

# Demystifying Social Economic Predicaments of Public Health in Nigeria: Inference for West Africa

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## Abstract

This study derived its credence from the surge of public health related problems caused by the recent economic crisis in Nigeria, and its possible consequences on neighbouring West African nations. It investigates the nexus between public health status and the social economic standards in Nigeria with the intention to unravel how economic crisis contributes to the prevalence of health related problems such as mental illness, hypertension, stress, among others, and why a solution may become sluggish due to the increase people living with the aforementioned health problems. Hence, the study conscientiously suggests how to address the identified challenges and prevent it from snowballing in other West African nations.

**Keywords:** economic crisis, public health, mental-illness, hypertension, stress, West-Africa

## Introduction

Given the fast growing population of Nigeria and her current status as the most populous Black nation in the world with estimated population of 184,201,962 inhabitants, the country currently host 47% of the West Africa population (World Bank report 2015). In contrary, unofficial reports have put the Nigeria's population around 250 million, by implication almost 60% of the West African population. Nigeria's huge population is also endowed with a robust cultural diversity, intellectual capacities and enormous natural resources which should ordinarily allay the fear of socio-economic challenges to public health and other developmental issues.

However, just like many other African nations, Nigeria has been confronted with enormous challenges particularly with surge of public health related problems occasioned by the recent economic crisis which is primarily caused by gross corruption, mismanagement of both human/natural resources and the snowballing effects of other external factors. It is instructive to note that with the Nigeria's socio-economic potentials, the country falls among nations with extreme poverty and poor health system For example, over 70% of Nigerian population live on \$1.25 or even lesser per day. The foregoing deplorable socio-economic and political situation in Nigeria has continued to affect the quality of lives, existing social and medical infrastructures that could help to improve public health standards among others.

Pathetically, as the Nigerian population increases, the electric power generation supply which serve as a cardinal instrument in health services and poverty alleviation drastically reduced to as low as 3760 megawatt as at year 2014 (National Electricity Regulation Agencies, 2014). In the recent time, it has further decreased to as low as less than 2000 megawatt.

Put differently, the recent economic crisis in Nigeria has contributed to the prevalence of health related problems such as mental illness, hypertension, stress among others and the solution to the socio-economic crisis in Nigeria has remain sluggish due to increase in the number of people living with some of the aforementioned health related problems. According to Stuckler D et al (2009) economic crises may have mental health effects, however, problem associated with mental health problems have significant economic effects. For example, the economic implications of mental health problems may include; lost productivity: like in European Union (EU) countries where los of productivity as a result of mental illness are estimated to average 3 and 4% of their gross national product (GDP).

In addition, Nigerian economic crisis and enormous cutback in her national revenue has resulted in unprecedented level of poverty, unemployment, high rate of inflation, vulnerability to health risk factors and drastic decline in the value of naira against U.S dollar. The foregoing explications explain why it is difficult for Nigeria to adequately tackle widespread of public health related problems due the huge financial burden involved.

In the United States alone, the estimated direct and indirect cost of caring for high blood pressure among other health issues (BP) in 2009 was \$51.0 billion (Go AS, Mozaffarian D, Roger VL *et al* 2013). This nature of financial burden is highly impracticable and difficult for developing countries like Nigeria to shoulder considering the ever increasing number of hypertensive patients in Nigeria.

By implication the overall financial burden to provide cares for hypertensive patients including the cost of catering for all the complications arising from hypertension such as cerebrovascular disease, ischemic heart disease and congestive heart failure as well as indirect costs such as the lost productivity of workers struck by stroke, heart failure, and ischemic heart disease (Van de Vijver *et al* 2013).

However, despite the huge funding from global health actors such as World Bank, United States Agency for International Development, European Union, the media and the business community (Human Impact Report, 2009), Nigeria is still lagging behind in showing commensurate outcomes for such investment as a result of corruption and poor health sector management.

This paper is divided into six major sections; introduction, an overview of public health status in Nigeria, economic recession and implication for socio-economic standards in Nigeria, the study interrogates the interplay between public health and the socio-economic predicaments in Nigeria. First, to demystify the dilemma created by current socio-economic crisis for effective public health system; and to provide answer to why the solution to the socio-economic crisis in Nigeria may become sluggish due to increase in the number of people living with any of the public health related problems, conclusion and the way forward are suggested.

## **An Overview of Nigeria's Public Health System**

In the contemporary global system, it is highly impracticable for any nation to achieve good governance and meaningful socio-economic development without developing a robust public health sector system. The foregoing is truism because 'health is widely regarded as wealth'. By implication a healthy population is *sine qua non* for a wealthy nation. For instance, mental health is an important economic factor. Good population mental health contributes to economic productivity and prosperity, making it crucial for economic growth (Weehuizen, 2008). Thus, in Nigeria and many other African countries, prevalence of precarious public health sectors has contributed to their economic woes/crisis and developmental failure.

More importantly, Nigeria has fallen below several require standards that are presumed to be the determinant of quality and quantity of public health system such as; level of education, adherent to safety in the working place, degree of public awareness on health related matters, prevailing socio-economic situation, existing standard of living, dietary level/personal hygiene, existence of cultural values that is suitable for robust public health system, behavioural/lifestyle of people and the nature of country dependency on foreign aid/assistance for public health management among others.

For instance, In 2009 World Health Organisation report shows that one million Nigerian children die at birth out of the nine million infant deaths recorded globally (WHO 2009). In a related development according to Akinrogunde, (2011) cited by Eme et al. (2014), it was reported that in Nigeria, healthy life expectancy at birth for male / female is between 41 and 42; Probability of dying under fire (100 have birth) 191; Probability of dying between 15 and 60 years (per 1000 population) is 447 for male and 399 for female; The under-five mortality rate is currently fix at 157 children per 1000, this implies that 1 out of 6 children born in Nigeria usually die before their fifth birthday- half of this number actually involve those less than one year old. It was also revealed that the health indices that concern the adult female population in Nigeria are among the worst in the world record: at least some 800 per 10,000 women die in Nigeria every year due to pregnancy related cases. In some parts of the country, the figure is actually more than twice the quoted average. Three quarters of all maternal deaths occur during delivery and the immediate post-partum period.

According to World Health Organisation, WHO (2009), it was reported that one million (1,000,000) Nigerian children die at birth out of the nine million (9,000,000) infant deaths recorded worldwide. In the same vein, the World Heart Federation in 2008 reported that an estimated 40% of adults aged 25 and above had been diagnosed with hypertension globally. And the number has continued to increase from 600 million in 1980 to 1 billion in 2008: which represents almost 15% of the world's population. It was also projected that by 2025 the number of hypertensive cases will rise up to over 1.5 billion. In tracing the growth trend of hypertensive cases, Developing countries particularly Africa will account for two thirds of those with hypertension patients due to their poor health systems.

In the same vein, the National Strategic Health Development plan 2009-2015, asserts that the health indicators in Nigeria have fallen below country expectation and internationally standards, due to very slow progress over the years. The health indicators in Nigeria shows that life expectancy at birth is 49 years while the disability adjusted life expectancy at birth is 38.3 years; vaccine-preventable diseases and infectious and parasitic diseases continue to exact their toll on the health and survival of Nigerians, remaining the leading causes of morbidity and mortality. The 2013 Demographic Health Survey reports that about 61% of women who recently had a live birth sought antenatal care from a skilled provider while 36% had their recent baby at a health facility.

Uptake of immunization for children in Nigeria is also low as only 25% of children are fully immunized at age one. Uptake of immunization in Nigeria has not improved from the 23% reported in the 2008 by NDHS, when compared to its neighbouring countries like Ghana where in 2008 79% of children aged between 12 and 23 months were fully immunized (National Population Commission 2008).

Consequently, cardiovascular disease (CVD) or heart related problems, has remain one of the most popular cause of death in Nigeria and ranked first among cardiovascular disease with its complications constituting about 25% of emergency medical admission in urban hospitals in the country (Ogah 2006). It was responsible for more deaths than malaria in Africa in the year 2000 alone (Ekwunife OI, Aguwa, 2011). As observed by IFPMA (2016) 80% of deaths due to CVD occur in poor communities and countries where health systems are frail and poorly manage. The poor health service delivery system and degraded public health standards in Nigeria is further exacerbated by damaging magnitude of an increasing materials and economic gap within and among people, which has grossly differentiates the might of the few rich from the aspirations of the poor masses.

The 2008 Nigeria Demographic and Health Survey in Nigeria also provide further clues into deplorable situation of health in the country through the following statistics; maternal mortality ratio is 545 maternal deaths per 100,000 live births, infant mortality rate is 75 deaths per 1,000 live births, children 12-23 months who have received all vaccinations at the time of the survey is 23 percent, and households that have at least one mosquito net were 17 percent. 88 percent of women and 94 percent of men have heard of HIV/AIDS but only 23 percent of women and 36 percent of men had comprehensive knowledge about modes of transmission and prevention (National Population Commission (NPC) 2009).

The prevalence of mental illness in Nigeria on the other hand, is in the range of 20% (Mental Health Leadership and Advocacy Program, 2012). It has also been reported that, relative to a population of about 174 million (World Bank, 2013), 64 million Nigerians are deemed to suffer from one form of mental illness or the other (Owoyemi, 2013).

According to World Health Organization (2015) Nigeria was ranked as 187 out of 191 countries in its ranking of the world's health standards. This implies that Nigeria's health care system is only better than that of Central Africa Republic, Democratic Republic of the Congo, and Myanmar. By implication poor countries such as Togo, Niger, Mali, and Chad were ranked well than Nigeria with 152, 170, 163 and 178 respectively. Similarly, the Statistics from the UNICEF, WHO and UNDP confirmed further that Nigeria has a lot to do in improving its health system and making healthcare affordable and accessible to the millions of Nigerians who are not getting the health services they require.

In another development, World Health Organization reports that the number of health workers per thousand populations in 2006 was estimated at 2.9 per 1000 in Africa; 5.8 per 1000 in Southeast Asia; 14.9 per 1000 in the Americas (North and South) and 40.3 per 1000 in Europe. The conventional wisdom deduced here is that, in all the continents surveyed, Africa lack adequate number of health workers required for efficient and effective management of its health system. This foregoing demonstrates a clear relationship between level of development/poverty and human resources for Health in Africa. Thus, by implication, Nigeria being the most populous country in Africa would be greatly affected by inadequate health personnel.

Arguably, there were 52,408 Nigerian Doctors on the medical register as at December 2007 making Nigeria a country with one of the largest stocks of human resources in health sector in Africa, comparable only to Egypt and South Africa (Chankova *et al.* 2006). However, there is paucity of quality, quantity and a skewed distribution of health workers towards urban and southern population in Nigeria (FMOH, 2009).

## **Recession and Socio-economic Predicaments in Nigeria**

Given the multiplicity of endogenous and exogenous factors and interests involved in economic transaction among people and across nations, the intermittent resurgence of conflict of ideas, misapplication of economic theory, regulatory negligence or policy inconsistency and economic recession are inevitable. This is the reason why some economists have traced the history of economic recession to the history of humanity itself, dating back to the 3rd Century. This was the period marked by military anarchy and imperial crisis (AD 235-284) which almost led to the collapse of the Roman Empire due to economic crisis, civil unrest, widespread of diseases and invasion.

According to Encyclopædia Britannica (2010) one of the most grievous recessions was the Great Depression which started in 1929 in the USA with the collapse of the USA stock market prices. According to Oyesola (2010) the great depression adversely affected both rich and poor nations respectively, due to unprecedented level of unemployment the world, tremendous decline in global trade (as a result of protectionist policies adopted by various countries of the world), and demand for goods and services drastically dropped globally.

Similarly, the 1973 oil crisis in which the Organization of the Petroleum Exporting countries (OPEC) cut down the supply of crude oil across the globe and enforced oil embargo in some counties represents another recession which had severe impact on the global economy and people around the world (<http://www.state.gov/r/pa/ho/time/dr/96057.htm>).

The most recent economic crisis happened when the U.S.A and many European countries witnessed sudden collapse of the housing market in 2007 which led to the global financial crisis that lasted for almost 2 years (between the period of 2008 and 2009). The negative consequences of that economic crisis largely depend on ability of affected countries to cut back their budgets and this substantially impeded on the availability of funds for health care services and general developmental programmes such as creation of employment opportunities, education and poverty alleviation programmes among others (see Bailey, 2009 and Läänelaid and Ain, 2009). It is instructive to note that, in recent time the ravaging impacts of recession has crippled financial endowment of both open economies as well as closed societies causing extensive devastation on social, economic and political system in both developed and under-developing nations of the world. The crisis has ravaged many economies around the world, causing noticeable instability in Nigerian economy. In addition to decline in Nigeria's external reserves, recession has also led to substantial crash of the stock market, diminishing of the Nigeria's revenue by over 60% and the unprecedented devaluation of the national currency, among others (Okonjo, 2009).

In tracing the predicaments that recently besieged Nigerian economy, it is important to mention some of the problems that have led Nigeria into recession and these includes; over-reliance on oil resources and its proceeds, the informal nature of domestic economic/business ecology, impact of global financial meltdown, uncontrolled and ever-increasing nature of internal debt, pathological nature of interaction between fiscal and monetary policies, monumental waste and mismanagement of national resources, unproductive nature of state government, wide spread of corruption, neglect/inadequate attention given to agricultural sectors, persistent decline in foreign exchange rate (Naira exchange rate to Dollar) and pervasive weakness of governmental institutions among others. The foregoing socio-economic and political pathologies has crippled the potential of Nigeria in leading the rest of Africa in terms of social, infrastructural, economical, political and human development.

The foregoing explications was further echoed by BUDGIT (2017) that emergence of recession in Nigeria is simply the manifestation of several years of Nigeria reliance on the proceeds from crude oil; prevalence unhealthy domestic business environment; external trade shocks; wilful dysfunction between fiscal and monetary policies; weak institutions and the lack of a diversify exports policy to boost foreign exchange earnings. However, successive administrations in Nigeria were able to somehow manage to hold out for almost sixteen years before the recession became loudly pronounced under President Buhari administration in early 2016.

The peripheral status of Nigeria and most of the African states in the global system made it more obvious that any outbreak of financial crisis in the Western world will automatically have negative consequences on the economy, developmental programmes and general wellbeing of Nigerian people and the government.

As observed by Schuman (2009) the outbreak of economic crisis in the developed countries result in inadequate funds to finance investment and offer loans to developing countries which heavily relies on Western loans and developmental assistance for health care services, socio-economic development and political programmes. It was further argued that due to decline in exchange rate in most developing countries the costs of servicing the existing foreign loans became skyrocketed.

Consequently, when household incomes decline due to resultant effects of economic recession, household's demand for goods and services will automatically reduced. By implication, firms would reduce their production of such goods and services in order to cut cost and minimise loss, as a result of low demand from households. The overall consequences on the country socio-economic development will reflect in terms of decline in production, industries close-up, loss/decline of employment opportunities, lack of funds for research and developmental programmes and absence of new product/invention.

More importantly, the devastating impact of recession on employment opportunities worldwide cannot be overemphasised. According to Central Bank of Nigeria (2012) in December 2007, the U.S. unemployment rate was 5.0 per cent and by October 2009, the unemployment rate rose to 10.0 per cent. The unemployment rate in Nigeria is fast accelerating with the increase in the number of graduates and it stood at 64.7% as at the year 2012 (World Economic Data 2013). In the same vein, the International Labour Organization (ILO) revealed that, at least 20 million jobs were lost by the end of 2009 due to the impact of the Global Financial Crisis, mostly in construction companies, real estate, financial institutions and the automobile industries, leading the world unemployment above 200 million for the first time in the world history.

The impacts of economic recession on social life involving activities such as; tourism, holidaying, gaming, festivities, travelling and consumption of products by households were also severe. As noted by Zagats (2009), U.S. Hotels, Resorts, Spas and business travel has decreased tremendously in the past year as a result of the recession. Thirty per cent (30%) of travellers surveyed by Zagats stated that, they travelled less for business today while only 21 per cent stated that they travelled more. The reasons for the decline trend in business travel include change in company's travel policy, dwindled personal economic fortune, uncertainties and high airline prices. In the same manner, hotels were responding to recession by cutting their rates, ramping up promotions and negotiating deals for both business travellers and tourists.

Similarly, the World Tourism Organization (2008) stressed that, international travel suffered a strong slowdown beginning in June 2008, and this declining trend intensified during 2009. This resulted in a reduction from 922 million international tourist arrivals in 2008 to 880 million visitors in 2009, representing a worldwide decline of 4 per cent, and an estimated 6 per cent decline in international tourism receipts.



Given the dependency nature of Nigerian economy and its peripheral status in the global trade, the foregoing decline in tourism, holidaying, business travel, festivities, international travel and certain households' consumption were also experienced and trends still persist in Nigeria since the outbreak of economic crisis in 2016.

In summary, due to recession, many of the things that add values to the quality of life and enhance people's earning potential: such as better employment, standard schools, effective public services, safe streets, green spaces, leisure and entertainment facilities are scarcely available to the poor majority of people and mostly accessible only to very few rich Nigerians

## **The Interplay between Public Health Syndrome and Economic Recession in Nigeria**

Existing studies have established the link between health status and prevailing economic standard of individuals or nations. However, it is difficult to adequately measure the effects of the economic recession on public health and other health related issues. This is true because many of the consequences of recession on health and general wellbeing of the citizen in Nigeria are not well documented due to other socio-cultural factors and other considerations. It is instructive to note that, the Asian economic crisis between the period of 1997 and 2000 was the first time a comprehensive investigation of the consequences of economic crisis on health care services were carried out.

As earlier stated, health is difficult to measure, particularly if a broad context of health is taken into consideration. Basically, factors like age, sex and hereditary (genetic) are critical but not exclusive in gauging health status. At the broader level, there are other global factors that affect peoples' health. For instance, health status of New Zealanders has been influenced by historical events of world wars and economic depressions. (Durie 1994). According to Dahlgren and Whitehead (1991), the major determinants of health care are; general socio-economic, cultural and environmental conditions; living and working condition; social and community influences; individual lifestyle factors and age, sex and hereditary factors.

However, experience from past recessions has shown that the impacts can be severe on infant mortality rate, morbidity rate, life expectancy, maternal mortality rate, low birth weight, widespread of communicable diseases, high mortality among elderly/children and incessant mortality rate as a result of many curable/preventable illness such as malarial, typhoid fever, primary infections among others.

As shown by Muanya (2009), an analysis of the 2008 and 2009 budgets show that contrary to the World Health Organization (WHO) recommendation and the Abuja Declaration by African countries to commit 15 per cent of their budget to health, the allocation for health as a percentage of the GDP actually decreased from six per cent in 2008 to five percent in 2009. (Mitik 2009:15) stated that the sectoral allocation to education and health in 2009 showed a 16% cut in education and 29% cut in health allocations.

It was also foreseen that the global economic crisis would impacted negatively on healthcare delivery in Nigeria as in many other developing countries through decrease in gross domestic products (GDP). Like many other developing countries in Africa, Nigeria recorded a negative GDP growth change in 2009 relative to year 2008. Her GDP fell from USD 207.116 billion in 2008 to USD 165.437 billion in 2009 signifying a – 41.679 percentage change (Eme el al. 2014). The foregoing has affected the government allocation to health sector. For instance, Nigeria allocated 4.5% and 3.5% of the total GDP to health in 2009 and 2010 respectively. Although health allocation later increased in 2012 to 5%, the allocation is still far below the 11% of GDP recommended by World Health Organisation (WHO). In spite of lower allocation to health, such fund were poorly utilised or mismanaged by designated officials. The foregoing situation explained the reason why an estimated 3,000 Nigerians travel to India on monthly basis for medical treatment and spend up to 20% of Nigeria's total annual budgetary allocation for health care.

Generally, it was predicted by the World Bank that the impact of the economic meltdown on health delivery would be severe. For example, the World Bank envisaged that decline in GDP at one or more points will increases average infant mortality by 7.4 per 1000 births for girls and to 1.5 per 1000 births for boys. And the fall in prices of commodity occasioned by the economic crisis would affect the capacity of many African countries, particularly the oil exporters, to fund social services, including health and that increased poverty would result in worse nutritional status, which would in turn affect the quality of health.PH 8

Moreover, the poor are disproportionately affected by mental disorders. People with the lowest socio-economic status (SES) have eight times greater relative risk for schizophrenia than those with the highest SES (Holzer et al., 1986). People with mental disorders are four times more likely to be unemployed or partly employed (Robins, 1991), one-third more likely not to have graduated from high school and three times more likely to be divorced (Cohen, 1993). A recent systematic review of epidemiological research in LMICs found a very strong relationship between many indicators of poverty and common mental disorders (Lund et al., 2011).

Poverty has also exposes people to risk factors for developing or worsening mental disorders. Succinctly put, lack of educational and employment opportunities, exposure to hazard living condition (such as poor housing or homelessness), debt, drug abuse and vulnerability to violence are all predisposing factors associated with poor mental health (see Fitch et al., 2011, de-Graft Aikins and Ofori-Atta, 2007, Havenaar et al., 2008, World Health Organization, 2005b).

Instructively, poor people are more often than not unable to access medical treatment or require spending huge part of their income on medical treatment, thereby worsening their already precarious financial position (Saxena et al., 2007).

The widespread of hypertension, stress and mental illness has been closely associated with socio-economic predicament that besiege Nigeria during the economic recession with potential snowballing effects on other neighbouring West African countries in terms of migration flow, health burden sharing, economic downturn and over stressing of health facilities available in neighbouring countries. To Desjarlais et al., (1995) the prevalence of mental illness in Nigeria is linked to the many socio-economic problems which may be regarded as precipitating factors. These factors include; the brain drain syndrome in Nigeria's public healthcare sector (Oyewunmi and Oyewunmi, 2014), poor funding of mental health services (World Health Organization, 2003); and increasing number of Nigerian psychiatrists and psychiatric nurses who practice overseas (Baba, 2005).

More importantly, this study argues further that the recent economic recession in Nigeria has further propelled series of public health related problems such as mental illness, hypertension, and stress among others. And the solutions to Nigerian socio-economic crisis including recession has become sluggish due to inadequate measure put in place to check and control the increasing number of people living with either hypertension, mental illness or stress given the huge financial burden involve in catering for people living with hypertension or high blood pressure and monumental loss of human resources needed to boost socio-economic development as a result of increasing number of people with mental illness and stress.

Shockingly, the predicted impact of the economic crisis on health outcomes is horrific. Increasing unemployment and poverty will lead to less food security and quality of nutrition, cutting back on already insufficient HIV treatment and care programmes because of the crisis. Child malnutrition and infant mortality might increase by 200,000 and 400,000 additional deaths in 2009 (UNICEF, 2009). Women, children, the poor, and minority groups, were expected to suffer disproportionately from the health impacts of the crisis (ACGS 2010:3).

By and large, an economic recession means that there is less economic growth, which leads to higher unemployment and inflation. By implication this can lead to decrease in household income and tax revenue: when families have less to spend they will buy less food and food of less quality. The household would also cut back their expenses on health care and education. In addition, government has to trim-down their budgets when tax revenues and foreign earnings diminish. The demand for public services would exceed its availability and supply which would cause problems in access for those who often depend on public services like public health care. The resultant consequence of the foregoing is prevalence of health related problems and poor funding of public health care system.

The foregoing depict a collocating relationship between economic crisis, inflation and sometimes devaluation of domestic currencies which causes an increase in the price of imported raw materials, medications and medical facilities/equipments. In Nigeria, the recent economic recession has impacted negatively on public health standards and on general wellbeing of many Nigerians across all adult age brackets through job loss, financial liability, loss of investments, decline in job opportunities for young graduates, vulnerability to crimes, diseases and violence among others.

Notably, as a result of recession and other factors, the budgetary allocation to the health sector in Nigeria is less than the 15 per cent minimum recommended for countries by the World Health Organization (WHO). Although, it is hard to measure the implications of the recession on people's health, however, experience from past recessions has shown that the impact can be severe. To Stukler et al (2009), suicides and homicides rose among working-age men and women when unemployment rose rapidly during times of recession in Europe. A one percent increase in unemployment caused an increase in suicides of 0,79%.

Unsurprisingly, mortality among elderly and children in Nigeria is higher during the recent economic crisis between the period of ending 2015 and 2017 in comparison to when there is economic boom. In analysing the impact of the economic recession on global health, there is a general concern expressed that the poor people and countries would be hit the hardest by the economic recession as unemployment would lead to a drastic decline in household income and government revenue; and in many countries unemployed people would lose their health insurance. This would result in the inability of the poor people to pay for health care services for themselves and their family members (Suryawati *et al.* 2004).

The outburst of economic recession in Nigeria has resulted in brain drain in the area of medical health care services, inability of the country to attract the best individuals to the health care profession and a shift from the original/licensed brands medication to other brands and unbranded drugs/medical facilities especially as a result imbalance exchange rate or devaluation in national currencies exchange rate to dollar which is making it more expensive for countries to obtain encourage hike in the cost of the original/licensed brands and imported medical equipments/drugs. To a greater extent, essential life medicines may become either unavailable or unaffordable (WHO, 2009b).

According to Central Bank of Nigeria (2012) companies' revenue and profit are usually affected by recession. More often than none, company would compromise product quality in an effort to cut costs and improve their profit base, and in the process lose their market share. For instance, a baker could offer the same loaf of bread at the same price but reduce major ingredients such as milk, butter, sugar among others in order to cut cost and improve their profit during recession.

Recession could force medical drug manufacturing companies to lower their standards by either substituting expensive pharmaceutical chemicals for cheaper/substandard one or reduce the required chemical component in certain drugs in their attempt to reduce the cost of production and make more profit. However, this sharp practice is not peculiar to recession period alone but such acts are more pronounced during economic recession.

As argued by Michael et al. (2010) there is a 'social gradient' in health: those living in the most deprived neighbourhoods die earlier and spend more time in ill health than those living in the least deprived neighbourhoods. The simple interpretation is that people living in the most deprived neighbourhoods are more exposed to harsh environmental conditions which negatively affect their health and general wellbeing. Michael et al argument accurately captured the Nigerian situation under the foregoing explications. This is true because, people's health outcomes, education, employment prospects and opportunities to build wealth and improve wellbeing are significantly influenced by both people's socio-economic status and where they live (OECD, 2014).

The mammoth of challenges confronting Africa in securing good health for its teeming population has become evident. Notable among these challenges are the constraints in Africa capacity to finance its health care system as evidenced by the low levels of public sector health funding in many African countries like Nigeria. Parts of obstacle to the issue of public health sector financing include; low domestic resource mobilization capacity, limited fiscal space, and constrained economic growth among others. Basically, there is a substantial lacuna between the available and needed fund for achieving the quality health that is in consonant with Millennium Development Goals (MDGs). Yet adequate public resources are important for addressing health inequities in Africa (ACGS 2010:5)

According to Ajakaiye and Fakiyesi, (2009:1) the crisis, which 'was triggered by the credit crunch within the US sub-prime mortgage market' raised serious concerns over its likely impact on healthcare delivery not just in the less developed countries but also in the OECD countries as well. It was projected that the crisis would have serious negative impact on healthcare, particularly in the less developed countries, through a number of channels. These include reduction in household incomes; fall in remittances, reduction in national health budgets, reduction in ODA, reduction in health-related overseas private assistance (say from foundations and fall in commodity prices. Overall, it was predicted that the impact of the economic meltdown on health delivery would be grave.

The foregoing concerns were reinforced by the fact that overall healthcare financing in Sub-Saharan African has been constrained, not only in terms of the volume of funds available, but also by the fragility of the underlying governance structures that have not adequately tackled effectiveness and efficiency of resource allocation and utilisation (Musau 2010:1).

Ajakaiye and Fakiyesi (2009:26) further argued that the share of the health sector in total expenditure between 1985 and 1999 as insignificant: (in year 2007 health budget in billion Naira was; in 2008 it was 138.17; in 2009 it was 154.57; in 2010 it was 161.84 and 2011 it rose to 235.8) All the figures mentioned were insignificant considering the exchange rate of Naira to US dollar, the fast growing population of Nigeria and mammoth of related problem confronting Nigeria as a country.

## **Conclusion and the Way Forward**

The outbreak of economic recession and its adverse consequences on health sector and general wellbeing of Nigerian people offer an opportunity for policy makers to rethink the crucial link between country health status and socio-economic development in Nigeria. It is evident that without ensuring adequate measure to check and control the increasing number of people living with public health challenges due to resultant effects of economic recession, the solution to the socio-economic crisis in Nigeria will continue to remain elusive. This is true because the cost of catering for people living with hypertension and mental illness will continue to rise and constitute a huge financial burden to the country. In addition, the increasing number of people living with hypertension, mental illness and stress among others will automatically increase the ratio of mortality rate and result to overall lost in productivity that will drastically reduce GDP in Nigeria.

Therefore, for Nigeria total recovery from economic recession, to prevent backlash effects of economic recession on other neighbouring West African countries that is currently responding through the act of xenophobia and to strengthen public health sector in country: the following recommendations were made;

1. To break the yoke of economic crisis and its untold negative effects on health services, tenacious efforts must be made by Nigerian government to diversify the economy from mono-cultural system of production by discouraging excessive reliance on crude oil proceeds through investment in agriculture, manufacturing and technology inventions that have the potential to boost Nigeria's national revenue and foreign reserves
2. Likewise, Nigerian government must strive to provide adequate funds to the health sector given its crucial role in socio-economic development and entire wellbeing of Nigerian population. To address the inadequate funding of health sector in Nigeria, new paths must be thread: leadership must be reoriented towards embracing effective and efficient health service delivery system. Health sector reform must be thoroughly design to engender repositioning of health management that would actively coordinate, monitor and ensure efficient utilisation of the resources available to health sector for the overall benefit of the entire citizenry.

3. Concerted efforts must be made to reduce the scourge of poverty through effective measure to control the level of unemployment, job loss, loss of investment, gross inequality, corruption, high level illiteracy, and poor economic policy formulation and implementation in Nigeria.
- 4 There is need for more of advocacy to increase investment in public health, encourage responsive and transparent utilisation of health resources and capacity building through training/research, interdisciplinary/interagency collaboration and best practices for health care workers must be prioritised.
- 5 Awareness on treatment services/prevention and interventions, including pharmacological, psychosocial and care-management strategies for schizophrenia, depression, alcohol misuse, epilepsy and suicide prevention must be created (see Bass et al., 2006, Bolton et al., 2003, and Patel et al., 2007).

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