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Health Service Delivery in Nigeria: Managing The Organizational Environments

Kelly Bryan Ovie Ejumudo, Ph.D
Department of Political Science, Delta State University, Abraka, Nigeria

Abstract
The issue of poor performance by the public sector in Nigeria has been a topical one. While the principal and growing function of Governments in the developing countries like Nigeria is to ensure an equitable distribution of public goods and services to its citizens, service delivery in the country has not only been below public expectations, it has also not been integrated into the public sector operations, processes, procedures, workings and management. In the public health sector, the situation is worrisome because of the nexus between health statuses, human and institutional capacity as well as national development. This study which examines the critical role of the management of environmental stakeholders in quality service delivery derived its data from in-depth analysis of valuable secondary sources. The study recommended, among others, the exigency of a service culture and development orientation in the public health sector, proactive and pragmatic management of health institutions and organizations as well as their interface with key environmental stake holders (players) and concerns and a synergistic mentality and systemic practice.
Keywords: health, service delivery, organizational environment and performance.

1. Introduction

Service, that has become the focus of increasing managerial attention and represents a major portion of the economies of the world's developed countries is at the heart of organizational performance, whether in the public or private realm. The centrality of service in public and private sector organizations and institutions is inextricably linked to the functionality, operationality, growth and development of societies because such organizations and institutions exist in, operate and are shaped by their environments. Service delivery therefore requires management of the en v has sundry stakeholders including external customers that expect real value for their money employees or internal customers that are critical to external customers satisfaction and loyalty, suppliers creditors, regulators and the like This view-point is hinged on the understanding that the above environmental stakeholders are critical active players with a valuable role in the service delivery process

In the public sector, despite the expectations of the public and the strategic role of the sector its poor performance has been a topical one (Ejumudo 2010). Although public sector performance was taken for granted they are today under attack for lack of performance In fact while public sector organizations and institutions are the shopping floor for government business, Nigerians have regrettably been short-changed by the quality of public service delivery Notably, governmental organizations have over the years been showcases for the combined evils of inefficiency ineffectiveness lawlessness and corruption and, as a consequence, impediments to effective implementation of government policies. It is therefore not surprising that in 1984 the African Association for Public Administration and Management organized a round table conference in Nairobi where the public service crisis was discussed (AAPAM 1984) and in December 2003 a team of experts was commissioned to re the state of service delivery in Nigeria including the examination of the institutional environment for service delivery the reflection on people's views and experiences and the determination of a road map for effective service delivery programmes The committee s findings suggest that services in Nigeria are not serving the people they are inaccessible poor in quality and indifferent to customers' needs As a result public confidence is poor, inequality level is high and institutional arrangements are confusing and wasteful No wonder the United States Ambassador to Nigeria, Terence McCulley, identified non-performing public health system as one of the reasons why Nigeria is underdeveloped (Vanguard 2011)

Since the primary purpose of Government is to improve the quality of life of its citizens the need for a far reaching transformation of the Nigerian public sector through action based service delivery programmes that will serve as a step in the process of actualizing a people-oriented government that is not disconnected from the people has become a reality. To this end, public institutions that have a social obligation to render services to the people have to brace up

to meet and exceed their legitimate expectations. In the health sub-sector, successive governments in Nigeria have paid lip service to its development, management and service delivery capacity, efficiency and effectiveness. Such lip service has the concomitant effect of neglecting the management component in the implementation of health development plans and programmes. This study therefore examines the critical role of managing the environmental stakeholders in the health sector for quality service delivery in Nigeria and recommends an attitude and climate change and collaboration with the key environmental players where service delivery is esteemed as the culture, going concern and logic behind public health sector existence.

2. Methodology

This study adopted a qualitative case study method. This research method, according to Robert Yin (2003), has three aspects viz: investigation of a contemporary phenomenon within its real life context, the existence of boundaries between the phenomenon and the real life context and the use of multiple sources of evidence. The qualitative case study method also lends itself to exploratory, descriptive and explanatory methods. Yin emphasized that exploratory research attempts to find out about a situation, while the descriptive and explanatory research types respectively seek to know "what happened" and how and "why it happened." This study which examined electoral fraud and the legitimacy crisis in Nigeria however attempted a description and an explanation of electoral fraud and the implication for the legitimacy crisis of governments and governance in Nigeria through in-depth analysis of valuable secondary sources of data.

3. Service: A Conceptual Clarification

The word service was derived from the Latin word "servus" which means slave (Ericson 2009). Services have often been associated with menial work performed by low or unskilled workers. Technological advances in manufacturing during the Industrial Revolution of the 19th century decreased the labor required to produce goods and at the same time improved the standard of living (Campbell *et al.* 2009). As a result, both the demand for services and the labour available to provide them increased. But it has been only with the past 50 years or so that there has been significant growth in services in industrialized countries, catalyzed in large part by advances in information technology. The current economic period is often referred to as the information or service economy, which is considered the successor to the manufacturing or industrial economy that succeeded the agrarian economy that was dominant through the middle of the 19th century.

Services, until recently, were not considered to add value to an economy (Ejumudo 2009). As a result, measures of service activities were not even included in the calculation of the gross national product (GNP) of a country. Instead, services were usually lumped into a miscellaneous or tertiary category behind agriculture, mining and manufacturing, particularly in the Third World or undeveloped countries. Today, services constitute a major portion of economies in the more highly developed countries, and economic data are now available on many of the major service sectors within these economies, a possible explanation for the search by many customers for something more than just good service. Technology is also transforming the way services are delivered and will continue to do so for the foreseeable future. In the past, service managers typically faced a trade-off in terms of what to provide to their customers. For example, if customers wanted low cost, then it was provided with slower service or less personalized service.

While these trade-offs still exist, technology is allowing managers to move to a superior performance or trade-off curve, thereby creating or adding value for the customer in the form of faster, lower cost, and/or more personalized services. Value can take the form of more personalized services as when you check into hotels like Grand hotel in Asaba, Wellington hotel at Effurun and Sheraton in Abuja and the staff knows you have stayed there before and give you certain preferences. The key for the service organization in creating or adding value for the customer is to provide additional benefits. And to sustainably gain and enjoy the cutting-edge advantage in any service sector or industry, organizational players have to go beyond customer satisfaction extra mile efforts so as to produce customer loyalty that sectoral or market leaders necessarily seek.

4. Health Services: A Conceptual Explanation

Health services include all services dealing with the diagnosis and treatment of disease or the promotion, maintenance and restoration of health (Cayer 2005; Oyibo 2010). They include personal and non-personal health services. A way to look at services is to divide them into the following three broad sectors, recognizing that there some degree of overlap: service industries, ancillary and support services and services in the manufacturing industry.

More specifically, the service sectors include health care, hospitality, financial services, professional services, retail services and transportation. Health services are the most visible functions of any health system, both to users and the general public. Service provision refers to the way inputs such as money, human resource, equipment and drugs are combined to allow the delivery of health interventions. Improving access, coverage and quality of services therefore depends on the availability of these key resources; on the ways services are organized and managed and on the incentives influencing providers and users. In the healthcare business, effective management is needed to ensure that quality services are provided to those in need.

Effective health service delivery in any country is concerned with bringing about an acceptable level of coherent programmes that will assist the country to provide health care to populations having insufficient or no access to health services. It should therefore develop guidelines for National Health Service systems, expressed in terms of their component parts that can he adapted and developed according to national needs. There should be a strong national will to undertake effective intensive action and the country should structure its health services by effective operation in the shortest possible time. It should also employ effective resources allocation, systems analysis, and management methods capable of implementing the decisions taken. Besides, it should adapt and put into use health technology methods, techniques, equipment, etc that are acceptable to the users and those for whom they are used. And finally it should encourage participation, involvement arid coordination in the planning, implementation, monitoring and evaluation of the services by local population and national and sometimes international agencies that can further the achievement of National Health Service goals. In sum, health services that consist of a network of institutions run by the government as part of a country's health administrative system and provide certain indispensable medical care and preventive services should be both accessible and acceptable to the entire population, suited to its needs and the socio-economic conditions of the country.

5. Health Sector Organizations and their Environments

Organizations including those in the health sector exist and operate in environments which imply that they have to manage the interface between them and the sundry stakeholders in the relevant environments. The environment, whether public, private or voluntary, connotes personality (Aldag and Brief 2004). It is a set of characteristics that are relatively enduring over time, typifying an organization and distinguishing it from other organizations (Knowles 1982; Forehand and Gilmer 1962; Hefiriegel and Slocum 1974). Such a set of characteristics create a distinctive environment, ecology or climate and it has the tendency or potency of influencing the attitude of its members including individuals, organizations and societies (Pritchard and Karasick 1993; Taguirui 1998). Environment or climate which is a commonly experienced but an abstract phenomenon, and often referred to by many expressions such as atmosphere milieu and culture is a relatively enduring quality of the internal environment that is felt by its members.

Environment that influence organizational behaviour and can be described in terms of the values of organizations, societies and the like (Taguirui 1998) can also be viewed as a global expression of what an organization or a society is (Schneider and Snyder 1995) Environment or climate which can equally be conceptualized as the study of how an organization society or any social system relate or interface with its environment (Webb 2000) consists of multiple or diverse dimensions (Campbell *et al.* 2009) Some environments or climates are considerable warm and supportive while others are indifferent, cold, hostile and competitive (Aldag and Brief 2004) The supportive and warm climate is the type that encourages and protects the individual s sense of personal worth and importance while an unsupportive and cold type is the defensive and manipulative one.

In every organization or society certain factors or elements exert profound influence on the existing environment or climate that is created or constructed whether by design or accidental (Rao *et al.* 1997) James and Jones (1974), for instance, identified five factors that influence climatic creation or construction viz context structure, process system values and norms Climate whether supportive or hostile is critical and can be changed, recreated or reconstructed (Gordon and Goldberg 1977; McClelland and Bumham 1976).

Environment can be internal or external and this leads to the problem of delineating or defining the boundary between the organization and its external environment or between the internal and external components of the organization s environment Some people consider patients in the hospital and students in the university to be part of the internal environment Others see these groups as customers or consumers of the services offered by the two respective organizations and place them in the external environment Most people agree, however that those individuals employed and financially remunerated for their work are part of the internal environment of

organizations All the same while it is reasonable to include within the organizations' environment all those who influence decision making in the organization, it is instructive to note that patients and students only enjoy access to the relevant organizations environments because of the nature of the services they seek or require

Essentially organizations largely depend on their internal and external environments for survival Inputs come from the external environment into the organization Levine and White (1991) referred to the collectivity of relevant others in the external environment as domain and arguably these relevant others must be recognized and considered in the managerial decision-making process. Dill (1998) and Pickle and Abrahamson, (2009) clarified the concept of relevant others when they classified the various stakeholders as follows:

5.1 *Customers*

All the players or stakeholders in an organization are essential to its functionality, operationality and survival; however, the customers are the most important group because the organization's over-riding purpose is the production of economic goods and services for the satisfaction of wants and needs. The customer receives these goods and services and, in addition, they provide the money for management to satisfy other parties or stakeholders. Without the customer, management would be unable to satisfy any group. The customer needs an acceptable quality of goods and services at an acceptable price. Some customers want higher quality goods and services, but expect to pay a higher price for them. What is acceptable quality and price also change constantly. Since the economic system uses competition as motivating device, the satisfaction of customers is a relative and ever- changing concept. The organization must therefore attempt to equal or exceed the efforts of its competitors to satisfy customers. In their attempts to compete, organizations continually change their offerings of goods and services. What satisfies the customer today may not necessarily satisfy him the next day and consequently the demands of the customer change constantly in terms of quality and price. Customers are thus critical to organizational performance, functionality and renewal.

5.2 *Employees*

Health institutions or organizations need employees to produce economic goods and services. The employees depend on the organization for monetary rewards, security and good working conditions as well as many other economic, psychological, and social satisfactions. Development of large organizations after the Industrial Revolution actually allowed absentee owners to bring pressure on management to increase the satisfaction of the owner group at the expense of the employee group. Some of them made use of this power. One employee was of little importance when he was only one out of hundreds or even thousands. Employees did try to combine their efforts and engage in collective bargaining. However, most had little success because management used various methods to avoid collective bargaining, such as firing employees who talked about or tried to form unions. These same employees were also members of a free and democratic society. Extensive labor legislation was the result of these managers being unwilling to satisfy the employee group. Today, employees are not to be seen as mere variable cost to be hired and fired. They are, in fact, the most critical and valuable resource, because all the other resources including financial investments are dormant except they are activated by the human element. Here, health personnel are expected to organize and direct the other resources for result-oriented service delivery in public health institutions. This explains the inevitability of employees recognizing and accepting their status and utilitarian value as internal customers whose inputs are critical to each other's output.

5.3 *Suppliers*

Suppliers are those organizations that provide raw materials, equipment, tools, and any other economic goods or services that the dependent organization uses in the production of economic goods and services. Suppliers also have their own individual wants and needs that management must satisfy. The purchasing health organizations like the university teaching or specialist hospitals are also customers to the suppliers. Just as the supplier cannot exist without the buying organization, the suppliers are critical to the service delivery in the health sector because they provide the necessary physical and material resources including equipment. The satisfaction of suppliers is therefore of paramount importance to the health institutions and organizations, especially as the world is in a competitive environment.

5.4 *Creditors*

Creditors are vital parties-at-interest in the public health sector because when administrators need funds to assemble the factors of production, they must often turn to creditors. As with other parties-at interest, creditors have their particular wants and needs. They demand security of their funds and a payment of interest that is equal to the security of their funds. Management of the health institutions and organizations must satisfy the wants and needs of creditors

if they expect to obtain more funds in the future. In other words, if management does not repay monies borrowed, plus the specified interest rates, it will have a hard time borrowing. Consequently, creditors exert a strong influence on management to force satisfaction of their wants and heeds. Creditors thus play a facilitating and complementary role to public health institutions and organizations, especially when government's funds are inadequate or are delayed due to bureaucratic red-tapism.

5.5 *Government and Owners*

Local, state, and federal governments are a necessary parties-at-interest in any organization. These governments provide the social structure needed for the production of economic goods and services. Governments provide roadways, flood control, police and fire protection, legal systems, national defense, and many other services that are essential to the operation of any health institution and organization. In return for these services, management must support and finance these governments in their operations. Consequently, governments have their own peculiar wants and needs. In order for governments to continue effective operations, organizations must provide approval and support for the basic concepts of the existing government. Financial support of these governments is a different matter, for governments have immediate and powerful weapons with which they are able to force management to satisfy this need. Since governments at all levels are critical .to the operationality and functionality of public health institutions and organizations, the management of such institutions must take the government into consideration in their day- to-day operations and activities. Again, since organizations use governments/owners funds to purchase the factors of production; the latter are essential to customer satisfaction and loyalty. In the public health sector, government as the owner has a critical role to play in service delivery primarily due to the fact that they provide the funds which are investments without which desirable returns in the form of efficient and effective service delivery cannot be a reality. It is therefore incumbent on public sector health institutions to manage the owners who are the investors.

5.6 Communities

For the most part, the communities have wants and needs are they expect the management of health institutions and organizations to be an integral part of the society or environment and to improve and enhance life within the community. Management must, for instance, help the communities in their efforts to enhance the environment for public good. Health institutions and organizations can also develop more intensive training programs to train the people who have been unable to obtain jobs because of lack of skills. Of course, some of the motivation for management's contribution to these areas has been because of governmental action. In addition, management must support many of the local community's organizations drives and initiatives. The community is traditionally slow and indefinite in its actions if its wants and needs are not satisfied. The philosophy and culture of corporate social responsibility has however become an issue that public health institutions and organizations, like their counterparts in the private sector have to adequately address as part of compensation to their operating environment and contribution to the development of society

5.7 Competitors

Of all the parties-at interest, competitors are probably of least importance to management and thus require the least satisfaction in respect of their needs and wants In a system that relies on competition as a major motivating force the only form of satisfaction that management owes its competitors is fair and honest practices Competitors have very few weapons at their command with which to force management to satisfy their wants and needs. However, competitors, like customers and employees, are also citizens in a free, democratic society and have equal voting powers It should also be noted that the satisfaction of competitors has a degree of relationship with satisfaction of customers, for only through competition does management obtain maximum satisfaction of the customer group In fact, competition is the motivating force that produces maximum satisfaction of human wants and needs Therefore, if management is not fair and equitable in its practices toward competitors, then customers cannot obtain maximum satisfaction,

6. A Critical Assessment of Public Health Service Delivery in Nigeria

The public sector as the sector of the economy established and operated by the government and its agencies is distinguishable from the private sector and organized on behalf of the citizenry The public sector is in fact part of the state that deals with the delivery of goods and services by and for the government whether at the national, regional state or the local level and its activities include delivering social services and security, administering urban planning and organizing national defenses. In so far as organizations exist as part of government machinery for implementing

policy decisions and delivering services that are of value to citizens the critical issue is whether there is adequate capacity for the expected quality of service delivery on a sustainable basis.

As far as the public health sector is concerned the primary responsibility of the organizations or institutions is to deliver services that the private sector may not deliver at all or to deliver services to those who cannot afford the market price of the product Fundamentally the ability of a government to legitimately tax and govern people is premised on its capacity to deliver a range of services required by its population which no other player will provide (Olowu 2005). In other words governments owe their existence and their legitimacy to the fact that there are services in which the possibility of market failure is great. Services include those that can be financed by user charges referred to as utilities and those that can only be financed by taxes referred to as services. Although interest has shifted to the partnering and complementary possible roles of the private sector, voluntary organizations, and communities in improving the delivery of public services, the public sector is under severe attack for weak capacity, institutional failures and poor services. Essentially, advances in technology have increased the possibility of greater involvement of several institutional actors in the provision of health services, the need for greater citizen involvement in governmental decision making has compelled governments to seek to enhance the quality of government services at a time when the available resources for delivering such services have suffered decline.

With the poor quality of governance in Nigeria, the delivery of services in the public health sector has notably continually been constrained. Arguably, some incremental efforts have been made in terms of policy formulation and programme execution; such efforts have not significantly translated into concrete improvement and enhancement of public service delivery in the health sector. Two plausible explanations for the poor performance are the decline in governance and near absence of quality culture. There is therefore a growing recognition and acceptance by governments that they do not need to dominate the provision of services. They only need, as a matter of exigency, to provide the enabling environment and play their own roles in an increasingly complex governance environment. As a consequence, the current focus on governance as the totality of institutional structures within a political community as distinct from government that is the state's instrument for formulating and implementing public policies has helped to strengthen the case for institutional capacity and diversity for the efficient and effective delivery of public services in the developing world like Nigeria. The contention of the United Nations Development Programme (UNDP) that sustainable development can be attained only when the tripod of public, private and voluntary sector institutions are recognized, accepted and utilized as legitimate actors in the governance arena depicts the utilitarian value of collaboration, synergy and interdependence in today's service world.

The levels of health care in Nigeria are: tertiary level which is the domain of the Federal Government, secondary or intermediate care level that is under the control of the state governments and the primary health care that is the lowest governmental level of health care under the jurisdiction of the local governments. The tertiary level that the responsibility rests with the Federal Ministry of Health headed by the Minister of Health is the highest level of health care and it provides mutually supportive referral system to the secondary care level. It provides specialist and rehabilitative, while the secondary level provides mutually supportive referral system to the primary health care level that provides at least the essential elements of primary health care that are delivered at the first point of contact between individuals and the health care system. Health service delivery structures are also largely tiered, and federal and state parastatal and agencies have been created to implement programmes and manage services across the different levels. The management of facility based service delivery is tangled in this structure.

The general understanding is that while policy development remains the responsibility of the Federal Government for those health issues that have national impact and cross border implications, State Governments may choose to respond to these national directions in the context of local priorities they have established. They also develop their own policy documents to which state budgets then respond. Responsibility for service delivery is also shared. Again, the general understanding is that the Federal Government is responsible for tertiary care and training of selected health professionals, state governments for secondary care and supervisory oversight of local government health units who are, in turn, responsible for the provision of primary care service delivery activities and its integration community-based outreach and support activities. The tiered health service delivery system in Nigeria has, over the years, been plagued by sundry factors including poor funding and management, disconnect between health policy initiatives, reforms and programmes of different regimes and weak institutional and human capacity building.

The Health and Development Dialogue (HDD) of 2005 had described the Nigerian Health Care Delivery System as blind, lacking the vision of its goals and strategies; ailing and deaf to respond to the cries of the sick and the dying, impotent, seemingly incapable of doing things its neighbouring states have mastered. The WHO (2006) summary

index of the performance of health systems ranking of its 191 member states also placed Nigeria in the 87 position, just ahead of Sierra Leone, Myanmar, Central African Republic and the Democratic Republic of Congo, post conflict war torn countries. The health sector performance in Nigeria had been largely unacceptable as Odumosu et al. (2009) rightly articulated. The health service delivery palaver in Nigeria reached a frightening level that the Federal Ministry of Health with the support of the National Council on Health (NCH) decided to undertake a Health Sector Reform (HSR) to improve the performance of the health service system for better health status of the population. The areas of concern as identified by the above ministry included defining the stewardship roles of the three tiers of government, strengthening the national service delivery system and its management, reducing the disease burden due to priority health problems, ensuring the availability of adequate health services, improving access to quality health services, enhancing customers awareness and community involvement in health and promoting effective partnership and co-ordination.

Beyond the national concern about the urgent need to respond to the health sector crisis with the focus on improving the stewardship role of government at all its operational levels, fragmentation continues to weaken referral capacity, promote duplication of service delivery and health promotion actions and limit the relevance of systematic analysis of needs. Vertically managed priority control programmes also take pride of the day, exacerbating systems challenges and inefficiencies in the management of resources for health care service delivery in Nigeria. The most significant cause of failure remains the yawning gap between plans and achievements, inadequate funding, poor management of available health resources, disconnect between health policy initiatives, reforms and programmes of different regimes, near absence of evaluation culture, relative neglect of preventive health service, increasing cost and poor access, inequity and pro-rich mentality and approach to health service issues and weak institutional and human capacity building. At the heart of the above problems and constraints is the poor realization of the value of and the actual management of the demands of the key environmental stakeholders and concerns of the health sector in Nigeria. The utilitarian value of the management of the environmental demands is arguably critical to delivery of quality and result- oriented services in Nigeria's health Sector.

7. Managing the Health Sector Environment for Effective and Result- Oriented Service Delivery through Service Culture and Development Orientation in Nigeria

Although good health is critical to human welfare and socio-economic development, the health sector in Nigeria has been facing daunting challenges. Considerable awareness and recognition of the challenges prompted the health sector reforms in Nigeria. The adoption of the Millennium Development Goals (MDG5) policy paper and the Nigerian Economic Empowerment and Development Strategy (NEEDS) initiative were also stimulants to the reforms. With the reforms, there has been a groundswell of activities supposedly aimed at tackling the problems underlying the health sector over the decades In pursuance of the reform agenda the Federal Ministry of Health convened a meeting of stakeholders to examine the public private partnership (PPP) option and the ways and means by which the abundant health care resources in the private sector could be harnessed for the benefit of the population (FMOH 2005) The Federal Ministry of Health has also made some efforts to maintain and improve the health sector performance.

In the face of the relatively well articulated health policies and implemented programmes and activities, the health of the Nigerian people is still being threatened and impaired by a largely poor and inefficient health care service delivery system (Aregbeyen 2004) Although it has been argued that despite the tight financial constraints in most developing countries significant improvements in health are still possible if the health authorities in these countries would consider effecting major restructuring of their health sectors for the purpose of enhancing efficiency, equity and effectiveness (World Bank 2004) the central issue is the poor realization of the benefits and value of the interface between the environmental stakeholders and concerns as well as the failure to effectively manage same for quality and result-oriented service delivery. After all, the key indicator of efficient and effective health care service delivery is the provision of health care at minimal cost for public good, which is for maximal benefit and impact. This explains why the first and primary step in the actualization of an enhanced pro-active and quality health care service delivery in Nigeria, is the recognition, acceptance, utilization and management of the interdependence and inter relationship between the different yet critical environmental concerns in the health sector.

This above environmental management will have an in built and in-grained full-blown service culture and development orientation. In this direction, the exigency of a proactive and pragmatic management of the sundry stakeholders viz customers employees, suppliers creditors government/owners communities and competitors cannot be over-emphasized This management requires analyzing, understanding and recognizing customers' needs and

expectations in public health service delivery principally because they (customers) are the focus and beneficiaries of any services requested and offered It therefore follows that the service culture that it demands will see the health service seekers as the king and the reason for the existence of public health service institutions (providers). In this light, public sector health service providers will strive to meet the expectations of customers (health service seekers) through quality and result oriented services Quality services here will include adequate resource allocation and deployment that will culminate in creating the right and clement environment with the appropriate infrastructure, facilities, equipment and drugs The above environment is inevitable considering the fact that several studies (Erinosho 2008; Adetuberu 2004) have documented the limited capacity (due to poor infrastructural base and management of health care and inadequate health manpower) of health institutions to cater for the health care needs of Nigerians.

In as much as managing the customer side of public health sector service delivery in Nigeria is necessary, it is not sufficient. This assertion implies that the employees are not only internal customers in public health institutions and organizations, they are also critical to meeting the expectations of health service seekers (external customers) and possibly exceed same by going extra mile. Health sector personnel should therefore have the right quality training and exposure so that they can be properly skilled, knowledgeable and fit to apply them for enhanced service delivery in the public health sector, especially as institutional capacity is largely a product of the quality of the human element which is at the heart of the wealth of nations (Ejumudo 2010). The valuable nature of the human side of public health sector organizations is evident in the fact that all other resources have to efficiently and effectively deployed and utilized by the human resource for quality service delivery. This key human asset is critically desirable because lack of competent and skilled manpower is to a large extent known and accepted to have contributed to the relative non-performing status of public health sector institutions (Aregbeyen 2004). After all, human resources development and personnel management are central to the achievement of effective reforms, improved quality of health services, enhanced health status and customer satisfaction. A well managed mix of human resource that is skilled, knowledgeable and having the right capacity and attitudinal disposition is therefore desirable and expedient for efficient and effective service delivery in the Nigerian public health sector.

Another critical variable in the management of environmental stakeholders and concerns is finance that is the life-wire in any health service delivery. Central to the finance element or aspect are suppliers, creditors and governments or owners. And since quality and result-oriented orientation and practice implies achieving quality in all processes and services with quality people having the requisite skills, knowledge and ability to work to peak performance in order to meet the needs and expectations of customers or health care seekers, health service organizations and institutions should, as a matter of exigency, manage its interface with the governments/owners, creditors and suppliers. Again, since quality service delivery means quality equipment, drugs and facilities, health institutions are expected to leverage on constant and appropriate supplies from organizations with quality products that will be financed by the various levels of government supported and enhanced by sundry creditors (financial institutions) that provide for the financial short-fall of the former through the intermediation between surplus and deficit groups by the latter. Given the age-long weak financial support for and poor investment in the public health sector by successive Nigerian governments (Unicef 2007), the need for enhanced financial sectoral allocation and efficient utilization of same for the provision of health services cannot be over-emphasized. After all, adequate availability of health facilities and quality services are largely determined by substantial provision and utilization of finance.

Generally, the flow of government funding to the health care system in Nigeria has been disappointingly low. For instance, the average annual federal government expenditure on health between 2001 and 2004 and the federal government allocation to the federal ministry of health are indicated in table 1 and 2 below:

TABLE 1: FEDERAL GOVERNMENT EXPENDITURE ON HEALTH: 1980-1998

Year	Total Federal Expenditure N Million	Federal Expenditure on Health ₦Million			Expenditure as a Ratio of Total Federal Expenditure	GDP at Current Factor Cost	Expenditure as a ratio of GDP
1980	14968.5	155.3	147.5	302.5	2.0	49632.3	0.61
1981	11413.7	119.8	128.4	248.2	2.2	50456.6	0.49
1982	11923.2	155.8	130.2	286	2.4	515170.3	0.50
1983	9636.5	143.6	136.0	279.6	2.9	56709.8	0.50
1984	9927.6	139.1	51.1	190.2	1.9	63006.2	0.30
1985	13041.1	167.7	56.6	223.9	1.7	71368.1	0.31
1986	16223.7	279.2	81.2	360.4	2.2	721128.2	0.50
1987	220.18.7	166.9	69.5	236.4	1.1	106883.2	0.22
1988	27749.	260.0	183.2	443.2	1.6	142678.3	0.31
1989	41028.3	326.6	126.0	452.6	1.1	222457.6	0.20
1990	60268.2	401.1	257.0	658.1	1.1	257873.0	0.26
1991	66584.4	619.4	137.6	757	1.1	320247.3	0.24
1992	92797.4	837.4	188.0	1025.4	1.1	544330.7	0.19
1993	191228.9	2331.6	352.9	2684.5	1.4	691600.0	0.39
1994	160893.2	2066.8	961.0	3027.8	1.9	911070.0	0.33
1995	248768.1	3335.7	1725.2	5060.9	2.0	1960690.0	0.26
1996	337217.6	3192.0	1659.5	4851.5	1.4	2740460.0	0.18
1997	428215.2	4860.5	7123.8	11984.3	2.5	2835000.0	0.20
1998	487113.4	4860.5	7123.8	11984.3	2.5	276570.0	0.20

Source: Central Bank of Nigeria, Statistical Bulletin (1980-1998).

TABLE 2: FEDERAL GOVERNMENT EXPENDITURE ON HEALTH: 1999-2010

Year	Total Federal Expenditure N Million	Federal Expenditure on Health ₦Million			Expenditure as a Ratio of Total Federal Expenditure	GDP at Current Factor Cost	Expenditure as a ratio of GDP
1999	947690.0	8793.2	7386.8	1910	1.7	3225990.0	0.50
2000	701059.4	11612.2	6569.2	18181.8	2.6	50456.6	0.49
2001	11923.2	155.8	130.2	286	2.4	510170.3	0.51
2002	9635.7	154.2	135.3	278.5	2.8	56720.1	0.52
2003	9927.6	153.1	136.2	191.3	1.8	630172.9	0.53
2004	14121.1	185.7	135.6	229.4	1.9	75539.1	0.54
2005	16223.7	279.2	134.7	3753	2.1	74343.2	0.51
2006	27718.7	168.9	70.5	236.4	1.8	106883.2	0.52
2007	27719.2	260.0	183.2	239.2	1.9	14488.3	0.50
2009	42222.3	326.6	184.0	452.6	1.8	222457.6	0.20
2010	60444.7	366.8	189.0	461.5	1.9	3.0	0.26

Source: Central Bank of Nigeria, Statistical Bulletin (1999-2010).

From table 1 and 2 above, it is evidently clear that the Federal government expenditure on health in Nigeria between 1980 and 1998 and 1999 and 2010 is not only inadequate, it smacks of poor realization of the benefits and value of the multi-sectoral nature and the cyclical link of the sundry relevant sectors as far the health care system is concerned. For instance, the health expenditure as a ratio of total federal expenditure in Nigeria between 1980 and 2010 did not exceed 2.9 percent. In fact, the ratio was as low as 1.1 between 1987 and 1992 that it can at best be described as infinitesimal and inconsequential, particularly against the background of the World Health Organization's recommendation that a minimum of 5% of the total budget allocation should be for the Health sector.

Finally, communities and competitors are to be managed by public health organizations and institutions by undertaking health education and enlightenment programmes that will expose the people to globally recognized and acceptable health culture, ethics, standards and habits and consequently reduce the burden of disease and promote preventive health care in Nigeria. Public sector health institutions have to also manage the competition from the environment where the private health institutions are operating, by continually improving on their processes, procedures, products and services so that they can enjoy the cutting edge advantage. In this wise, government should induce competition among public health providers by developing the quasi-market (Le-Grand 2010). The impact of competition on quality is evident when public sector payers pay health service providers on behalf of consumers who are free to choose between providers or suppliers as Halonen and Propper (2009) rightly articulated. Thus, competition between public and private sector health service providers is beneficial mainly because it enhances health service delivery in a market- driven environment. Arguably, with competition from the for-profit private sector, public health organizations and institutions will strive to deliver exceptional and tailor-made services to health seekers. And since health care in the private sector consisting of traditional medicine and modern health care services are provided largely by public sector employees that set up private practice after office hours, public health personnel require motivation for commitment and loyalty to the public service and this will bring about significant improvements in the availability of and accessibility to health facilities and services, particularly among rural dwellers. Health institutions and organizations can equally develop more intensive training programs to train the people who have been unable to obtain jobs because of lack of skills and resultantly compensate their operating environment in a socially responsible way.

8. Conclusive Remarks and Recommendations

The Nigerian public sector where performance is seemingly an exception rather than the rule and public offices have for too long been showcases for the tripod evils of inefficiency, corruption and poor management that have become impediments to effective implementation of government policies (Servicom 2008), the real victim is the nation which is denied effective positive contribution of the public sector to national development and at the receiving end are the Nigerian people who are being short-changed by the consequential effects of the poor and appalling quality service of the sector. At least, these organizations embody the values of the Nigerian society and the nature and character of the public sector environment in Nigeria is such that the ability of the sector to meet social needs in the face of critical national objectives is constrained, especially with the central weakness of public institutions that is typified by dependence upon a budget that perpetuates economic survival rather than on payment from a satisfied customer. The age-long emergent dilemma has become a problematic in Nigeria where there is no service culture and where the much sermonized development planning efforts and programmes are lacking clear-cut orientation.

In the Nigerian public health sector, it is truism to assert that the standard and nature of service is a reflection of the poor management of the operations, processes, activities and efforts of the significant groups like employees, government, suppliers, creditors and the challenge of the competitors that are critical to and affect the service delivery in the sector. It is the disconnect in the management orientation and practice as far as the health sector system and service delivery is concerned that has made genuine and real integration, synergy and eclectic approach almost an exception rather than the rule in Nigeria. This is the plausible explanation for the relatively lack of interface between and among the stakeholders and their concerns as well as service failure in the health sector that is at the heart of and resultantly central to sustainable development in Nigeria because of its link with every other sector. It is therefore instructive to add that the development of any society including Nigeria is inextricably tied to its health standards and the health status of its citizens. Engendering and actualizing quality, result-oriented and performing health service delivery in

Nigeria ultimately demands a clear-cut service culture and development orientation that will encapsulate integrated and multi-sectoral reforms which, will serve as a catalyst for a full-blown re-orientation,

attitudinal predisposition and genuine commitment to pragmatically efficacious service delivery for service provision is a product of the totality of the resource generated, allocated, deployed, coordinated and utilized in a synergistic and complementary fashion There is therefore arguably the need for a restructured re created, re-engineered, revitalized, repositioned and renewed service based Nigerian public sector environment that would be genial to and clement for a quality-driven and performance-oriented health sector through proactive and pragmatic management synergistic mentality and systemic practice.

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