

Driving Equitable Access to Healthcare for NCD Sufferers in Nigeria through a Legal Informatics Approach

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Abstract

Non-Communicable Diseases (NCDs) accounts for 70% of the deaths resulting from health challenges annually across the globe. This paper discusses the provisions of local legislations and policies in Nigeria with particular emphasis on the financing available to persons with NCDs. Of particular concern are those legislations and policies that seem to protect persons with such diseases as to their fundamental right to dignity and health. This paper adopts a mix of qualitative and sociotechnical approaches and explores the vital legal, policy, and government project implementation documents in a bid to identifying the barriers to implementation of policies, highlight the costs of social exclusion of the rights of sufferers in human and economic terms. Following a careful analysis a legal informatics single window model of care is constructed to demonstrate how NCD sufferers may be taken care of with recourse to the subsisting laws and how any breach of the rights of the sufferers could be tracked and remedied. It is believed that such approach would ameliorate the health financing burdens of present and future NCD sufferers among the citizenry.

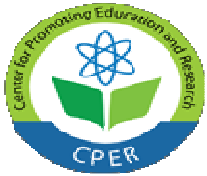
Keywords: Non Communicable Diseases, NCDs, Legal Informatics, Health Law, Human Rights

1. Introduction

Non-Communicable Diseases (NCDs) accounts for 70% of the deaths resulting from health challenges annually across the globe¹. Non-communicable diseases often called chronic diseases are diseases of long duration² and generally slow progression. According to the WHO, major causes of NCDs are tobacco use, alcoholism,

¹ Ayodamola Owoseye, "Seven in ten deaths caused by Non Communicable Diseases – WHO", 2018, <https://www.premiumtimesng.com/news/more-news/258949-seven-ten-deaths-caused-non-communicable-diseases.html>, last accessed 2 February 2019

² WHO, Noncommunicable diseases, <http://www.who.int/mediacentre/factsheets/fs355/en/>, last accessed 4 February 2019



unhealthy diets, and physical inactivity. Across the world, it has been recorded that 50% of the premature deaths arising from these diseases occur in low and lower-middle income countries³ Nigeria inclusive. Common prevalent non-communicable diseases are Cardiovascular Diseases (CVDs), Cancer, Chronic respiratory diseases (such as chronic obstructed pulmonary disease and asthma), and Diabetes. Some NCDs like CVDs and Cancer are life threatening while others, like sickle-cell anemia, diabetes may be managed through careful and consistent use relevant therapeutics. NCDs are marked by their manner of onset, gloomy prognosis, and often chronic nature. Suffice it to say that most NCDs are characterized by long duration, severity and slow progressive debilitations, involving personal hardships and heaviest financial cost for medical care. The duration is long in manifest in highly variable and daily symptoms⁴.

CVDs is a broad group that includes coronary artery diseases (CAD) like hypertensive heart disease(HHD), angina pectoris, myocardial infarction, stroke, heart failure, rheumatic heart disease(RHD), cardiomyopathy, heart arrhythmia, congenital heart disease, valvular heart disease, carditis, aortic aneurysms, peripheral artery disease, thromboembolic disease, and venous thrombosis⁵.

In a survey carried out by the American Centre for Disease Control in 2012 alone, the US recorded that half of its adult population 117 million people had one or more chronic health condition. One of four adults had two or more chronic health conditions⁶. It was also reported that seven of the top ten causes of death in 2010 were chronic diseases. Two of these chronic diseases heart disease and cancer together accounted for nearly 48% of all deaths⁷.

According to the World health Organization, NCDs kill 38 million people each year⁸ and 28 million the said deaths occur in low and middle-income countries such as Nigeria. The WHO has maintained that CVDs are the leading cause of death and disability around the world with average of 17.5 million deaths a year. That is, CVDs accounts for 33.3% of all deaths in the world and 50% of all deaths traced to NCDs. It is projected that by 2030, about 23.6 million people will die from CVDs the single leading causes of death.

In 2008, NCDs accounted for an estimated 28 per cent of the total deaths⁹ in Nigeria. Cardiovascular diseases accounted for 12 per cent of these deaths across all age groups whereas cancers, non-communicable variants of respiratory diseases and diabetes contributed 4 per cent, 3 per cent and 2 per cent to total deaths respectively. In Nigeria, it is estimated that over 71,000 people die each year from cancer related causes, with about 102,000 new cases diagnosed each year¹⁰. According to a recent 2018 report, Nigeria has the worst cancer mortality rate in Africa as 80% die from the disease¹¹.

This development notwithstanding, very little is being done on prevention and even less on establishing excellent treatment centers that can cater for the growing number of cancer cases in the country. There are a few

³ WHO, Supra

⁴ Bruce Jennings et.al, Special Supplements: Ethical Challenges of Chronic Illnesses, The Hastings Centre Report., 18(1),1988, pp. 1-16

⁵ S. Akpunonu, "Reducing the Burden of Heart Diseases in Nigeria", The Guardian Newspapers; September, 2018, <https://guardian.ng/features/health/reducing-burden-of-heart-disease-in-nigeria/>, last accessed 24 December 2018

⁶ BW Ward, JS Schiller, RA Goodman, Multiple Chronic Conditions Among US Adults: A 2012 Update. *Prev Chronic Dis*, 11:130389,2014. DOI: <http://dx.doi.org/10.5888/pcd11.130389>

⁷ Centre for Disease Control and Prevention, "Death and Mortality". NCHS FastStats <http://www.cdc.gov/nchs.faststats/deaths.htm>; last accessed 3 February 2019

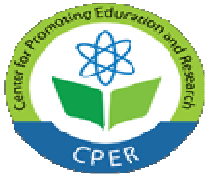
⁸ ibid

⁹ CommonwealthHealth.org, "Non-Communicable Diseases in Nigeria", 2019; Available at

http://www.commonwealthhealth.org/africa/nigeria/non_communicable_diseases_in_nigeria/

¹⁰ Adaobi Ezeokoli, "Cancer Treatment In Nigeria – Time For A Paradigm Shift?", Ngeria Health Watch, 3 November 2015. Available at <https://nigeriahealthwatch.com/cancer-treatment-in-nigeria-time-for-a-paradigm-shift/#.XGF6KVVKjIU>

¹¹ Chukwuma Muanya and Matthew Ogune, "Nigeria: Four Out of Five Nigerian Cancer Patients Die", Punch Newspapers, 19 April 2018. Available at <https://allafrica.com/stories/201804190355.html>



treatment centers for cancer and cancer related illnesses but they are always in the news for the wrong reasons a failure of their radiotherapy infrastructure¹². The same sad story for other NCDs.

This trend in mortality has since worsened with more deaths recorded annually across all age groups. Reaching out to this number is an urgent need and has become a priority, given the fact that chronic disease, cuts across age barriers, and unlike studies in the 30s, have come to settle on new born, youth and the working force of the nation. If chronic illness is more about negotiating with illness, than about combating the disease, the attitude of the state towards should be rethought in a broader context. The State has to be more sensitive to the vulnerable needs and should be reflective in state policies. While it does appear that Nigeria has evolved good health policies and laws in recent times, their resultant effects may be at best described as blurry and unrealistic.

It is worthy of note that health policy approaches in most developing and developed countries have placed emphasis on care of persons living with chronic diseases. This is because these diseases are not curable but manageable. But from the available survey, evidence for prevention is strongest for measures aimed at reducing preventing, managing, and controlling increase while large gaps remain in our knowledge of the rights of those who already have these chronic diseases. With the foregoing gap being a major concern in health care rights advocacy, it has become absolutely necessary to discuss financing options for unemployed persons and those who lack the means of supporting themselves because health laws, policies and programs have the ability to either promote or violate human rights, including the right to health. Taking steps to respect and protect the human rights of these persons include upholding the nation's responsibility to address everyone's health, in spite of the state and nature of the health. The lack of adequate legal content under relevant laws in Nigeria understates and underscores her readiness to fulfil and or enforce the rights of these persons to health.

1.1 Concept of Right to Health

According to Robert Shelton, there is a universal agreement that affirms the existence of the rights of human persons to health care¹³. It is also universally agreed that health has a far reaching economic value¹⁴. Since its formal recognition, numerous international and regional treaties, instruments, conventions and treaties have recognized the right¹⁵. Health is conceived as a catalyst in the economic and social development process chain which every country in the 21st century must thrive to have. At the core of the human right discourse on healthcare delivery is an effective and efficient healthcare delivery system. An effective healthcare delivery system has all that it would take to deliver the intended or expected result to the members of the community or society in which it operates. That is, it must be accessible, prompt and of good quality. Efficiency connotes the relationship between resource inputs and the resultant outputs. A healthcare delivery system is said to be efficient if it attains its objectives at the least possible cost. Accessibility refers to the ability of patients to get and receive health care services. This could be physical and effective availability, while quality refers to quantify of care, clinical quality and service quality. The goals of a healthcare system include: an improved health of the population, increased responsiveness to legitimate demands of the population and fair distribution of financial burdens¹⁶. A vibrant

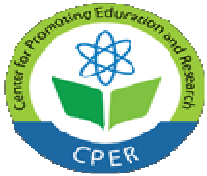
¹²Adaobi Ezeokoli, *supra*

¹¹ RI Shelton, "Human Rights and Distributive Justice in Health Care Delivery", *Journal of Medical Ethics*, 4(4), 1978, pp. 165-171 at 163

¹² Hyacinth, Ichoku et.al, *Fiscal Space for Health Financing in Nigeria*, *African Journal of Health Economics*, AJHE, No 0002, 2015

¹⁵ Wilson Nwankwo. "Evolving Effective Healthcare System through Public Private Partnership", *International Journal of Engineering Research & Technology*, 5(2), 2016

¹⁴ WHO, *World Health Report*, 2000



healthcare system will deliver treatment and prevention programs more efficiently and improves overall health of the citizenry. A vital function of the healthcare system is resource generation and financing¹⁷.

In the pursuit of optimal healthcare and efficient health delivery system, there has been an increasing health spending in many countries. However, there is a wide gap between developed countries and low income countries in terms of governmental spending on health. Current spending on health is estimated to be \$4.1trillion, out of which 80% is borne by member countries of the Organization for Economic Co-operation and Development (OECD). Low income countries, especially countries in the Sub-Saharan Africa, of which Nigeria is one, have the lowest per capita in the world¹⁸.

1.2 Statement of the Problem

A critical point of concern is that most sufferers of NCDs do not possess the wherewithal to tackle the health challenges. Majority of persons in this class have been constructively denied of their rights to access to care owing to their inequitable placement in the society as to education and employment. Though this individual deficiency often counter or downplay the fact that chronic diseases require adequate attention, we must note that a given medical condition of this nature is not alien within the person, or does it mark a temporary reversible departure from the person's moral state of mind; but a condition that is a component of the person's overall state of mind. In this regard, it has been observed that such lowly or average persons in our society receive poor quality medical care or whatever treatment is given to them regardless of whether or not the treatment regimen is potent and efficacious. In the end the patient lives with untreated symptoms, unmet psychosocial and personal care needs which in no distant time result to premature death.

Having regard to the foregoing, there is no gainsaying that the issue of specific rights for persons with NCDs is apt. To ensure such rights are bestowed on such persons as identified above, it would require a very critical study of the Nigerian health care structure, policies and legislations as to their provisions for protecting the vulnerable and the NCD sufferers alike irrespective of their placement or endowment in the society. There is a need for policy makers and the State to focus more on the generic problems and effect of chronic illness across the population. Based on the current trend, there are no concrete policies/programs put in place in Nigeria to stem the emerging epidemic¹⁹. This is not surprising given the fact that there is little or no reliable data are available on chronic NCD diseases. The question is how the State or its policy makers could arrive at a realistic health policy formula on a given issue without recourse to appropriate data on the said issue. As regard secondary intervention (preventing complications and improving quality of life in affected communities and persons), even though the Ministry of Health in Nigeria acknowledges the presence and devastating impact of NCDs burden²⁰, there has not been yet any significant chronic disease plans or policies. Chronic diseases and its sufferers are neglected on the public health agendas of most developing countries, Nigeria inclusive, while more attention has been paid to infectious diseases²¹.

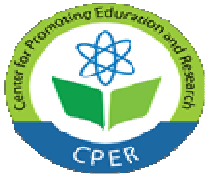
¹⁵ibid

¹⁶ Hyacinth Ichoku et.al, supra.

¹⁹ The Minister of Health announced that the Federal Government of Nigeria has developed a new National Policy and Strategic Plan of Action on NCDs and a national nutritional guideline on prevention, control and management of the ailments. The Guardian Newspaper, (supra)

²⁰ Ama de-Graft Aikins, Nigel Unwin, Charles Agyemang, Pascale Allotey, Catherine Campbell and Daniel Arhinful, "Tackling Africa's Chronic disease Burden: From the Local to the Global", *Globalization and Health*, 6(5), 2010.. See also United Nations General Assembly (GA/11138). Non-Communicable Diseases Deemed Development Challenge of 'Epidemic Proportions'. Sixty-sixth General Assembly Plenary 3rd, 4th & 5th Meetings. 19th September, 2011. PubMed

²¹ An estimated 80% of regional budgets has been allocated to communicable disease in the last decade. Pobe JOM: Community Based High Blood Pressure programs in Sub-Sahara Africa. *Ethnicity and Disease*. 1993, 3 (Supplement): S38-S45 PubMed



Accordingly, there is an urgent need to develop an appropriate legal framework based on human rights concept that would ensure the enjoyment of capabilities of individuals. The capability concept is an approach that protects and promotes valuable state of being and doing.

Nigeria, like most low and medium income countries (LMICs) have health financing policies at odds with the incentives needed for effective and efficient NCDs care. For instance, under the formal sector social health insurance program of the NHIS, the benefit package includes out-patient care, pharmaceutical care and diagnostic tests as contained in the NHIS Drug list, hospital care in a standard ward for a limited cumulative 21 days per year following referral and, under tertiary healthcare service, hospital stay in orthopaedic cases for 6 cumulative weeks. The scheme generally does not provide an extensive package for long time sufferers.

1.3 Objectives of the Study

Studies have revealed that despite public health initiatives specifically targeted against NCDs, there is a high degree of health inequities as it affects the availability and affordability of health facilities to sufferers. Majority of the policies and facilities in place are aimed at prevention and control of NCDs to a large extent. In the light of the foregoing, this paper is aimed at identifying the disconnect that exist along the chains of prevention, treatment, and control vis-à-vis the equitable and affordable access across all sufferers regardless of social status. The specific objectives of this paper are:

1. To examine the constitutional rights of the citizenry to health and dignity to human person.
2. To establish whether or not NCD sufferers can validly explore such rights in a bid to reduce their suffering as it affects their burden of medical care
3. To critique the effectiveness and efficiency of the existing health policies and legal framework as it affects the care of NCD sufferers in a bid to create a more robust legal framework
4. To define a model that will enhance the implementation of an effective equitable system that enable NCD sufferers obtain regular health assistance regardless of their social status.

1.4 Research questions

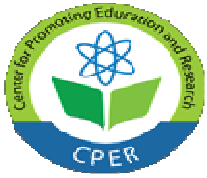
In order to attain the objectives of this study, the following research questions were formulated:

- a. What are the relevant local legislations and health policies that are directed towards the Nigerian Government's constitutional obligation of providing access to health facilities at all levels of care to all members of the citizenry?
- b. Are there some interventions and legislations in place for persons with NCDs in Nigeria?
- c. In the light of (c) above does the sufferer has right to enforce his/her rights if such exists?
- d. Are there smart ways to ensure equitable access to healthcare especially for persons with NCDs in line with WHO's global action plan 2013-2020²²?

1.5 Significance of the Study

With respect to the fundamental rights to life, dignity of the human person, healthcare respectively, the importance of this paper are discussed below:

²² WHO, Global action plan for the prevention and control of NCDs 2013-2020, 2013



First, the peculiarities of Nigeria in respect of social stratification, economic statuses, policies and legal frameworks, which are unarguably different in other jurisdictions, are considered thoroughly in the light of equity and social justice.

Second, the defined and guaranteed protection and enforcement of human rights are the bedrock of a civilized society. Considering the significant number of people affected by the plague of NCDs and the estimated mortality rate annually; there is no doubt that any discourse or recommendation which would contribute towards salvaging this disaster would be welcomed by the people and government at various levels.

Third, the issue of equitable health care in the realm of NCDs can only be ignored to the detriment of human society. It is evident that in the last two decades, there has not been any visible transformation in this critical area owing to the fact that budgeted funds and facilities are often grossly inadequate; to address and reform the sector will entail not just funding but regard must be had to other components such as governance, legal frameworks, all-inclusive health policies.

Fourth, since reduction in global poverty and within-country inequities in the treatment of NCDs require national investment, it is necessary to formulate policies around the treatment-services for NCDs which must be more nuanced, stratified and scalable.

This paper advocates for the narrowing of the gap between NCD sufferers in Nigeria and healthcare delivery system. The action that this research envisages is that the government and other stakeholders use the resources at their disposal while taking into account equity and social values²³.

This paper critiqued some relevant legislations and policies thereby making positive legal and economic contributions towards the management of the scarce economic resources meant for public healthcare infrastructure development in Nigeria. By virtue of Nigeria's recognition of citizen's right to health and its commitment to its protection through obligations under international treaties and domestic legislation; it is deemed important to provide health policy makers with the requisite inputs and tools of which this study is geared at providing.

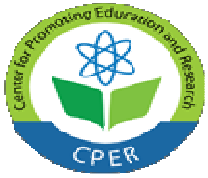
2. Method

A mix of desk and sociotechnical research approaches was adopted. Regard was had to descriptive and analytical approaches (where necessary) including sociological enquiries and review of relevant legislations using a phased method.

First, we searched Medline, PubMed, The Cochrane Library, Popline, Science Direct and WHO Library Database, Nigeria Centre for Disease Control Database with search terms such as Non-communicable diseases, Cancer, Cardiovascular Disease, Health policies, Health financing in Nigeria, Public health financing, Legal informatics models for health care, Socioeconomic problems in public health delivery, etc., We also reviewed a bunch of relevant literature and documentation on the following:

- a. Health care developments in Nigeria
- b. Constitution of the Federal Republic of Nigeria 1999[as amended]
- c. Local Statutes [where applicable]
- d. Health Policy documents and Guidelines
- e. Case Laws [where applicable]

²³ I Robert, R Jackson, Beyond disease Burden: toward solution oriented population health, Lancet, 2013; 281: 2219-21



- f. Federal Ministry of Health
- g. Federal Ministry of Justice

Second, we conducted a sociological inquiry to obtain a first-hand data on National Health Insurance Scheme and two Health Maintenance Organizations (HMOs). We also made enquiries to relevant public agencies such as:

- a. Federal Ministry of Justice
- b. National Human Rights Commission(NHRC)
- c. Federal Ministry of Health
- d. Nigeria Centre for Disease Control

Thirdly, an analysis of documents containing the relevant local legislations and policies on healthcare was made. The analysis was restricted to the following legislations and policy documents:

- a. The National Health Act 2015
- b. National Health Insurance Scheme Act 2004
- c. The Revised National Health Policy;
- d. Constitution of the Federal Republic of Nigeria 1999 [as amended]

Following the analysis some information gap was identified and subsequently the function of a smart legal single window model of care for NCD sufferers was conceived and developed.

3. Results and Discussion

3.1 Rights, Legislations, and Policies that create obligations on the part of Government

Right to Health

Nigeria became a signatory to various treaties and conventions meant to promote the wellbeing of the human person. Two of such notable conventions are: The Universal Declaration on Human Rights and the African Charter on Human and People's Rights.

The Universal Declaration on Human Rights²⁴, provides that everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control²⁵. The right to health is provided in the International Covenant on Economic, Social and Cultural Rights (ICESCR) as follows: "*The State Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*"²⁶.

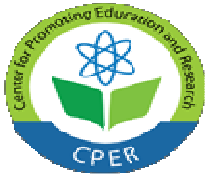
Similarly, the Covenant on the Rights of the Child provides that: "*State parties recognize the right of the child to the enjoyment of the highest attainable standard of health*"²⁷.

²⁴ The UDHR, though not binding, but can be argued has attained some legal effect as to become part of customary international law – United States Diplomatic and Consular Staff in Tehran (United State of America/Iran Judgment ICJ Reports, 1980, 3 para. 91 (24 May 1980)

²⁵ Article 25 UDHR

²⁶ Article 12 (1) International Covenant on Economic, Social and Cultural Rights

²⁷ Article 24 (1) Conventions on the Rights of the Child



In a similar vein, the African Charter on Human and Peoples Right provides that: “Every individual shall have the right to enjoy the best attainable state of physical and mental health”²⁸.

Other covenants which affirm the right to health include the Alma Ata adopted at the International Conference on Primary Health Care in 1978; Convention on the Elimination of All Forms of Racial Discrimination²⁹; International Labour Organization No 169³⁰ concerning indigenous and Tribal Peoples in Independent Countries; the International Convention on the Elimination of all Forms of Racial Discrimination; the European Social Charter³¹; the Charter of Fundamental Rights of the European Union³²; the American Convention on Human Rights³³; the American Declaration of the Rights and Duties of Man; the American Convention on Human Rights³⁴; the Protocol of San Salvador³⁵, etc.

The concept of a human rights to health did not develop until after the second World War when the World Health Organization (WHO)³⁶, a specialized agency of the UN. The WHO is the first international legal document to contain an explicit right to the health. Several bodies have adopted numerous resolutions affirming and reaffirming the right to health³⁷. Thereafter, several other documents have provisions relating to the right to health, more significantly, in the ICESCR.

Regarding the applicability of these treaties and conventions within domestic framework, it is instructive to note that with the exception of the African Charter on Human and People’s rights, which has been incorporated into domestic legal order, no other treaty bearing on the right to health has direct application in Nigeria. Like most common law countries, Nigeria adopts a dualist approach in receiving international law; meaning that notwithstanding ratification, treaties acquire legal force only upon enactment by the National Assembly. That is, domestication of an international treaty is a necessary condition for the application of the treaty in the country. The right to health is contained in some 60 national constitutions³⁸. Some states, in their national Constitutions have included provisions for the protection of the right to health; for example, the 1987 Philippines constitution provides for the right to health in its article when it provides that: “*The State shall protect and promote the right to health of the people and install health consciousness among them*”³⁹

Locally, chapter 2 Section 17 (3) (d) of the Constitution of the Federal Republic of Nigeria 1999[as amended] provides: “that the State shall direct policy towards ensuring that there are adequate medical and health facilities for all persons”⁴⁰. Though this chapter of the Constitution being the Fundamental Objectives of government has been rendered non-justiciable by virtue of Section 6(6)(c) of same Constitution and affirmed in the landmark case of Archbishop Anthony Olubunmi Okogie & others v. Attorney General of Lagos State⁴¹ relief is

²⁸ Article 16

²⁹ By its Article 5 (a) which provides that “State parties shall take up all appropriate measures to eliminate discrimination against women in the enjoyment of „the right to protection of health and to safety in working conditions, including the safeguarding of the function of reproduction”

³⁰ Article 25

³¹ Article 11 European Social Charter

³² Article 2 and Article 35 of the Charter of Fundamental Rights

³³ Article 4 of the American Convention

³⁴ Article 1 of the Declaration

³⁵ Article 10 of the Protocol of San Salvador

³⁶ The WHO came into force on April 7, 1948

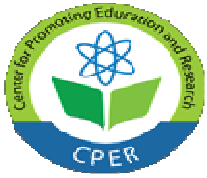
³⁷ The World Health Assembly (WHA), Human Rights WHA Res 23.41 (21 May 1970) (reaffirming that the right to health is a fundamental right); Paragraph 1 of the Alma-Ata Declaration of Alma-Ata (12 September 1978) in World Health Organization (ed.), from Alma-Ata to the year 2000 Reflection at the mid-point, 1988. The Declaration was adopted by the International Conference on Primary Health Care, convened by the WHO and UNICEF and attended by country, UN and NGO Delegates.

³⁸ O. Schechter, “International Law in Theory and Practice. General Course in Public International Law” (1982-V) 78 RdC 9, 334

³⁹ Article II, section 15

⁴⁰ Chapter 2 Section 17 (3) (b) Constitution of the Federal Republic of Nigeria

⁴¹ Okogie v. Attorney General of Lagos State(1981) 1 NCLR 105



found in Section 13 of same Constitution which clearly provides: “*It shall be the duty and responsibility of all the organs of government, and of all the authorities and persons, exercising legislative, executive, and judicial powers, to conform to, observe and apply the provisions of this chapter of the Constitution*”. This provision is to the effect that the Government of the day may be judged in the eyes of its citizenry by simple reference to its achievements regarding the fundamental objectives made in Chapter 2 of the Constitution. Buttressing this assertion is the provision in Section 14(2)(b) which is to the effect that security and welfare shall be the purpose of government. Welfare of the citizenry is paramount and thus forms the essence of government without which the government cannot justify its existence. Agreeably, welfare is a very broad term and before every rational member of the society it is impossible to assume an average state of public welfare in the society without reference to the health of the population in question.

Right to Dignity of human person

Like the right to health discussed above, Chapter 4 Section 34 of the Constitution of the Federal Republic of Nigeria 1999(as amended) rightly provides for the right of the citizen to dignity of his person. By virtue of this right as outline in 34(1)(a):

“No person shall be subject to torture or to inhuman or degrading treatment”.

From a layman’s perspective of the above law, the only clear element is torture whereas inhuman or degrading treatment may be considered a complex phrase for which appropriate interpretation is required. However, researchers have rightly identified the scope of the right to dignity of the human person. Kaufman et al (2011) have identified some of the violations of the rights to human dignity to include: ***social exclusion***, rape, torture, labor exploitation, bonded labor, and slavery. Social exclusion presupposes inequality and inequity in which case it may be affirmed that any arrangement that socially exclude a certain category of citizens such as NCD sufferers from access to healthcare has violated their fundamental right to dignity of person.

The National Health Act 2015

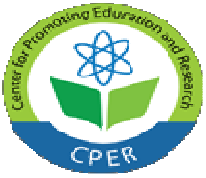
This Act⁴² is the first National health legislation encompassing the various legal frameworks to drive regulation, development and management of a National Health System; set standards for rendering health services in the Federation and other matters concerned therewith. We have examined some of its provisions in relation to effective healthcare.

A. Health Funding

Section 11 of the Act provides for a Health Provision Fund to which the Federal Government shall contribute one percent (1%) from the consolidated revenue fund. Fifty percent of the fund shall be for the provision of basic minimum package of health services to citizens. Section 11 is stated thus:

- (1) There is established the Basic Health Care Provision Fund (in this Act referred to as "the Fund"),
- (2) The Basic Health Care Provision Fund shall be financed from:
 - a. Federal Government annual grant of not less than one per cent of its Consolidated Revenue Fund.
 - b. Grants by international donor partners; and
 - c. Funds from any other source.

⁴² National Health Act Laws of Federation of Nigeria 2015



(3) Money from the Fund shall be used to finance the following:

- a. 50% of the Fund shall be used for the provision of basic minimum package of health services to citizens, in eligible primary or secondary health care facilities through the National Health Insurance Scheme (NHIS)
- b. 20 per cent of the Fund shall be used to provide essential drugs, vaccines and consumables for eligible primary health care facilities;
- c. 15 per cent of the Fund shall be used for the provision and maintenance of facilities, equipment and transport for eligible primary healthcare facilities; and
- d. 10 per cent of the Fund shall be used for the development of human resources for primary health care;
- e. 5 % of the fund shall be used for emergency medical treatment to be administered by a Committee appointed by the National Council on Health.

(4) The National Primary Health Care Development Agency shall disburse the funds for subsection 3 (b),(c) and (d) of this section through State and Federal Capital Territory Primary Health Care Boards for distribution to Local Government and Area Council Health Authorities.

(5) For any State or Local Government to qualify for a block grant pursuant to sub-section (1) of this section, such State or Local Government shall contribute:

- a. In the case of a State, not less than 25 per cent of the total cost of projects; and
- b. In the case of a Local government, not less than 25 per cent of the total cost of projects as their commitment in the execution of such projects.

(6) The National Primary Health Care Development Agency shall not disburse money to any:

- a. Local Government Health Authority if it is not satisfied that the money earlier disbursed was applied in accordance with the provisions of this Act;
- b. State or Local Government that fails to contribute its counterpart funding; and
- c. States and Local Governments that fail to implement the national health policy, norms, standards and guidelines prescribed by the National Council on Health.

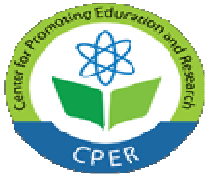
(7) The National Primary Health Care Development Agency shall develop appropriate guidelines for the administration, disbursement and monitoring of the Fund with the approval of the Minister

B. Access to health care

By virtue of Section 15 of the Act, every citizen of Nigeria is entitled to a basic minimum package of health services however; the Minister of Health in consultation with the National Council on Health has the prerogative to prescribe the set of health services that will constitute the basic minimum package. Though the general access to health is emphasized by Section 3(3) of the Act which provides:

Without prejudice to the prescription by the Minister in section 3(1) of this Act, all Nigerians shall be entitled to basic minimum package of health services.

According to Section 20 of the Act, a health care provider, health worker or health establishment shall not refuse a person emergency medical treatment for any reason whatsoever? The basic minimum health package is



defined in Section 64 of the Act to mean the set of health services as may be prescribed from time to time by the Minister after consultation with the National Council on Health.

C. Other Provisions

Other notable provisions include:

- a. Universal Health Coverage and meet the Millennium Development Goal (MDGs) target. Elimination of quacks from professionalism and provides basic health funds needed by Nigerians;
- b. Provide healthcare insurance to certain class of people who are actually deprived
- c. Reduce maternal and infant mortality rate; more pregnant women have access to free delivery services while their children are assured of standard pediatric services in the nation's health facilities;
- d. Improved funding of health care services at the grass root so that people don't have to travel far to access medical services;
- e. Empower the States to participate in improving health centers through a counterpart fund that would enable them benefit from the consolidated funds;
- f. Cut down on medical tourism plaguing the health sector of the country: ailments that can be treated in Nigeria will no longer be referred abroad; eliminate gross abuse of tax payer's money on account of the incessant foreign medical trips by political and public office holders
- g. funds mapped to be used to train nurses and midwives;
- h. Provide health care insurance for certain class of people and the less privileged;
- i. NHIS to provide health coverage for pregnant women, children under five years, the elderly and the physically challenged persons;

The National Health Insurance Scheme (NHIS) Act 2005⁴³

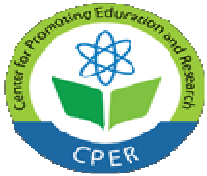
Nigeria's National Health Insurance Scheme (NHIS) was established by virtue of Decree No.35 of 1999 to improve health care delivery by providing a sustainable alternative source of funding health care services. The scheme was not operational till June 2005. NHIS is a social security arrangement that provides financial security to the citizens against unforeseen ill health. The Scheme comprises programmes that cover formal sector workers, informal sector workers and the vulnerable groups.

Section 5 of the Act gives the specific objectives which include to:

- a. Ensure that every Nigerian has access to good health care services;
- b. Protect families from the financial hardship of huge medical bills;
- c. Limit the rise in the cost of health care services;
- d. Ensure equitable distribution of health care costs among different income groups;
- e. Maintain high standard of health care delivery services within the Scheme;
- f. Ensure efficiency in health care services;
- g. Improve and harness private sector participation in the provision of health care services;
- h. Ensure adequate distribution of health facilities within the Federation;
- i. Ensure equitable patronage of all levels of health care;
- j. Ensure the availability of funds to the health sector for improved services.

The responsibilities of the scheme are defined under Section 6 of the Act. It provides thus:

⁴³ National Health Insurance Act Cap. N42, Laws of the 2 Federation of Nigeria, 2004



The Scheme shall be responsible for-

- a. registering health maintenance organizations and health care providers under the Scheme;
- b. issuing appropriate guidelines to maintain the viability of the Scheme;
- c. approving format of contracts proposed by the health maintenance organizations for all health care providers;
- d. determining, after negotiation, capitation and other payments due to health care providers, by the health maintenance organizations;
- e. advising the relevant bodies on inter-relationship of the Scheme with other social security services;
- f. the research and statistics of matters relating to the Scheme;
- g. advising on the continuous improvement of quality of services provided under the Scheme through guidelines issued by the Standard Committee established under section 45 of this Decree;
- h. determining the remuneration and allowances of all staff of the Scheme;
- i. exchanging information and data with the National Health Management Information System, Nigerian Social Insurance Trust Fund, the Federal Office of Statistics, the Central Bank of Nigeria, banks and other financial institutions, the Federal Inland Revenue Service, the State Internal Revenue Services and other relevant bodies;
- j. doing such other things as are necessary or expedient for the purpose of achieving the objectives of the Scheme under this Decree.

A. Administration and Provision of Services

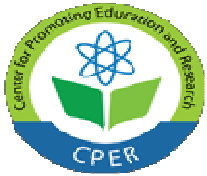
NHIS is charged with the responsibility of regulating the Scheme (Public and private sector). NHIS is responsible for registering Health Maintenance Organizations (HMOs) and Health Care Providers (HCPs), issuing appropriate guidelines for the scheme and determining, after negotiation, capitation and other payments due to HCPs, by the HMOs. The HMOs are limited liability companies (private or public owned) charged with the responsibility of collecting contributions, paying HCPs for services rendered and ensuring quality assurance. Healthcare services are provided by registered private and public hospitals and clinics (HCPs). Beneficiaries (Enrolees) are to register through an HMO and choose a primary HCP which serves as their first contact („gate keeper“) to the scheme and coordinates their access to secondary and tertiary level care.

B. Provider reimbursement

Health care providers under the scheme are classified as primary (the gate keeper-private hospitals and clinics, primary health care centres and outpatient departments of general, teaching or specialist hospitals), secondary (general hospitals including other medical centres, Pharmacies, Laboratories, Dental clinics, Radiography centres, Physiotherapy clinics e.t.c.) and tertiary (specialist and teaching hospitals).

Health care providers under the scheme are paid either by capitation or fee-for service rendered. Capitation is the payment to a primary health care provider by the HMOs on behalf of a contributor; this is made monthly whether or not the services are used. Fee-for service is made by HMOs to non-capitation receiving health care providers who render services on referral from other health care providers. When a registered beneficiary in a health facility consumes some form of health care, the beneficiary does not need cash to access required treatment except the 10% co-payment for the cost of drugs. Thus the usual practice of converting assets to cash in order to pay for health care (catastrophic health expenditure) can be avoided.

C. Scope of Coverage



The contributions paid cover healthcare benefits for the employee, a spouse and four biological children below the age of 18 years. More dependants or a child above the age of 18 could be covered on the payment of additional contributions by the principal beneficiary. The benefit package is comprehensively designed to cover most of the health care needs of Nigerians. Health care providers under the Scheme are to provide the following to the contributors:

- a. Out-patient care, including necessary consumables.
- b. Prescribed drugs, pharmaceutical care and diagnostic tests as contained in the National Essential Drugs List and Diagnostic Test Lists.
- c. Maternity care for up to four live births for every insured contributor/couple in the Formal Sector Programme.
- d. All new born eligible to cover will be covered during the postnatal period of twelve weeks from the date of delivery.
- e. Preventive care, including immunization, as it applies in the National Programme on Immunization, health education and family planning education.
- f. Consultation with specialists, such as physicians, paediatricians, obstetricians, gynaecologists, general surgeons, orthopaedic surgeons, ENT surgeons, dental surgeons, radiologists, psychiatrists, ophthalmologists, physiotherapists, etc.
- g. Hospital care in a standard ward for a stay limited to cumulative 21 days per year.
- h. Eye examination and care, excluding spectacles and contact lenses.
- i. A range of prostheses (limited to artificial limbs produced in Nigeria).
- j. Preventive dental care (including consultation, dental health education, amalgam filling, and simple extraction).

D. Exclusions

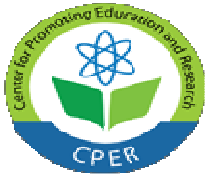
The following conditions and procedures are excluded from the benefit package of NHIS.

- a. Occupational/industrial injuries and Injuries resulting from natural disasters, social unrest and extreme sports
- b. Transplant and cosmetic surgeries
- c. Drug abuse/addiction
- d. Epidemics
- e. Family planning commodities
- f. Domiciliary treatment
- g. Advanced procedures e.g. for complex congenital abnormalities, artificial insemination and IVF.
- h. Post-mortem examination

National Health Policy 2016⁴⁴

Before the adoption of the new Health policy by the National Council on Health, the nation's highest decision making body in the health sector, on September 2016, the health sector has seen a lot of documentary reforms. The trend in success and failures agrees with the fact that whereas a national health policy constitutes a suitable framework for the design and successful implementation of a government-led comprehensive health sector reform in Nigeria, its realization depends on a myriad of factors such as good governance, accountability, political to mention a few. The deplorable state of the national health system still subsists 19 years after it was ranked 187th

⁴⁴ Revised National Health Policy, Federal Ministry of Health, Abuja



out of 191 member States by the World Health Organization (WHO)⁴⁵. More worrisome is the fact that nothing seems to have changed. A look at the Revised Health Policy reveals the following problems duly acknowledged under the following headings:

A. “Health status

- a. *Most of Nigeria’s disease burden is due to preventable diseases and poverty is a major cause of these problems.*
- b. *Some other health status indicators like under-5 mortality rate and adult mortality rate are higher than the average for sub-Saharan Africa.*

B. Health policy, legislation, and health sector reform agenda

- a. *There is a limited capacity for policy/plan/programme formulation, implementation, monitoring and evaluation at all levels.*
- b. *Primary Health Care (PHC), which forms the bedrock of the national health system, is in a comatose state because of poor political will, gross under funding, and lack of capacity at the local level.*

C. Health service delivery and quality of care

- a. *A very high proportion of primary health care facilities serve only about 5-10% of their potential patient load, due to consumers’ loss of confidence in them, among other causes.*
- b. *The secondary health care facilities are in prostate conditions.*
- c. *Diagnostic and investigative equipment in tertiary health institutions are outdated.*
- d. *The referral system between various types of facilities is non-functional or ineffective*

D. Health finance

- a. *Public expenditure on health is less than \$8 per capita, compared to the \$34 recommended internationally. Private expenditures are estimated to be over 70% of total health expenditure with most of it coming from out-of-pocket expenditures in spite of the endemic nature of poverty.*
- b. *There is no broad-based health financing strategy.* ⁴⁶

3.2 Interventions and Legislations directed to NCD sufferers

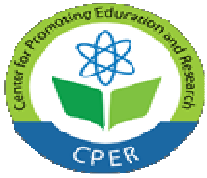
It is very evident that Nigeria is rich with legislations and policies directed towards the provision of health care to its teeming population.

Funding is a major component of any healthcare infrastructure, and having regard to the enormous costs of healthcare, the 1% grant from the consolidated revenue as stipulated in the National Health Act is meager and inadequate for providing the basic minimum package of health services to the Nigerian people. Regrettably, the present administration seemed to have disregarded this vital 1% provision in the Act in its health budget

It is instructive to note that the widely praised National Health Act gives power to the Minister of Health to ascertain the basic health facility every citizen is entitled to enjoy. This is a bit obscure as the level of care covered may be altered at will by the Minister in consultation with the National Council on Health regardless of the effect of such on the citizenry. Also in determining persons who may be entitled to exemption from payment for health services in public health establishments the Minister shall have regard to “the needs of vulnerable groups such as women, children, older persons and persons with disabilities.”

⁴⁵ World Health Report: Health Systems - Improving Performance. Geneva: World Health Organization, 2000

⁴⁶ Revised National Health Policy



There is no doubt that such obscure provisions may constitute a clog in the wheel of effective health care delivery.

The Act also harps on Health insurance which is a function of an employee/employer's financial strength. According to the NHIS, in addition to the cost of package chosen by an enrollee, there is also burden of 10% co-payment for drugs at the Healthcare provider. It is instructive to note that majority of NCD sufferers are often unemployed or those who have lost their jobs as a result of the resultant incapacity from the disease hence cannot be potential contributors to the health insurance. The implication is that the NHIS is not presently structured to alleviate the financial burden on NCD sufferers having regard to the chronic nature of the diseases. Hence, it may be rightly affirmed that the legislative and policy frameworks do not guarantee the protection of those persons with NCDs.

3.3 Enforceability of the fundamental rights to Health and dignity of the Human Person

The right to health as enshrined in Chapter 2 of the Constitution of the Federal Republic of Nigeria 1999[as amended] was declared non-justiciable in the landmark case of *Okogie v. Attorney General of Lagos State*⁴⁷. Following that case it has become difficult for any citizen to challenge Government's failure to providing equitable access, to healthcare on grounds of the constitutional provision hence persons with NCDs are consequently placed at odds.

The Right to dignity of person is connected to the right to health especially as it affects equitable access to healthcare. It is worthy of note that the right to dignity of human person unlike the right to health is a fundamental right the breach of a fundamental rights action is maintainable through the Fundamental Rights (Enforcement Procedure) Rules.⁴⁸ This is captured by Section 46(1) and (2) of the Constitution of the Federal Republic of Nigeria 1999[as amended], which provides that "any person that alleges a breach or a possible breach of his fundamental rights and freedoms under Chapter IV of the Constitution may apply to a High Court in that State for redress; and the High Court shall have original jurisdiction to hear and determine any application made to it, and may make such orders, issue such writs and give such directions as it may consider appropriate for the purpose of enforcing or securing the enforcement of any right within the State"⁴⁹.

The High Court in this context refers to any of the Federal High Court, State High Court or the High Court of the Federal Capital Territory⁵⁰. It is also worthy of note that the provisions of the aforementioned law is to the effect that no human rights case may be dismissed or struck out for want of locus standi. In other words, human rights activists, advocates or groups as well as any non-governmental organizations, may institute human rights application on behalf of any potential applicant⁵¹. As interesting as it may sound, the right to dignity of human person is so clumsily captured in the Constitution making it somewhat difficult to define the scope of the right. The effect of the aforementioned lacuna is that though the right to dignity of human person as applicable to social exclusion is enforceable, the documentary opacity of its scope may becloud its enforceability on the part of the ordinary citizen.

3.4 The Way out of the Quagmire: The Legal Informatics Approach

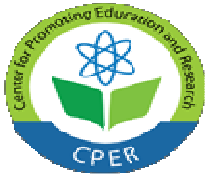
⁴⁷ *Okogie v. Attorney General of Lagos State*(1981) 1 NCLR 105

⁴⁸ Fundamental Rights (Enforcement Procedure) Rules, 2009

⁴⁹ Section 46(1) and (2) of the Constitution of the Federal Republic of Nigeria 1999[as amended]

⁵⁰ Order 1, rule 2 of the Fundamental Rights (Enforcement Procedure) Rules, 2009

⁵¹ J. Kanyip, "The fundamental rights (enforcement procedure) rules, 2009: the constitutionality of the abolition of locus standi and time limitation", 2015. <https://jkanyip.wordpress.com/2015/08/08/the-fundamental-rights-enforcement-procedure-rules-2009-the-constitutionality-of-the-abolition-of-locus-standi-and-time-limitation/> last accessed 4 January 2019



There is no gainsaying that NCDs are a terror to the continued corporate existence of Nigeria. The Government though have not shown adequate preparedness to combat the menace, must wake up from its slumber and put up measures towards lessening the burden of the sufferers.

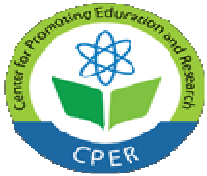
The National Health Act 2015 has been praised as “one stop shop” legislation. Having regard to the provision of the Act which empowers the Minister of Health to ascertain persons who may be entitled to exemption from payment for health services in public health establishments especially with regard to the “the needs of vulnerable groups such as women, children, older persons and persons with disabilities”, ***the ultimate question that arises is how would the Minister determine such without a functional information-driven health delivery system?*** In response to the above question especially as it affects NCD sufferers, we have proposed an informatics model that may be explored. The informatics model is a single window system of care which will enable all stakeholders in the healthcare delivery system especially NHIS, health maintenance organizations(HMOs), healthcare providers(HCPs), Employers, Employees, Sufferers, Justice authorities, and other relevant stakeholders have a single window of communication through which cases of care and resulting health management contracts could be initiated, monitored, executed, and where breaches against timely intervention could be reported and offending parties prosecuted.

The model is an integrated computerized system (with a critical national database infrastructure) that allows communication over the Web and mobile phones. The model is presented in Figure 3.1. In the system the roles and responsibilities of all key stakeholders are captured through a central database. Communication flows are also defined as well as what constitutes breaches. The key stakeholders are identified as actors and include the following:

- i) NHIS office
- ii) HCPs
- iii) HMOs
- iv) NCP sufferers
- v) NHRC office
- vi) Ministry of Justice
- vii) Ministry of Health
- viii) Nigeria Centre for Disease Control

Features of the System

The Single Window of Care connects all parties involved in the healthcare management. It would enable care seekers (NCD sufferers) to have 24-hour access to the healthcare. It also connects government agencies to facilitate the processing and approval of requests, complaints; and breaches. The functions participants like NHIS, HMOs, HCPs, Ministry of Health, and Nigeria Centre for Disease Control (NCDC), Ministry of Justice, and National Human Rights Commission in the new arrangement will be extended to ensure that NCD sufferers have access to care. Like in the existing arrangement of the NHIS scheme, the new arrangement will require that NCD sufferers be registered with designated Health care Providers (HCPs) who would have the capacity to establish to determine if the case qualifies as a NCD as well as the social status of the sufferer. Based on the above, the Ministry of Health will give consent to enable the sufferer receive treatment with or without any personal financial commitment to the HCP. Where consent is granted and scope of treatment defined for the Sufferer, the rights of the sufferer are automatically registered on the system. Such rights can be enforced by the Ministry of Justice and the NHRC if



breached in any way thereafter. The NHIS determines the likely cost of treatment and establishes formal entries to the system to that effect and relates with the HCP regarding the payment of the approved intervention on behalf of the NCD sufferer. The NCD sufferer can transmit requests, complaints, assess the status of any intervention through his phone or web (where necessary). The NCDC takes notice of all NCD cases and executes existing policies in consultation with the Ministry of Health regarding the prevention and control. In a nutshell the functions of the system include:

- Integration of all levels of care for the NCD sufferers such as lodgment of requests, complaints, documents, documentation, capitations/fee-charges, etc.
- Tracking of health transactions from the time documents, requests, complaints are lodged to the post-treatment period.
- Provision of health statistics for budgeting, planning and other decision making processes.
- Reporting of human rights breaches on the part of the HMOs, HCPs, etc. as to their failure to cater for requests made by the NCD sufferers.

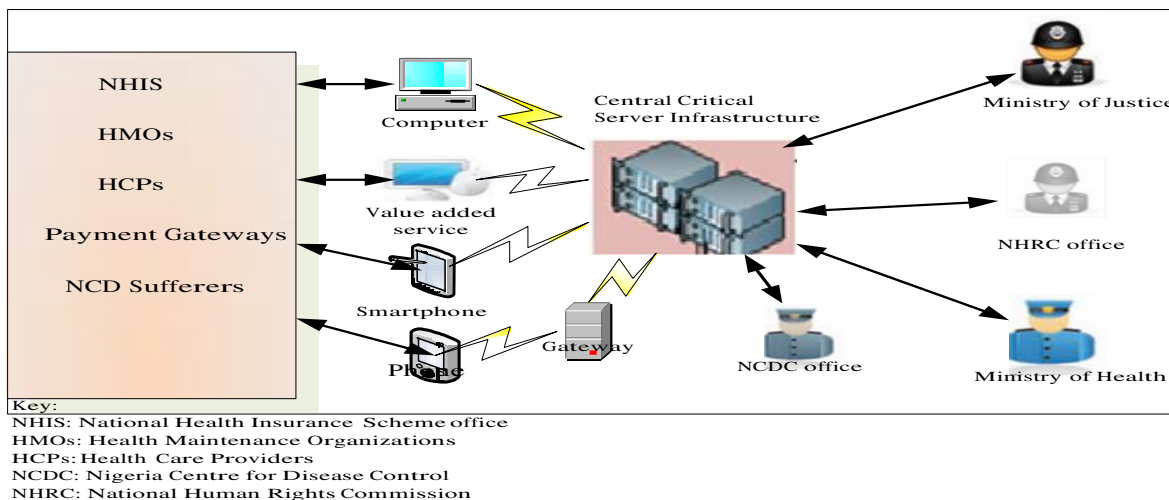


Figure 3.1: The Single Window Model for Managing NCD Sufferers

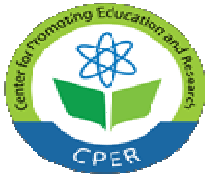


Figure 3.2 shows the NCD intervention flow under the single window mode using a use case diagram. The cycle stipulates the flow of communication and data in the single window model of care. Each use case (sphere) specifies the basic roles of the stakeholders. Some of the information exchanged between the stakeholders is automatically triggered. For instance, when an approval of a case occurs, the NCD receives a message to commence treatment at approved HCP.

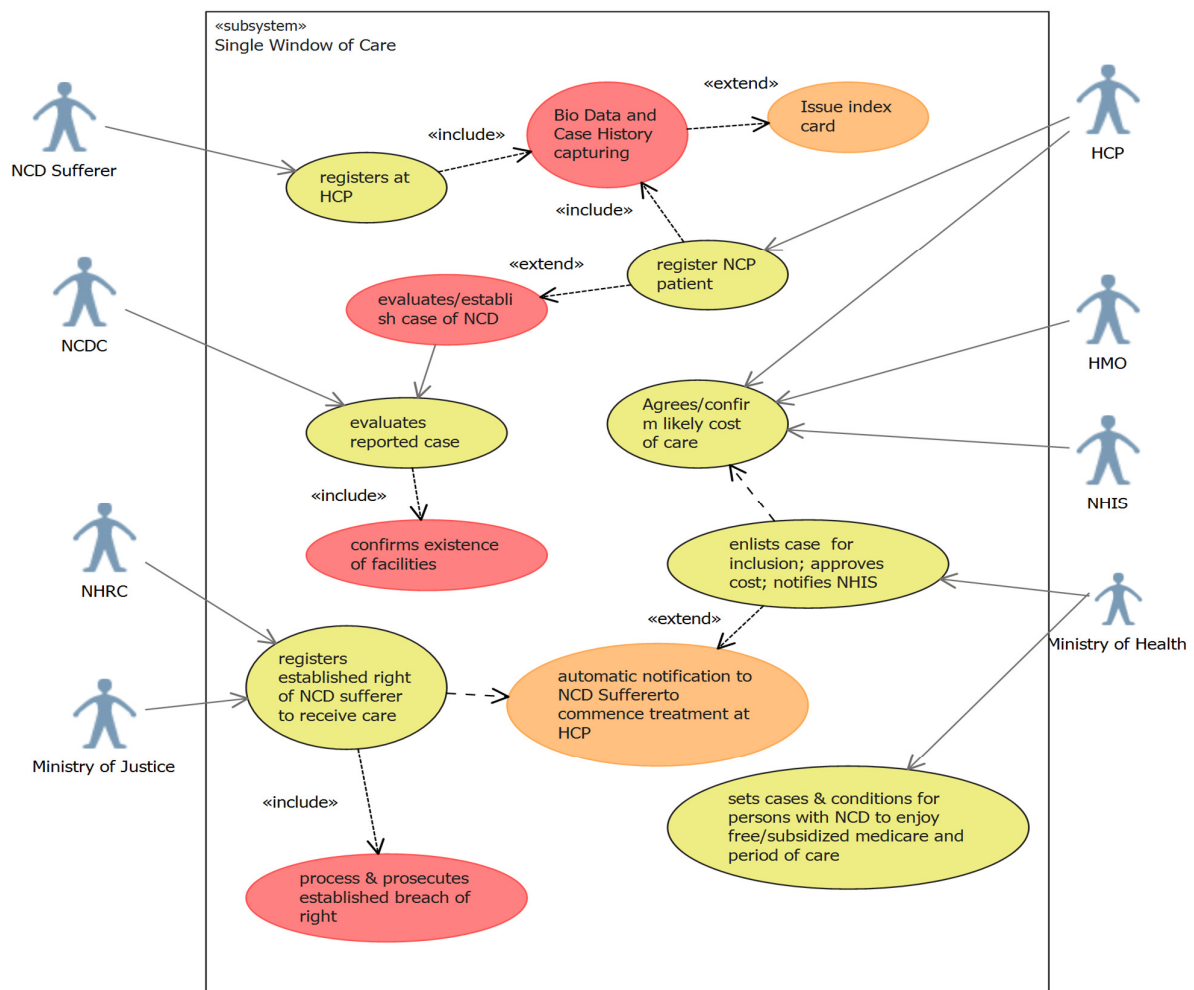
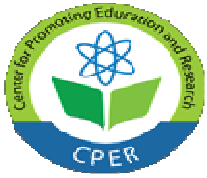


Figure 3.2: NCD care Intervention use case diagram



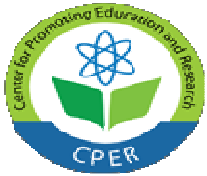
4. Conclusion

NCDs pose grave danger to the corporate existence of Nigeria. Nigeria has a plethora of health policies and legislations the chief of which is the Constitution of the Federal Republic of Nigeria 1999[as amended] and the National Health Act (NHA) 2015. While the provisions of the said NHA are commendable, there are some obscurities as to some of its provisions which may constitute a clog in the wheel of effective and efficient health care delivery especially as it affects the sufferers of NCDs who may not have the wherewithal to cater for their often protracted illnesses.

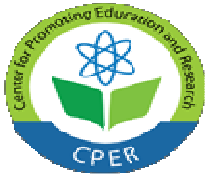
The same is true for the Constitution whose provisions as to the rights to health and dignity of the human person are enshrouded in ambiguity. As for the NHA, a window exists whereby the Minister is empowered to determine those persons that may be entitled to enjoy healthcare without treatment. However, in a nation of about 200 million people with large geographical area, real-time information is required for the ministry of health to perform this function. Based on the foregoing, we conceived a single window of care especially for the sufferers of NCDs. Christened “informatics model”, the system is expected to provide a 24/7 real-time information exchange platform for all stakeholders in the healthcare delivery channel. We believe that the adoption of this model will guarantee prompt effective response to the increasing menace of NCDs which have remained the all-time single leading cause of death in Nigeria and nations around the world.

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