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ABSTRACT

The purpose of this paper is to review the current health care system in Nigeria in the context of quality and affordability and to propose a plan through which a better health care delivery system can be implemented so that the best and most affordable services can be provided to the majority.

Equitable healthcare does not mean that everyone will have healthcare, it does mean however that irrespective of socioeconomic status, each citizen of a country has equal probability of accessing healthcare services based on need (Macinko et al, 2002). That is, if a rich man and a poor man fall ill, they can both go to the hospital and be treated, without either being turned back whether or not they can afford hospital fees.

As the National Health Insurance Scheme rolled out in 2005 does not serve the bulk of Nigerian citizens, other means need to be employed to ensure sure the people in this country get the healthcare they need. In this paper, I will propose three models that aim at solving some of the most evident problems currently affecting healthcare delivery in Nigeria. These strategies are: revision of the pay scale for healthcare professionals, setting capital reserve requirements for healthcare establishments and creating local insurance schemes for each county that cater to its citizens. It is my aim to subsequently develop a complete strategic plan that is practical enough to be implemented by the Nigerian government in order to ensure that the defects in healthcare delivery are thoroughly fixed. Restructuring the healthcare sector may take anywhere up to ten years depending on how much effort and attention is put in. Many of the suggestions in this paper are suited to be adopted over a ten-year period and are sustainable enough that they

can be continued well after this test period. The plans are flexible so that as better systems are conceived, they can replace these methods.

DEMOGRAPHICS

Nigeria is a sub-Saharan African country situated in the Western part of the continent. It is bordered in the north by the Republic of Niger and Chad; in the south by the Atlantic Ocean; in the east by Cameroun; and the west by the Republic of Benin. Her official language is English, making Nigeria one of the only two Anglophone countries in Francophone West Africa. Nigeria is roughly divided into three major ethnic groups: Hausa, Igbo and Yoruba, which also determine the major languages spoken by her citizens. The country became independent from British colonial rule on October 1st 1960 and became a federal republic three years later in 1963. The country sits on a total area of 356,669 sq mi and has a GDP per capita of $2200. Nigeria has an estimated 200 million citizens with a little over 50 million of them engaged in the labor force (US Department of State, 2011).

Nigeria accounts for over half of West Africa's population and has an economic growth rate of 6.1%. Current exchange rates put $1 =155 Naira. The country is in the process of electing new leaders and has had a relatively stable election seasons as compared to part seasons (US Department of State, 2011).

CURRENT SITUATION

In term of health indices, Nigeria currently lags behind as one of the riskiest places to live in. The CIA World fact book estimates the life expectancy of Nigerian women and men to be 48.4 and 47.8 respectively. Infants do not have better chances of

living either – 91.54 out of 1000 infants die in Nigeria (2011). According to the African Press Service, 700 newborns under the age of 28 days die daily in Nigeria (2011). Compared to other African countries, Nigeria is not doing as well as she should, given her per capita income of $2200. Other African countries like Tanzania, Cameroun and Kenya with per capita incomes a third of this amount have decreased infant mortality by 40% in the last two decades, as compared to Nigeria's 15% decrease. Currently, the country has the 9th highest mortality rate in the entire world. Indeed many of these problems are compounded the population growth rate of 1.93% per annum (CIA, 2011).

The burden of disease borne by Nigerians is quite high. Compared to the rest of the world, Nigeria has the third highest number of people living with HIV/AIDS (estimated over 3.5 million individuals) and the second highest number of people dying from AIDS. Malaria and yellow fever still affect a large percentage of the country's population. Poverty is a huge problem in Nigeria. Even with the 32nd largest GDP in the world, over 70% of the population lives below poverty line (CIA, 2011).

STRUCTURE OF THE HEALTHCARE SYSTEM

The federal ministry of health (FMOH) primarily controls the healthcare sector in the country and is one of the fourteen ministries set up by the Federal Government of Nigeria (FGN). FMOH heads 36 state ministries of health (SMOHs), one per state. Because the system is decentralized, federal and state ministries are fairly autonomous in operations but do cooperate upon need. As Ichoku states:

"From the point of view of public healthcare delivery, the organizational structure largely conforms to the constitutional principles of autonomy of federating units. It

enables each level of government to identify its health priorities and pursue them with minimal intervention from the other levels and it defeats the very purpose of co-ordination." (2004)

However, the autonomy of the state ministries of health can be both a blessing and a curse; FMOH has failed to play many of its major roles due to the independence claimed by many of these SMOHs, who are usually keen to formulate their own policy in periods preceding budget approval but are not as keen to execute them when the rubber hits the road. A cloud of ambiguity usually exists as well as to what roles are specifically meant for FMOH to perform and what roles are exclusively under the jurisdiction of the SMOHs. Ideally, tertiary healthcare, preventative healthcare should be administered and controlled through FMOH whereas primary healthcare is primarily under the care of SMOHs. When these roles clash and there is no clear distinction as to who should be working on what, there is dysfunction and ineffectiveness in the entire health care system, the brunt of which is borne by patients themselves (Omator, 2008).

Speaking about this disconnect, immediate past minister of health and current director general of UNFPA, Babatunde Osotimehin asserted that:

"the way to make progess is…. to have coordination across the board because when the local councils don't know what the state is doing and the states don't know what the federal government is doing, it leads to duplication. Already, the resources we have are not adequate… we are not suing them efficiently to get the outcomes we are chasing…" (Osotimehin, 2011)

It is important to note that in Nigeria, as in many other West African countries, only about 20-30% of healthcare services are actually provided by the public healthcare system is a free private healthcare market.

In 2005, FGN launched the National Health Insurance Scheme with the goal of providing universal health care coverage to every citizen in at least fifteen years. Currently, the scheme serves the 20% of the population that is formally involved in the public sector on an obligatory basis. Although backed by the government, the system is managed by private health maintenance organizations (HMOs). The government subsidizes the 15% premium by paying 10%, leaving employees to pay just 5% (percentages are out of total salary paid out to these employees). This health insurance also covers five dependents (typically a spouse and four children). The benefits package includes: outpatient care and consumables, emergency care, and other essential health services (Ichoku et al, 2009).

The private market is responsible for rendering most health care on a for-profit basis in form of clinics, specialist hospitals, drugstores and maternity homes (cite). Indeed, one cannot walk down any major street (and perhaps even minor ones) without coming across a healthcare facility of some sort. Many of these facilities however are unregulated and subpar, with the few that are of quality being more expensive than most members of the population can afford (Ichoku at al, 2009).

Currently, however, the government supports Private Voluntary Health Insurance (PVHI) initiatives such as private insures and HMOs (World Bank, 2009). These two groups of organizations usually support individuals engaged in the private formal sector.

This will be discussed more thoroughly in the section titled 'the two fold problem of access and affordability.'

In January 2011, the President of Nigeria, Goodluck Jonathan, in his bid to strive towards achieving the Millennium Development Goals, launched a new healthcare initiative called the National Strategic Health Development Plan (NSHDP). The objective of the new national health plan is to 'streamline modalities towards meeting health-related MDGs for the poorest population, scaling up health services, consolidating and broadening emerging progress in the health sector.' Under the new plan, donor agencies and international organizations that intend to intervene in the nation's health system must adhere to the new plan as well as restrict their activities to the new policy drive of the government. According to the president,

"The partnership testify to our openness and commitment to transformation and to deliver results in the health sector, I have specifically charged the ministry to report regularly, including through the media our collective performance score cards on the measurable improvements that we have signed onto." (Efeizomor, 2010)

The exact actions and operations from which this would result is unknown.

CURRENT HEALTHCARE SPENDING

Nigeria has typically funded healthcare at abysmally low amounts since the early 1980s. At the time, healthcare spending averaged 1.9 per cent of the total federal government expenditure in the 1980s (Amaghionyeodiwe, 2009). In year 2000, FGN healthcare funding shrunk to the all-time low of about 0.2 per cent of GDP (UNDP, 2000). Even though, healthcare expenditure at the time was $15 per capita, the

government contributed a mere $2 per capita in healthcare subsidies (13% of total healthcare spending).

Other forms of healthcare financing and third-party intervention such as social and private healthcare insurances are virtually non-existent. Thus, in spite of the generally accepted fact of market failure in this sector, the healthcare market in Nigeria is determined more by the price system than any other consideration (Amaghionyeodiwe, 2009)

The failure to coordinate among the tiers of the public healthcare sector is a characteristic of the private sector. As Lambo (2003) notes, the Nigerian healthcare system is fragmented and uncoordinated. The apparent disconnect between the federal, state and private sector healthcare efforts ensures that there is no effective framework for public-private partnership.

Currently, the country is in the process of passing a new healthcare bill and initially, talk had been made about employing the UN suggested measure of dedicating 15% of the budget to healthcare. Upon further discussion, it was revealed that the healthcare bill only stipulated that the government spend 2% of is budget on healthcare related expenditure. Speaking in Lagos, Osotimehin called the amount ‘huge’, a contradiction of his formerly noted stance where he endorsed the UN suggestions. The funds gotten from this new budget are expected to be spent primarily on strengthening the primary healthcare sector, human resource development and the NHIS.

In my opinion, these reforms will only succeed in putting a band-aid over a surgical wound for a few reasons. First of all, the fact that the NHIS only covers the 20%

of Nigerians working in the public, formal sector means that the majority of citizens will not benefit from the healthcare bill. As long as information from the private sector is ignored by the system, comprehensive planning and reform will be near impossible. Another obstacle on the path of this new bill is the poor referral system. Even if money were directed towards primary care, the lack of interconnectedness in the medical network would ensure that the patients are unable to get the help they need when it sis above the capability of the primary care provider (Ichoku et al, 2004).

OTHER ISSUES FACING HEALTHCARE IN NIGERIA.

Apart from the structural issues facing Nigerian healthcare system, other important factors have led to the broken down state that the country has found itself in. One of these is the inadequate manpower in this sector. Many of the qualified doctors, nurses and other healthcare professionals emigrate to the West in search of better working conditions, benefits and ultimately pay. Currently, medical residents in Nigeria are paid the equivalent of $9,100 per annum before taxes. Attending physicians are paid a mere $26,600. To protest their meager pay, in Lagos State, Nigeria's financial capital, medical doctors recently went on a six week strike over the pay freezes that had they had been subjected to despite assurances made by the government as far back as in 2007 that they would receive pay raises. Scores of patients died and the public largely blamed the doctors for 'playing politics with patients.' According to citizen of the state who lost his newborn child and wife in the throws of labor due to lack of medical attention, Lagos doctors are now considered 'killers and businessmen who are only interested in their own pockets'. The state commissioner for health stated in his own defense that ' it is not likely

that we [the state] will have 100 percent implementation in one day, we are assure the striking doctors that the payment structure is continuous.' (Obioma, 2011)

Because of problems such as these that essentially serve to de-motivate and demoralize medical professionals, the brain drain attracts many of the brightest talents to developed nations where they can practice medicine hassle –free. Ultimately, their gain is the country's loss. Although no cause-effects studies have been officially carried out, one can naturally assume that this 'brain drain' does not benefit the healthcare situation of the host country in any way.

THE TWO-FOLD PROBLEM OF ACCESS AND AFFORDABILITY

Poverty is increasing and the health of the population is failing. The main financing for this system and the bridge between the population and the healthcare system is out-of-pocket payments (OoP). OoP include co-pays on insurance policies for treatment and over (World Bank, 2009).

Since the NHIS is unavailable to the majority of the populace till further expansion plans can be implemented, the onus has been indirectly placed on private companies to provide coverage for the mass number of citizens. PVHI currently faces certain unique issues challenging its adoption in Nigeria. For instance, it is a problem that many private insurances are subsidiaries of upper and middle level business organizations that have more resources at their disposal and pay staff well enough for them to afford insurance premiums. Another problem facing the blooming of private health insurance is that because of the initial difficulties that will arise in terms of start-up costs when pooling risks and foraying into new, unchartered territory, health insurance may prove to

be exclusionist to the very individuals that it is being set up to protect. Opinions exist among World Bank analysts that due to the history of corporations and the '*retainership'* system in Nigeria, private health insurance has the propensity for 'jeopardizing equal access to care because of its... catering to higher-end market segments' (World Bank, 2009)

The question remains this: What can be done with the existing structures in the economy to create an affordable, transitional system that ensures no more lives are wasted before the comprehensive NHIS kicks in 2020?

THE PROBLEM OF ACCESSIBILITY: SOLVED

Organizations and even countries with limited resources in today's economy have been forced to re-evaluate their operations in order to direct expenditure to areas and projects that will guarantee the highest return. However, the problem with running a country on an organization's model is that if leaders are not cautious and judicious in seeking out objectives that maximize the wellbeing of every member of their constituency. The 70-80% of Nigerians who have no access to good and affordable healthcare is testimony to the fact that the nation's leaders do not see healthcare as a return on investment. This is however unfortunate, as a healthy society is beneficial in much more ways than one. Aside from the improved quality of life that access to healthcare will give citizens, a directly related benefit is an increased productivity in the labor sector that will directly increase output and corresponding revenue available to the government and corporations. One should consider these reasons motivation enough to improve healthcare.

If these reasons aren't good enough, it is important to think back to ten years ago when the banking industry in the country was crawling and rife with inefficiency, liquidation, and fraud. In the space of decade, the Nigerian banking sector has been brought to the forefront as one of the fastest growing in the entire world. The banking industry has served as a powerhouse for the growth of the entire economy (not oil, as many would suspect) and Nigeria's economy is poised to take over from Africa's largest economy (South Africa) within the next year. Well what is it that stops the government from applying the same principles to healthcare?

MODEL A

In 2006, commercial banks in Nigeria were required by the central regulating structure, the Central Bank of Nigeria (CBN), to possess a minimum reserve of 25 billion naira ($190 million) otherwise they would be shut down. 40% of this amount had to be held in liquid assets. Only a few of the banks that existed then had the resources to match this requirement and as a result, banks that wanted to maintain their 'bank-next-door' appeal without being absorbed into these mega-banks were forced to consolidate with other 'banks-next-door.' Good and bad things happened: the banking system was strengthened like never before, there were just as many more branches for customers to go to (If a bank that had 300 branches before partnered with 4 other banks with the same number of branches, customers now had 1500 branches they could access), and jobs were lost in areas where efforts were being duplicated (especially top management positions). However, jobs were also created, as manpower was needed to bridge the gaps that existed between the former banking units and to create a homogenous and uniform network. All in all, the number of banks decreased from 89 to 24.

The same process can be applied to the health sector in Nigeria. Aside from the 'general' hospitals that exist in major cities in different states, reliable structures are few and far between. Instead, there are a host of 'clinics' and 'hospitals' that one would not wish on their worst enemy if he were to fall ill. Many of these clinics are run by general practitioners and a few nurses and do not have the capability and revenue to deal with the complex health issues that members of their immediate communities are plagued with. The efforts of these healthcare professionals are noble but misdirected. What if there was a way to direct this passion so that it is more effective in achieving its aims? What if FGN required that these clinics meet a reserve amount of capital before they could be reaccredited and approved for operation? In light of the fact that hospitals and clinics are not as revenue generating as banks, the reserve amounts for this sector would be lower than the $190 million required of the banks. Reserve amounts could also be scaled based on the scope of operation of the particular facility i.e facilities that provide primary care would be expected to have lower reserves than those that provide secondary and tertiary care. The SMOHs would be delegated to enforce this regulation through a reaccreditation process that would serve to ensure that each hospital and clinic had the minimum reserves required or they would shut down. A percentage of the reserve amount could be applied to capital goods such as healthcare equipment, basic utilities such as constant supplies of electricity, water, waste removal and other services necessary to efficiently run a hospital.

The benefits of this reserve system include the following: (a) Smaller establishments merging with long time neighbors increases partnership among medical professionals. (b) There will be a broad range of specialties for patients to choose from since it would pay all healthcare personnel to diversify their establishments in order to

attract more patients and ultimately, more revenue. (c) There will be greater ease in accessing healthcare because patients can now chose from various locations patients at their convenience. (d) The reserve amount ensures that hospital and clinics actually work. Qualified individuals will be running good hospitals and providing good healthcare to citizens. (e) Healthcare professionals will have a bigger incentive than charity to continue practicing in the country since the larger patient base will ensure a steady income, more conducive working environment and eliminate the stress than comes from working in subpar healthcare establishments. They will also tend to strike less since they are being paid.

The initial challenges this system will face however seem to be quite large. Meeting reserves will be no small task for many health care establishments who are scraping together to make ends meet. If credit options are open for groups with solid business plans that delineate their plans to repay loans back after a set period of time, I believe the government would not be hard pressed to provide subsidized loans with low, fixed interest rates to such groups. As little as 4% of the nation's GDP can be set aside to strengthening healthcare and used to provide these loans. The loans would be disbursed through FGN after SMOHs have approved applicants based on different measures of trustworthiness and ability to repay these loans. If FGN is able to invest in healthcare, then healthcare professionals will be incentivized to continue striving towards providing healthcare to citizens at manageable and sustainable costs that do not unduly task their own wellbeing and survival.

Perhaps the most rewarding benefit to Nigeria that directly results from a stronger health sector is the possibility that exists for the country to become West Africa's Mecca

for healthcare. Just like the banking sector has given Nigeria something else to be known for part from her oil, good healthcare will draw patients from far and wide and boost the economy. Nigeria should aim to be on the same playing field with South Africa in roughly the same ten-year period that it took for the banking sector to be where it is now.

AFFORDABILITY OF HEALTHCARE: SOLVED

As much as I believe mergers will strengthen the private healthcare sector and improve accessibility to good healthcare, huge reforms still have to be made in order to make healthcare affordable to the majority of citizens who still live on less than a dollar a day. It will be of no practical value to have good facilities if no one is able to afford them. Since the NHIS does not quick in for another couple of years for majority of citizens (if it ever does kick in) other systems have to be employed in the interim to ensure citizens are able to afford healthcare costs. The current market for health insurance is so large that the health insurance sector could be another driving force of the Nigerian economy if implemented properly. What if health insurance was run through the LMOHs just like the voting/electorate system? What would that mean for citizens who need healthcare?

MODEL B

Local insurance schemes would be run like the electorate system is currently run in Nigeria; people who live within a certain local government area (LGA/county) usually vote at certain sites set up an supervised by their LGA. They can only vote within that LGA and are registered under that LGA for other things like motor vehicle licensing, tax and levy payments etc. If each local government area established a health insurance scheme that was automatic for all residents then risks pools would be large enough for

these schemes to be feasible. Each citizen would be charged a fixed premium on a progressive basis such that citizens in higher income brackets pay slightly higher premiums than those in lower income brackets. Premiums should not be priced above 6-10% of each individual's income so that they are affordable.

Because the infrastructure will already be in place due to the mergers, premiums can be directly applied by the insurer to healthcare related and not administrative expenses. The local health insurance scheme helps to solve the problem of duplicating of duties between the LMOHs and SMOHS. When the NHIS kicks in, the decision will be made whether or not to absorb the local insurance schemes or keep both as options and allow citizens to choose whether or not they want to remain on their local scheme or switch to the federal scheme. To keep the system flexible for patients, different LGAs will need to negotiate whether or not patients are allowed to cross county lines to access healthcare. In the case of life-threatening emergencies however, individuals will be able to get medical attention at the closest healthcare establishment to them.

THE PROBLEM OF DE-MOTIVATED PROFESSIONALS: SOLVED

Strengthening the healthcare system will not be possible if they are no healthcare workers present to carry out the tasks that need to be done. The subpar working conditions and remuneration has succeeded in frustrating many healthcare workers and has driven many of them to seek greener pastures in other countries and sometimes in other professions. Nigeria has the challenge of finding a way to retain recent medical graduates who are not inclined to enter a sector fraught with issues and also to attract

healthcare professionals in the Diaspora who are hesitant to return home because they have lost faith in their country. How can this be done?

MODEL C

In order to retain medical graduates in the country, the salary structure has to be revised and upgraded so healthcare professionals are paid competitively. This can occur in one of two ways:

Recent university graduates are mandated by FGN to serve the country through the National Youth Service Corps (NYSC) if they intend to hold a job or public office within the country at any point in their lives. Medical residents are expected to do this as a part of their residency and are remunerated as corpers, not as medical residents. Across the board, a corper earns far less than any medical resident earns each year. What if the government paid medical residents slightly higher salaries right from their corper days? Many residents are in need of basic necessities such as housing, transportation and funds to feed their families, which they are unable to afford on corpers salaries. Why doesn't the government provide housing and transportation allowances to medical residents? This could be in form of actual living arrangements or subsidized living arrangements, functional vehicles, stipends for those starting families as well as for purchasing medical equipment and literature. This would help alleviate the financial woes of many healthcare personnel, freeing them to focus on their graduate medical education and patient care.

For attending physicians/consultants/nurses, there should be a heavily enforced pay scale that determines the flat rate that each individual is paid based on experience and

competence, sort of like tenuring the individual. Commissions can also be paid to these professional based in the number of patients they see and how long they are able to retain patients for. This reduces the stress of a heavy patient load and allows those who want to earn more money do so by taking on more patients. This payscale will sometimes be swayed up or done based n fluctuations in the economy that affect demand and supply for healthcare services. The fluctuations, however, can be buffered by security measures to ensure that the compensation package at the end of the month only varies within a small range.

CONCLUSION

The healthcare sector in Nigeria can be likened to a family with many members who each have problems of their own. Focusing on these different aspects at once means that the central body spread itself thing but Nigerian cannot afford not to focus on these problems. Gone are the days of relying on foreign NGOs (PEPFAR, Gates Foundation, USAID etc) to come in and solve fundamental issues that affect the core of healthcare delivery in the country. Aid is just what it is, aid. It cannot be substituted for failure in the organization of healthcare in a country with over 200 million citizens.

The three models I have explained above are ideas I have conceived based on my knowledge and experience with the Nigerian healthcare sector. It is my goal to develop these ideas further into a complete strategic plan so that they can be implemented in bettering healthcare delivery in Nigeria.

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