ministries of Health shall review the resources allocated to, and the facilities available at, the secondary and tertiary levels. Whilst high priority shall be accorded to primary health care, within available resources, the secondary and tertiary levels shall be strengthened. The long-term goal is that eventually all Nigerians shall have easy access not only to primary health care facilities but also to secondary and tertiary levels as required. Particular attention shall be placed on the needs of remote and isolated communities which have special logistic problems in providing access to the referral system.

4.0 CONCLUSION

This unit deal with health care system and constitutional background to help healthcare policy system of coordination in level of healthcare and community participation it also give us the impression of federal ministry of health stand point in healthcare system and its implementation.

5.0 SUMMARY

The Nigeria healthcare system includes the three levels of government. Federal, State and local government, including private sector in healthcare delivery sectors.

The Exclusive legislative list external health relations belong to the federal ministry of health.

6.0 TUTOR MARKED ASSIGNMENT

1. Defined primary health care.
2. Explain the following terms
   - Reference system,
   - Tertiary healthcare

7.0 REFERENCES/FURTHER READINGS

Akinsola, H.A 1993. A to Z of Community Health and Social Medicine in Medical and Nursing Practice with Special reference to Nigeria. Ibadan: 3 A.M Communications.

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UNIT 5 NATIONAL HEALTH STRATEGY

CONTENTS

1.0 Introduction
2.0 Objectives
3.0 Main body
    3.1 Roles and Functions of Federal Ministry of Health
    3.2 Roles and Functions of State Ministry of Health
    3.3 Financial and Material Resources
    3.4 Referral System
    3.5 Roles and Functions of the Local Government
4.0 Conclusion
5.0 Summary
6.0 Tutor Marked Assignment
7.0 References

1.0 INTRODUCTION

The implementation of this 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 the different arms of government shall be defined from time to time. A managerial process for health development shall be established.

Governments of the Federation shall translate the national health policy into strategies to achieve clearly stated objectives and, whenever possible, specific targets.

2.0 OBJECTIVES

- Understand our national health strategy.
- Understand the functions of federal and state ministry of health.
- Enable students to demarcate boundaries between state and federal ministry of health as regards inter-governmental health relations.
- Understand our referral system.

3.0 MAIN CONTENT

3.1 Roles and Functions of the Federal Ministry of Health

(a) The Federal Ministry of Health shall:
    i. take the necessary action to have this national health policy reviewed and adopted by the Federal Government;

ii. devise a broad strategy for giving effect to the national health policy through the implementation by Federal, State and Local Governments in accordance with the provisions of the Constitution;

iii. submit for the approval of the Federal Government a broad financial plan for giving effect to the Federal component of the health strategy;

iv. formulate national health legislation as required, for the consideration of the Federal Government;

v. 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 this national health policy;

vi. assess the country's health situation and trends; undertake the related epidemiological surveillance and report thereon to Government;

vii. promote an informed public opinion on matters of health;

viii. support State and through them Local Government in developing strategies and plans of action to give effect to this national health policy;

ix. allocate Federal resources in order to foster selected activities to be undertaken by States and Local Governments in implementing their strategies and related technical programmes, services and institutions;

x. issue guidelines and principles to help States prepare, manage, monitor and evaluate their strategies and related technical programmes, services and institutions;

xi. 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;

xii. promote research that is relevant to the implementation of this national health policy and State health strategies, and,

to this end, to establish suitable mechanisms to ensure adequate coordination among the research institutions and scientists concerned;

xiii. promote cooperation among scientific and professional groups as well as non-governmental organizations in order to attain the goals of this policy;

xiv. monitor and evaluate the implementation of this national health policy on behalf of Government and report to it on the findings;

(b) International health: The Federal Ministry of Health shall set up an effective mechanism for the co-ordination of external cooperation in health and for monitoring the performance of the various activities. Within the overall foreign policy objectives, this national health policy shall be directed 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;

iv. Collaborating with United Nations agencies, Organization of African Unity, West African Health Community, and other international agencies on bilateral and/or regional and global health care improvement strategies without sacrificing the initiatives of national, community and existing institutional and other infrastructural arrangements;

v. Working closely with other developing countries, especially the neighbouring states 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.

3.2 Roles and Functions of State Ministries of Health

(a) The State Ministries of Health shall be strengthened so that they become the directing and coordinating authority on health work within the State.

(b) Ensuring political commitment:

- The Ministries of Health shall direct activities according to the strategy for health and co-ordinate them on behalf of the government;

- The Ministries of Health shall take initiatives to ensure the commitment of their governments as a whole to the realization of this national health policy as adopted by all Governments of the Federation. In addition, on behalf of the State Governments, they shall make efforts to ensure the support of public figures and bodies as appropriate, such as political, religious, trade union and civic leaders, and influential non-governmental organizations. They shall mobilize popular support by involving individuals and families in their own health care and by involving them collectively in technical and financial community action for primary health care.

- The Ministries of Health shall propose to their governments appropriate mechanisms for ensuring the action required in all relevant social and economic sectors, such as inter-ministerial committees and multi-sectorial State Health Committees.

- The Ministries of Health shall advise on the introduction of health reforms and enabling legislation as necessary, for example, to define the right and obligations of people concerning their health as well as those of various categories of health workers and institutions to protect people from environmental hazards; and to permit communities to develop and manage their health and related social programmes and services. Care should be taken to avoid protracted deliberations on legislation as a substitute for action, and to ensure that people understand the nature of the legislation and approve of it.

(c) Ensuring economic support

i. Ministries of Health shall seize all opportunities of gaining the support of economic planners and institutions, by

convincing them that health is essential for development and that it contributes to production, and by refuting the contention that the pursuit of health consists merely in the consumption of scarce resources of marginally useful medical care that has limited impact on the health of the people;

ii. Ministries of Health shall also display vigilance, employing specialized personnel if necessary, in order to ensure that health needs and protective measures are made integral parts of development projects, taking account of cost-effectiveness-for example, in irrigation schemes, dams, and industrial development projects.

(d) Winning over professional groups: To ensure the support of the health professionals, Ministries of Health shall consider ways of involving them in the practice of primary health care and in providing support and guidance to communities and community health workers. To this end they shall approach the health and health related professional organizations providing them with information, holding dialogues with them, impressing upon them their social responsibilities and indicating how they can best discharge these responsibilities. They shall also consider ways of providing tangible incentives.

(e) Establishing a managerial process: Ministries of Health shall establish systematic permanent managerial processes for health development as outlined in Section 7.7.

(f) Public information and education:

i. Ministries of Health shall assume a highly active role in disseminating the kind of information that can influence various target audience. Thus, statements on the aims and potential socio-economic benefits of the State Health strategy, as well as progress reports on its implementation, shall be disseminated to the public;

ii. Ministries of Health in collaboration with Local Governments shall promote health education activities through health personnel and the mass media and in educational institutions of all types, with the aim of enlightening the whole population on good health maintenance, the prevailing health problems in their state and community and on the most appropriate methods of preventing and controlling them.

3.3 Financial and Material Resources

Just as the successful implementation of the State health strategy shall mean mobilizing all possible human resources, it shall also depend on mobilizing all possible financial and material resources. This implies first of all making the most efficient use of existing resources. At the same time, additional resources shall undoubtedly have to be generated. In this context Ministries of Health shall;

i. Review the distribution of the State resources from all sources, with particular reference to primary health care vis-à-vis secondary and tertiary levels, urban versus rural areas, and to specific under-served groups;

ii. Reallocate these resources as equitably as possible or, at least allocate any additional resources for the provision of primary health care, particularly for under-served population groups;

iii. Include an analysis of needs in term of costs and materials in all consideration of health technology and of the establishment and maintenance of the health infrastructure;

iv. Consider the benefit of various health programmes in relation to the cost, as well as the effectiveness of different technologies and different ways of organizing the health system in relation to the costs;

v. Estimate the order of magnitude of the total financial needs to implement the State health strategy;

vi. Attempt to secure additional resources for the strategy if necessary, having shown they have made the best possible use of existing funds;

vii. Identify activities that might attract external support and Federal Government assistance;

viii. Present of their government a master plan for the use of all financial and material resources, including for example government direct and indirect financing; social security and health insurance scheme; local community solutions in terms of energy, labour, materials and cash; external loans and grants.

(h) Intersectorial Action: Ministries of Health have an important role in stimulating and coordinating action for health with other social and economic sectors concerned with State and community

development, in particular agriculture, animal husbandry, food, industry, education, housing, water supply, sanitation, communication, social development and non-governmental agencies.

i. Ministries of health shall approach other sectors with a view to motivating them to take action in specific fields;

ii. Ministries of Planning, Finance, and Agriculture shall be approached, as appropriate, with a view to reaching a proper balance between food crops and cash crops;

iii. The agricultural and the housing and public works sectors shall be approached with respect to the provision of safe drinking-water and sanitation;

iv. Planning and development ministries shall be approached to ensure that proper attention is given to health aspects of development schemes, such as the prevention of certain parasitic diseases;

v. The education and cultural sectors shall be asked to participate in wide-ranging health educational activities in communities, schools, and other educational training and cultural institutions;

vi. Those responsible for public works and communications shall be requested to facilitate the provision of primary health care, through improved communications, particularly for dispersed populations;

vii. Access to the mass media shall be facilitated through Ministries of Information and the like;

viii. The industrial sector shall be made aware of the measures required to protect the environment from pollution and to prevent occupational diseases and injuries;

ix. The industrial sector shall also be requested, as the need arises, to consider the possibility of establishing industries for essential foods and drugs.

(i) Coordination within the health sector: To achieve coordination within the health sector Ministries of Health shall pay attention to the following:

i. Collaboration between the various health services and institutions, following agreement on allocation of

responsibilities in order to make the most efficient use of resources. These shall include services and institutions belonging to government, the private sector, non-governmental and voluntary organizations active in the health sector as well as women's and youth organizations;

ii. Collaboration between the various levels of the health system following agreement on the distribution of functions and resources;

iii. Collaboration within and among the various categories of health workers following agreement the division of labour.

(j) Organizing primary health care in communities: In order to facilitate inter-sectorial collaboration, primary health care shall be organized taking account of administrative boundaries. Communities shall be helped to organize themselves; and responsibility, authority, and appropriate budgets shall be delegated to them. The Ministries of Health shall provide guidelines and practical support as necessary to those communities that organize their own primary health care.

3.4 Referral System

i. Ministries of Health shall review the functions, the mechanisms and institutions in the health and related sectors, particularly at the first referral level, and shall motivate staff and retrain them as necessary to provide support and guidance to communities and community health workers;

ii. Ministries of Health shall develop a system of referral of patients and problems so that the first referral level is not overloaded with problems that could be dealt with by primary health care in the community, and so that patients and problems are referred to those who sent them, accompanied by information on action taken and guidance for further action.

iii. Ministries of Health shall review transport and communication facilities together with local authorities and representatives of the other ministries concerned to permit the referral systems to function efficiently.

(l) Logistic System: Ministries of Health shall review their logistic system to ensure regular and timely distribution of supplies and equipment, as well as the availability of transport and equipment, as well as the availability of transport and its maintenance,

starting with facilities in communities and working centrally through intermediate to the peripheral levels.

(m) Health manpower:

i. State Ministries of Health, in collaboration with the Federal, Ministry of Health and other ministries and educational bodies concerned, shall ensure the education and training of health manpower to perform functions that are relevant to the country's priority health problems along the guidelines shown in Chapter 10;

ii. Ministries of Health and other ministries concerned, for example, Education, Culture, Labour, Finance, and Public Administration, shall take steps to ensure that health workers are socially motivated and provided with the necessary incentives to serve rural communities.

(n) Health care facilities:

i. Ministries of Health, together with Ministries of Local Government and Public Works, shall review the distribution of existing health care facilities run by the State and Local Governments as well as other public, private and voluntary bodies, and shall continually update State master plans of requirements for health centres, clinics and for first referral hospitals, accessibility to those most in need shall be the foundation of the master plans.

ii. Ministries of Health shall review the functions, staffing, planning, design, equipment, organization, and management of health centres, clinics and first-referral hospitals, in order to prepare them for their wider function in support of primary health care. Before investing in buildings, the cost of running them shall be carefully considered.

(o) Priority health programmes: Ministries of Health shall identify priority health programmes in the light of the essential programme elements of primary health care and the epidemiological situation in the State, the shall ensure that the delivery of those programmes is given top priority by all concerned.

(p) Health technology: Ministries of Health shall make a systematic assessment of the health technology being considered for use in each priority programme with the aim of applying technology that is appropriate for the country or the state concerned (see Chapter 11).

3.5 Roles and Functions of the Local Government

(a) The Constitution assigns to local government councils certain functions which are essential elements of primary health care; environmental sanitation; provision and maintenance of health services; as well as the provision and maintenance of primary education.

(b) With the general guidance, support and technical supervision of State Health Ministries, under the aegis of Ministries of Local Government, Local Government Councils shall design and implement strategies to the Constitution, and to meet the health needs of the local community.

(c) Motivation of the Community: The Local Government Councils shall elicit the support of formal and informal leaders, traditional chiefs, religious and cultural organizations as well as other influential persons and groups in support of community action for health.

(d) Local strategy for health: The Local Government Health Authorities shall:

i. determine how best to provide the essential elements of primary health care;

ii. identify for each priority programme the activities to be carried out by the individuals and families, by the communities, by the health service and by other sectors;

iii. identify the support action required for each component of the programme;

iv. provide relevant health information to the people on such matters as personal hygiene, environmental sanitation, prevention and control of communicable diseases as well as such matters where a change in the life style of the people can have significant impact on their health status;

v. design and operate mechanisms for involving the communities in the critical decisions about the health services;

vi. mobilize resources to support the health programme. This shall include the use of voluntary effort and other traditional methods of achieving community goals;

vii. ensure that the essential infrastructures for the primary health care programmes are available and well maintained. With regard

to physical facilities, the emphasis should be on making sure that they meet the requirements for providing services but are not overly elaborate to the point where their maintenance constitutes a drain on resources.

viii. collect relevant data about the health resources, the health status of the community and about their health behavior, including the utilization of health services. Such data shall form the basis of the information of the local health services.

4.0 CONCLUSION

The national health strategy is the unit that harness the totality of means at which the health policy is implemented.

It emphasize the role of the federal state ministries of health in actualizing government policies and strategy

5.0 SUMMARY

This unit encompassed the following:

- The role of state and federal ministries of health
- The referral system
- The financial and material support for healthcare
- Dissemination of strategy healthcare information and plans.

6.0 TUTOR MARKED ASSIGNMENT

1. What are the likely strategies for local government health programme
2. What are the relationships in healthcare delivery

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UNIT 6 NATIONAL HEALTH SYSTEM MANAGEMENT

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1.0 INTRODUCTION

2.0 OBJECTIVES

- Understanding the management process in our health care
- Know on healthcare and its planning process.
- Understand the functions of federal university of health

3.0 MAIN CONTENT

3.1 The National Management Process

A national managerial process shall be established to include the following elements:

(a) The national health policy – comprising the goals, priorities, main directions towards priority goals, that are suited to the social

needs and economic conditions in the different states and form part of national, social and economic development policies;

(b) Programming – the translation of these policies through various stages of planning at the local, state and national levels into strategies to achieve clearly stated objectives.

(c) Programmed budgeting – the allocation of health resources by Governments of the Federation for the implementation of these strategies;

(d) Plan of action – describing strategies to be followed and the main lines of action to be taken in the health and other sectors to implement these strategies;

(e) Detailed Programming – the conversion of strategies and plans of action into detailed programmes the specify objectives and targets and the technology, manpower, infrastructure, financial resources, and time required for their implementation through the health system;

(f) Implementation – the translation of detailed programmes into action so that they come into operation as integral parts of the health system; the day-to-day management of programmes and the services and institutions for delivering them, and the continuing follow-up of activities to ensure that they are proceeding as planned and scheduled;

(g) Evaluation – of health developmental strategies and operational programmes in order progressively to improve the effectiveness and efficiency of their implementation;

(h) Reprogramming as necessary – with a view to improving the master plan of action or some of its components, or preparing new ones as part of a continuous managerial process for national health development;

(i) Relevant health information – to support all these components at all stages to ensure regular and wide dissemination of needed information.

3.2 National Health Planning System

(a) Scope and Purpose: The national health planning system shall form an integral part of the national health policy and any ensuing legislation. It will be an important administrative

framework for assigning duties and responsibilities as well as determining the working relationships between different levels of health management;

(b) The national health planning system shall relate to the determination of broad policy and priorities, and their translation into forward plans for the utilization of resources. It shall not be concerned with detailed implementation of individual projects or developments, but only with determining their priority and timing and the resources to be allocated to them.

(c) The functions inherent in the health planning system shall be broken down between:-

i. the research, analytical and considerate processes which result in strategic policy choices and long term objectives shall be a continuous process which cannot appropriately be fit into an annual cycle, though an annual summary of long term to programming decisions;

ii. the programming and budgeting process will result in decisions to put into effect specific courses of action within a definite timescale as a means of achieving the long-term aims, and to allocate resources to them. This process, which gives rise to the preparation of financial estimates, budgets and operating targets, shall be subject to annual revision and updating in a formal planning cycle.

3.3 National Health Planning and Development Guidelines

(a) The Federal Ministry of Health shall by regulations issue guidelines concerning national health policies, plans and programmes, and shall, as it deems appropriate, by regulation revise such guidelines.

(b) The Federal Ministry of Health shall include in the guidelines issued:

i. standards respecting the appropriate supply, distribution and organization of health resources;

ii. a statement of national health planning goals, objectives and targets developed after consideration of the priorities stated above. The goals, objectives and targets shall be expressed in quantitative terms to the maximum extent practicable.

(c) In issuing guidelines, the Federal Ministry of Health shall consult with and solicit for recommendations and comments, the Ministries of Health, the State Ministries of Education and Local Government, professional associations and special societies representing health organizations.

3.4 National Council on Health

(a) The National Council on Health shall advise the Government of the Federation with respect to:

i. the development of national guidelines;

ii. the implementation and administration of the National Health Policy; and

iii. various technical matters on the organization, delivery, and distribution of health services.

(b) The council shall be composed of the following members:

i. The Minister of Health (Chairman);
ii. The Commissioners for health.

(c) The Council shall be advised by the Technical Committee.

3.5 Technical Committee of the National Council on Health

The Technical Committee shall be composed of:

i. The Permanent Secretaries;
ii. The Directors of Federal Ministry of Health;
iii. The Professional Heads in the State Ministries of Health;
iv. A Representative of Armed Forces Medical Services;
v. Director of Health Services, Federal Capital Territory, Abuja.

3.6 Expert Panels

(a) The Technical Committee shall set up as required, appropriate programme expert panels including the representatives of health related Ministries:-

i. Agriculture, Rural Development and Water Resources;
ii. Education;

iii. Science and Technology;
iv. Labour;
v. Social Development, Youth and Sports;
vi. Works and Housing;
vii. National Planning;
viii. Finance.

(b) Health related bodies:-

i. National Institute of Medical Research;
ii. Medical Schools;
iii. Schools of allied health professionals;
iv. Non-governmental organizations;
v. Professional associations.

3.6 Planning Function by the Federal Ministry of Health

(a) The Federal Ministry of Health shall service the National Council on Health and have multi-disciplinary staff with expertise in at least the following:-

i. health administration;
ii. health statistics;
iii. health planning;
iv. epidemiology;
v. development and use of resources (health economics).

(b) The Federal Ministry of Health shall prepare and submit for annual review medium and long-term national health plans that detail the health problems and needs of the country. Each plan shall also detail the goals and objectives, priorities, implementation and evaluation procedures of solving the health problems and meeting the health needs of the country.

(c) Each National Health Plan shall be made up of the State health plans submitted by every State Ministry of Health suitably revised to achieve the appropriate coordination or to deal more effectively with the national health needs.

(d) The Federal Ministry of Health shall assemble and analyze the following data and indicate how their quality can be improved:-

i. the state of health of the nation and its determination;
ii. the state of the health care delivery system in the country;
iii. the effect the health care delivery has on the health of the general public;

iv. the number, type and location of the health resources including health service manpower and facilities;
v. the pattern of utilization of health resources; and
vi. the environmental and occupational exposure factors affecting immediate and long-term health conditions.

(e) The Federal Ministry of Health shall also provide guidelines on planning approaches, methodologies, policies, standards, and development of health resources.

(f) The Federal Ministry of Health shall also provide guideline for the organization and operation of state health planning and development units including:-

i. the structure of a state health planning and development unit;
ii. the conduct of the planning and development processes;
iii. the performance of state health planning and development functions; and
iv. the planning performance of Local Government health authorities.

3.7 Managerial Process at State Level

(a) To permit them to develop and implement their strategies, Ministries of Health shall establish a permanent, systematic, managerial process for health development which shall lead to the definition of clearly stated objectives as part of the state strategy and, wherever possible, specific targets. They shall facilitate the preferential allocation of health resources for the implementation of the State strategy, and shall indicate the main lines of action to be taken in the health and other sectors to implement it. They shall specify the detailed measures required to build up or strengthen the health system based on primary healthcare for the delivery of state programmes. The managerial process shall also specify the action to be taken so that detailed programmes become operational as integral parts of the health system, as well as the day-to-day management of programme and the services and institutions delivering them. Finally, it shall specify the process of evaluation to be applied with a view to improving effectiveness and increasing efficiency, leading to modification or updating of the State strategy as necessary. Health manpower planning and management shall be an inseparable feature of the process. For all the above, the support of relevant and sensitive information will be organized as an integral part of the health system.

(b) Ministries of Health shall establish permanent mechanisms to develop and apply their managerial process and to provide adequate training to all those who need it. These shall include mechanisms in ministries themselves, as well as all networks of individuals and institutions, to participate in the managerial research, development and training efforts required for health development.

3.8 State Health Advisory Committee

(a) There shall be established an advisory committee in each state known as the State Health Advisory Committee. The Committee shall advise the State Government on health policy and programmes and be chaired by the Commissioner for Health.

(b) The State Health Advisory Committee shall consist of representatives of:-

i. State Ministry of Health;
ii. State Hospital Management Board;
iii. State Ministry of Local Government;
iv. Non-Government Organizations;
v. Federal Health Institutions;
vi. Health related Ministries;
vii. Professional bodies;

(c) A State Health Advisory Committee shall perform the following functions:-

i. review and co-ordinate the medium and long-term as well as annual health plan of the State;

ii. review and revise as necessary (but at least annually) the State Health Plan which shall include the health plans of the Local Government Health Authorities within the state;

iii. review annually the budget of each such local Government Health Authority;

iv. advise the Health Planning Unit of the State generally on their performance of its functions.

3.9 State Health Planning Function

(a) Each Ministry of Health shall establish an appropriate mechanism for the implementation and planning of its development functions.

(b) The State Ministry of Health shall submit an annual health plan that shall outline the health problems, needs, goals and objectives, implementation and evaluation procedures for the State. It also shall submit medium and long-term plans to the Federal Ministry of Health after the approval of the State Executive Council.

(c) Each State Ministry of Health shall perform within the State the following functions:-

i. conduct the health planning activities of the State and help in implementing and coordinating the various components of the State Health Plans;

ii. prepare, review and revise as necessary (but at least annually) a preliminary State Health Plan which shall include the Local Government Health Authority plans;

iii. assist the State Health Advisory Committee of the State in the review of the State health facilities plan and in the performance of its functions generally;

iv. review on a periodic basis (but not less often than every three years) all institutional health services being offered by the State.

3.10 Technical Assistance for State Health Services

(a) The Federal Ministry of Health shall provide to the State Ministry of Health:-

i. assistance in developing their health plans and approaches to the planning of various types of health services;

ii. technical materials, including methodologies, policies and standards appropriate for use in health planning;

iii. other technical assistance as may be necessary in order that such institutions may properly perform their functions.

(b) The Federal Ministry of Health shall include in the materials the following:-

i. specification of the minimum data needed to determine the health status of the nation and the determinants of such status;

ii. specification of the minimum data needed to determine the status of the health resources and services of the country;

iii. specification of the minimum data needed to describe the use of health resources and services within the state;

iv. planning approaches, methodologies, policies and standards which shall be consistent with the guidelines established for appropriate planning of health resources, and which shall cover the priorities as listed in Chapter 4.

v. guidelines for the organizational and operation of the State Health Planning Units, and Local Government Health Committees.

3.11 State Hospitals Management Board

a) The State Hospitals Management Board shall function under the general supervision of, and policies established by the State Ministry of Health which shall maintain overall responsibilities for the health services of the State.

b) The Board shall be responsible for the management of hospitals which come under the jurisdiction of the State Ministry of Health.

c) The Board shall collaborate with the local Health Authorities and their respective health committees to ensure close integration and continuity of services from peripheral units (under the local Health Authority) to the referral units which are administered by the Board.

d) The functions assigned to the Ministry, to the Board and to the Local Health Authorities shall be clearly demarcated with unambiguous delineation of responsibilities and powers.

e) The composition of the Board shall include representatives of the:-

i. Ministry of Health;

ii. Community leaders;
iii. Professional associations;
iv. Staff members of hospitals and institutions managed by the Board;
v. Federal Health Institutions, where appropriate; and;
vi. Non-Governmental Organizations;

f) The officials of the Board shall be selected with great care to ensure dynamic, efficient management of the programmes.

3.12 Local Government Health Committee

(a) The Local Government Councils in consultation with the State Ministry of Health shall establish Local Government Health Committees covering each Local Government Area for the purpose of delivering health services to the communities.

(b) The composition of each Local Government Health Committee shall include representatives of:

i. Local Government Council;
ii. State Hospital Management Board;
iii. Leaders of the local community;
iv. Non-Governmental Organizations;
v. Training Institutions (including University Institutions if appropriate);
vi. Representatives of the Professional Staff; and
vii. Other health institutions.

(c) The Local Government Health Committee of this composition shall effect the execution of the plans for health services within the specified Local Government Area. The State Commissioners for Local Government and Health shall review the membership and activities of the Local Government Health Committee once every three years and replace any member who may leave the Committee any time during the tenure of office.

(d) The functions of Local Government Health Committee shall include the following:

i. formulate project proposals;
ii. deliver comprehensive health services within the area with community participation and inter sectorial coordination;
iii. collect basic data of services and resources; and
iv. mobilize resources for health programme implementation in the spirit of self-reliance.

3.13 National Health Care Financing

The Federal and State Government shall review their allocation of resources to the health sector. Within available resources, high priority shall be accorded to primary health care with particular reference to underserved areas and groups. Community resources shall be mobilized in the spirit of self-help and self-reliance.

3.13.1 In the light of the importance of health in socio-economic development, all Governments of the Federation shall review their financial allocation to health in relation to the requirements of other sectors of the economy. High priority programmes for primary health care shall have the first consideration on any additional resources that may be available.

3.13.2 Within the health care system, efforts shall be made to redistribute financial allocation among promotive, preventive and curative health care services to ensure that more emphasis shall be placed on promotive and preventive services.

3.13.3 Governments of the Federation shall explore avenues for financing the health care system including health insurance schemes.

3.13.4 As a general policy, users shall pay for curative services, but preventive services shall be subsidized. Generally, public assistance shall be provided to the socially and economically disadvantaged segments of the population.

313.5 Governments of the Federation shall encourage employers of labour to participate in financing health care services to employees.

3.13.6 Within the right of individuals to participate in the economy of the nation, private individuals shall be encouraged to establish and finance private health care services in under-served areas.

3.13.7 Within the concept of self-reliance, communities shall be encouraged to finance health care directly or find local community solutions to health problems through contribution of labor and materials.

3.13.8 Mechanisms shall be established to undertake continuing studies on:-

(a) the benefit of various health programmes in relation to the costs, as well as the effectiveness of different technologies and ways of organizing the health system in relation to the cost; and

(b) the inclusion of an analysis of needs in terms of cost, material and personnel in all consideration of health technology and of the establishment and maintenance of health infrastructures.

4.0 CONCLUSION

We have come to the climax of the module of this course.
Candidates or students are expected to have gain a lot in this work or study, and make recommendation on how to improve healthcare delivery in Nigeria.
This unit deals with healthcare planning, financing and strategy.

5.0 SUMMARY

This unit treated the management system in healthcare process in Nigeria. This involved national healthcare process, programmes, budgeting and implementation.
It also incorporates healthcare policy of federal state and local government.

6.0 TUTOR MARKED ASSIGNMENT

1. What are the problems involve in healthcare financing in Nigeria?
2. What are the roles of state ministry of health?
3. Examine intergovernmental relation in healthcare delivery in Nigeria?

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