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## **Improving Outcomes in the Nigeria Healthcare Sector through Public- Private Partnership**

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### **Abstract**

Nigeria's healthcare sector over the years has continued to degenerate with health indicators currently below national targets and internationally set benchmarks. Budgetary allocations to the sector have remained far below the World Health Organization (WHO) and African Union (AU) recommendations of 11% and 15%, respectively, of a country's Gross Domestic Product (GDP) dedicated to the health sector. The poor healthcare system has led to loss of confidence resulting in frustrations and unbearable consequences for the poor and low income segment of the society whereas, top government officials and the affluent resort to outbound medical tourism. Using a qualitative research methodology that focuses on descriptive analysis, the paper reviews health system performance in Nigeria in line with the achievement of United Nations health-related Millennium Development Goals (MDG's) and targets. The paper recommends for institutionalization of the Public-Private Partnership (PPP) model in the Country's healthcare sector. Public - Private Interaction offers opportunity of leveraging private sector investment in the sector and further enhances improvements in service delivery as well as increases access to quality

healthcare. The paper contributes to current scholarly discussions on improving outcomes in healthcare delivery system and the curbing of excessive foreign medical tourism which is found to deplete the country's foreign reserves.

**Key words:** Nigeria, Healthcare Sector, Health Outcomes, Health Indicators, Public-Private Partnership

### **Introduction**

Nigeria has an estimated population of 185 million people, which constitutes about 2.5% of the total world population (National Population Commission, 2015). Meanwhile, the country's healthcare system currently ranks 187 out of 197 sampled member countries of the United Nations (Tide, 2015). This is an indication of the continuous decline in the healthcare delivery system arising from neglect of the country's national health infrastructure over the years. Contextually, a country's health infrastructure refers to the quality of healthcare system and the accessibility to health care delivery. Adebayo and Oladeji (2006) opined that it is part of a larger concept of the health system which contains the health policy, budgetary allocations, implementation and monitoring. The general performance of the health system has been undermined by the inability of successive governments to pay deserving attention to the healthcare sector. Budgetary allocations and per capita government expenditure on healthcare over the years have remained low and this has adversely affected health outcomes leading to the inability to meet health-related Millennium Development Goals. Ademiluyi and Aluko-Arowolo (2006:104) also view that health infrastructure has to do with people, institutions and legal framework, all interacting systematically to mobilize and allocate resources for health management, prevention and care of diseases, illnesses and injuries. This therefore, anchors on the availability of capable human resources for health, effective funding and communication, health research, a willing government and the existence of a standard framework that adequately recognizes and addresses the healthcare needs of the population.

Budgetary allocations to the health sector remain far below the World Health Organization (WHO) and African Union (AU) recommendation of 11% and 15% respectively, of a country's Gross Domestic Product (GDP). The World Health Organization (WHO) had recommended that 11% of a country's budget should be dedicated to its healthcare sector, whereas, in April, 2001, the Heads of State of African Union countries met and pledged to set aside a target

of allocating 15% of their annual budget to improve the health sector (World Health Organization 2011:2). The implication is making health a higher priority in government budgets, since the effectiveness of a country's healthcare delivery system is central to meeting its health goals. Nigeria is a signatory to the Abuja Declaration, which commits the government to spending 15% of the total government budget on health. However, health spending as a proportion of the federal government expenditures was at the lowest and shrank from an average of 3.5% in the 1970's to less than 2% in the 1980's and the early 1990's (Federal Ministry of Health, 2004: 6). By the mid 1990's, the percentage of public health expenditure to total government expenditure stood at 7.05%; 4.22% in 2000; 6.41% in 2005; 4.3% in 2009 and 4.4% in 2010 (Central Bank of Nigeria Statistical Bulletin, 2010). This shows that average of 5% was allocated to the health sector between 1995 and 2010, indicating a slight increase of about 2% from the previous 1980's and early 1990's. The percentage of public expenditure on health stood at 5.4% in 2011; 5.8% in 2012; 5.7% in 2013; 6.0% in 2014 and 5.5% in 2015 (Budget office, Federal Ministry of Finance, 2015). This shows that less than 6% of the total budget was allocated to the Health sector between 2011 and 2015. From the foregoing, it is observed that the country has been off track with respect to achieving the health-related Millennium Development Goal's. Also, the proportion of total expenditure allocated to the Health sector for the past twenty years has been very low (mean level of 5.5%) compared to international benchmarks of 11% and 15% set by World Health Organization and African Union respectively.

This paper reviewed the impact of government under expenditure on the Health sector over the years and its impact on the quality of health outcomes. The paper identifies outbound medical tourism as a consequence of the general poor healthcare system and further proposes for effective institution of Public-Private Partnerships as a means of improving outcomes in the Nigerian Healthcare Sector.

### **National Health Policy Framework**

**Revised National Health Policy, 2004:** The Revised National Health Policy of Nigeria was put forward in 2004. It was a review of the National Health Policy and Strategy which was promulgated in 1988 and aimed at "Achieving Health for all Nigerians". The Policy is thus, in recognition of the country's poor health system performance which was ranked 187 among 197

member States of the World Health Organization in 2000; the poor health status of most Nigerians; the limited capacity for policy/plan formulation, implementation, monitoring and evaluation at all levels and the absence of a National Health Act defining the health functions of each of the three tiers of government (Federal Ministry of Health, 2004, p. 3). The new National Health Policy was formulated within the context of:

- the Health Strategy of the New Partnership for Africa's Development (NEPAD);
- the Millennium Development Goals (MDGs) to which Nigeria, like other countries, has committed to achieve;
- the New Economic Empowerment and Development Strategy (NEEDS) which is aimed at re-orienting the values of Nigerians, reforming government and institutions, growing the role of the private sector, and enshrining a social charter on human development with the people of Nigeria;
- the development of a comprehensive health sector reform programme as an integral part of the NEEDS (Federal Ministry of Health, 2004, p. 4).

The overall policy objective is to strengthen the national health system such that it will be able to provide effective, efficient, quality, accessible and affordable health services that will improve the health status of Nigerians through the achievement of the health-related Millennium Development Goals. The main health targets of the policy are the same as the health targets of the Millennium Development Goals (Federal Ministry of Health, 2006, p. 6).

**National Health Financing Policy, 2006:** The National Health Financing Policy, 2006 focuses on the provision of adequate and sustainable financing for effective, efficient and equitable health system performance in the country. Uzochukwu, Ughasoro, Etiaba, Okwuosa, Envulade and Onwujekwe (2015: 442) write that the policy focus is on promoting equity and access to quality and affordable healthcare, and to ensure a high level of efficiency and accountability in the system through developing a fair and sustainable financing system. The National Health Financing Policy was also formulated within the same framework as the National Health Policy. The overall goal is to ensure that adequate funds are available and allocated for accessible, affordable,

efficient and equitable healthcare provision and consumption (Federal Ministry of Health, 2006: 13). The specific objectives include:

- to establish mechanisms for continuous availability of adequate funds for the provision of cost-effective health services;
- to ensure that all citizens have timely access to quality health services as needed and for better health outcomes without financial barriers;
- to ensure the efficient use of financial resources for health;
- to put in place adequate regulatory frameworks for health financing (Federal Ministry of Health, 2006:13).

**National Strategic Health Development Plan, 2009:** The National Strategic Health Development Plan (NSHDP) aims to offer a roadmap for improving the country's poor healthcare system. This is geared towards addressing issues plaguing the sector such as lack of effective stewardship by government, fragmented health service delivery, inadequate and inefficient financing, weak health infrastructure, poor distribution of health work force and poor co-ordination amongst key players (Federal Ministry of Health, 2009: 2). The eight priority areas of the National Strategic Health Development Plan include:

- Leadership and Governance
- Health Service Delivery
- Human Resources for Health
- Financing for Health
- Health Management information systems
- Partnership for Health
- Community Partnership and Ownership
- Research for Health (Federal Ministry of Health, 2009).

The National health policy context is anchored on providing interventionist framework for improved healthcare delivery system. It seeks to achieve this goal through sound health system management that also recognizes adequate funding as a means of achieving an effective, efficient and equitable health system. However, the management of national health system and the funding attitudes by successive governments over the years have proved grossly incapable of strengthening the weak and fragile National healthcare delivery system. Saka, Isiaka, Akande, Saka, Agbana and Bako (2012: 54) view that the

process of change needs to extend beyond the re-definition of policy objectives and discussions of the ideological orientation of the healthcare system. Saka et al (2012: 54) further contend that health sector reform will therefore, be concerned with defining priorities and reforming the institutions through which these policies are implemented.

### **Key Aspects of the Health Sector**

This section discusses key aspects of the Nigerian healthcare system which has been seriously undermined by the negative attitude of successive governments. According to Oshotimehin cited in Omoluabi (2014, p. 24) "...the Nigerian health sector is characterized by mal-distribution of health work force and poor co-ordination amongst key players, lack of effective stewardship role of government, fragmented health service delivery, inadequate and inefficient financing and a weak infrastructure". These aspects therefore, include, Organization and Management of Healthcare System, Health Indicators, Human Resources for Health and Expenditure on Health.

**Management of Healthcare System:** The Nigeria Health System (NHS) is fashioned after the three tiers of government. It is in principle decentralized into a three-tier structure with responsibilities at the federal (national), state and local government levels. At the national level is the Federal Ministry of Health (FMOH) which provides oversight for the three tiers of the national health delivery system in general, though with specific control over departments and agencies under it. The Federal Ministry of Health is responsible for policy and technical support to the overall health system, international relations on health matters, national health management information system and the provision of health services through the tertiary and teaching hospitals and national laboratories (Federal Ministry of Health, 2013). At the State level is the State Ministries of Health (SMOH) which are responsible for secondary healthcare provisioning. They are responsible for the secondary hospitals and for the regulation and technical support for primary healthcare services. The third tier is the Local Government which provides primary healthcare services through local clinics and dispensaries. Eneji, Juliana and Onabe (2013, p. 260) contend that it is primary healthcare that suffers the most neglect as women and children, especially the poor, die from avoidable health problems such as infectious diseases, malnutrition, and complications at pregnancy and childbirth. However, while there seem good

organization of the health sector, corruption and bad governance has marred performance over the years with attendant consequences on the weak and poor of the society.

**Health Indicators:** These refer to the characteristics used to measure and describe the health aspects of a population. According to the National Strategic Health Development plan (2009, p. 2) "... the health indicators in Nigeria have remained below country targets and internationally set benchmarks including the Millennium Development Goals, which have recorded very slow progress over the years". Kpamor (2012, p. 2) also writes that Nigeria has some of the poorest health indicators in the world. However, despite the Health Policy Framework and other programmes, the health situation in the country has remained poor with consequences of trauma and death for the lowest income segments whereas, the rich and top government officials overcome this challenge by travelling abroad for medical tourism. The World Health Organization (WHO) in 2014 identified Nigeria as one of the 46 countries that have failed to meet the Abuja Declaration 13 years on and one of the 38th countries that are not on track in meeting the health-related Millennium Development Goals (MDGs) by 2015 (World Health Organization, 2014).

This paper examined this health indicator through data from relevant secondary sources. According to the World Health Organization (2013) the average life expectancy of a Nigerian at birth is 54 years while the disability adjusted life expectancy is 38 years. Vaccine-preventable diseases and infectious and parasitic diseases continue to affect the health and survival of Nigerians, thereby, resulting to morbidity and mortality. The Maternal Mortality Ratio is 545 (this is the ratio of the number of maternal deaths per 100,000 live births). Infant Mortality Rate is 75 (this is the number of children dying at less than 1 year of age, divided by the number of live births that year). Under Five Years Mortality Rate is 157 (this is the number of deaths of children under the age of 5 per 1,000 children in that age group over a period of year) (World Health Organization, 2013). According to the World Bank (2014) the HIV prevalence (% of the population 15+) stands at 38.0%, the number of children ages 0-14 living with HIV (in thousand) is 320, whereas, tuberculosis case detection rate (% of all forms) is 53.0. Omoluabi (2014: 14) writes that wide regional variations exist in health indicators across zones. For instance, infant and child mortality in the North West and North East zones of the country are generally twice the rate in Southern zones, while the maternal mortality in

the North East and North West is over 6 times the rate recorded in the South West zone. These indicators depict an apparent shortfall in the attainment of the health-related Millennium Development Goals and targets of reducing child mortality, improving maternal health or maternal mortality, and combating HIV/AIDS, malaria and other diseases.

**Human Resources for Health:** Nigeria has less than one-tenth of the actual required number of health personnel to meet its health needs by World Health Organization (WHO) standard. This paper identifies the main categories of human resources in the healthcare system as doctors, nurses, midwives, pharmacists, health extension workers etc. Table 1.1 shows categories of registered health workers in 2014.

Staff category	Number	No. of health workers/100,000 of population
Doctors	53,210	35
Nurses	158,623	107
Midwives	105,979	78
Dentists	97,373	4
Pharmacists	18,187	15
Medical Lab. Scientists	5, 149	5
Community Health Practitioners	151,863	83
Physiotherapists	2,873	2
Radiographers	1,381	1
Nutritionists	1,291	1
Health Record Officers	1,799	1

**Source:** Federal Ministry of Health, 2014. Note: this table shows categories of health workers based on registration and may not reflect the current human health resources across the country.

Comparatively, in Egypt, South Africa and Ghana, the rate is 28, 8, and 1 medical doctor respectively, per 10, 000 of the population, and 35, 41 and 11

midwives, respectively per 10, 000 of the population (Ciuci Report, 2014, p. 2). In terms of the density of the human health resources, by geo-political zones, there are more medical doctors, nurses and midwives in the Southern than in the Northern part of the Nigeria. For instance, the South West has more than 43% of registered medical doctors against the North Central with 9.73%, North East with 5.01%, North West with 9.02%, whereas, South East and South South have 19.92% and 14.78% respectively (Nigeria Health Work Profile, 2014). It is further important to note that overwhelming percentage of the health workers, (about 78%) of the medical doctors work in hospitals and clinics either in public or privately owned in urban areas whereas, the remaining 22% are scattered across the vast rural areas that account for more than 70% of the country's population. It is unfortunate to note that out of approximately 22% that work in the rural areas, more than 75% of them are non-resident. Reasons for these are not limited to poor and difficult working conditions and poor remunerations, especially remuneration discrepancies between tertiary, secondary and primary levels. Other factors include government attitudes and the absence of effective and clear policy and regulatory framework. A major consequence is the continuous emigration of health professionals including doctors, midwives and nurses outside the country. Omoluabi (2014:28) writes that since the year 2009, Nigeria has been losing an average of 700 doctors and more than 600 nurses and midwives annually to Europe, America, Australia and South Africa. The push factors towards overseas work are the same that discourage health personnel from residing and working in the rural areas across the country which is characterized by low accessibility, absence of basic amenities, basic medical supplies and equipment.

**Health Financing:** Health expenditure as a proportion of the country's Gross Domestic Product (GDP), over the years has been below international benchmarks. The World Health Organization (WHO) recommends that the total health spending, including both government and private spending, should amount to a minimum of USD 54 per person (World Health Organization, 2010). In 2010, the Government of Nigeria allocated USD 9.21 which is equivalent to N1, 218 per person; USD 11.50 or N1,782 in 2012; USD 10.90 or N 1,709 in 2013 and USD 10.23 or N1, 525 in 2014 (Federal Ministry of Finance, 2010; 2012, 2014). All the value of private spending (Out-of-pocket expenditure) within this period could not be determined due to unavailability of data, however, earlier study estimates the value of household expenditure as a

proportion of the total health expenditure at a mean value of 64.59% (Soyibo, 2002), while a recent study by Burke and Sridhar (2013, 6) indicates 72.1%.

It can therefore, be deduced that the bulk of health expenditure (above 70%) is borne by households without insurance. According to the World Health Organization (2014) this very high percentage of household financing is way above the 15% threshold beyond which household risk is pushed into poverty by healthcare expenses. This regressive pattern of healthcare financing makes for a heavily unbalanced system and shifts the bulk of expenditure to private individuals irrespective of the ability to pay. Riman and Akpan (2012, 299) write that the heavy reliance on the ability to pay through Out-of-pocket payment reduces healthcare consumption, exacerbates the already inequitable access to quality healthcare and further exposes households to financial risk. The implication is that the poor which constitutes 75% of the total population is helpless in terms of accessing decent healthcare services. Healthcare financing is effectively linked to affordability and equity in accessibility of healthcare services, and guarantee of financial risk prevention. It is therefore, unfortunate to note that the following ECOWAS countries, namely, Sierra Leone, Mali, Burkina Faso, Senegal, Benin, Togo, Liberia, Ghana, Cape Verde, and the Gambia all spent more than Nigeria as a proportion of their Gross Domestic Income (GDP) and in achieving health-related Millennium Development Goals (MDG's) in 2013 (Mamaye, 2013: 1).

The present context of the country's healthcare system has negated the achievement of health-related Millennium Development Goals, and seriously affects access and affordability of healthcare services and the general health outcomes. While it is noted that majority poor are helpless and suffer the consequences, the affluent and top government officials resort to medical treatments abroad.

### **Outbound Medical Tourism**

Despite the fact that over the years, the proportion of Gross Domestic Product (GDP) allocated for healthcare financing in the country has remained far below international recommendations, these funds are also badly managed and a sizeable chunk embezzled by government officials. The consequence has been an abysmal sector incapable of addressing the healthcare needs of the population. Omuluabi (2014: 14) contends that the ruined state of the country's healthcare sector resulting from inadequate supply of medical personnel and

equipment, poor management and poor power supply has led to a general loss of confidence in the sector. As such, while the lower segment of the population is helpless and continue to die of preventable diseases like malaria, diarrhea and blood pressure related complications and cardio-vascular diseases, top government officials and the affluent travel abroad for healthcare. Outbound tourism is a situation where patients travel abroad for medical care (Muhammed, 2013, p.1922). The basic premise of medical tourism is that better quality care could be achieved at a comparatively cheaper cost. However, in the Nigerian case, these services are sought at a higher cost abroad.

Nigerians are undoubtedly, one of the biggest victims of medical tourism in the world. The former Minister of Health, Babatunde Oshotimehin stated in 2011 that at least 3,000 Nigerians travel each month to India for medical treatment and spend close to USD 2000 million or N30 billion annually. This is equivalent to about 20% of the budgetary allocation for the healthcare sector in 2010. According to Business Day Nigeria (2013) 47% of Nigerian medical tourists visited India in 2012 for medical attention. This 47% amounted to 18, 000 persons and they expended N41. 6 billion (about USD 260 million). The most frequently visited countries are United States of America, United Kingdom, Germany, Switzerland, India, United Arab Emirates, Israel and South Africa. The nature of treatments sought by Nigerians in these countries are alternative medicine, corrective and transformative surgeries, oncology etc. (Ciuci Report, 2014: 4). The fact remains that this huge amount could be saved annually if Nigerians who travel abroad for medical services could be treated locally and the money re-invested in the provision of healthcare infrastructures.

### **Public-Private Partnership in Healthcare Delivery**

Access to affordable and quality healthcare is critical to economic growth and development in Nigeria and elsewhere. However, the country's health indicators are too poor and remain below national targets, thereby, resulting in poor health status ranking. Eneji, Juliana and Onabe (2013, p. 260) wrote that the country has suffered from decades of neglect, thereby, endangering health status and national productivity. Annual public sector budgetary allocations to the health sector over the years are low and often below international recommendations. This compounds the country's healthcare challenges.

Nigeria's healthcare system is characterized by a weak public sector, serving more than 90% of the population and more than 70% of this financed through out-of-pocket payments. However, this public sector, which serves more than 90% of the population is funded through the fiscus. As the challenges in the healthcare sector becomes increasingly worrisome, this paper recommends for a firm institution of Public-Private Partnership model in the country's health sector. Public-Private Partnership refers to a government sponsored initiative or scheme which involves the use of private finance to facilitate the provision of services to the public and /or the delivery of social infrastructure assets (Tan & Overy, 2012). According to the Africa Research Forum (2013:1) "...it involves initiatives that establish a contract between a public-agency and a private entity (for-profit or not-for-profit) for the provision of services, facilities and/ or equipment". Public-private partnership had existed in France as early as 1792 AD when the Perrier Brothers was granted a concession for water distribution in Paris. Public-Private Partnership in recent practice was introduced in 1992 in United Kingdom by the British Conservative government and subsequently expanded across the world (Hearne, 2009: 2). As a neo-liberal theory of state interventionist approach, Public-Private Partnership is imperative in fostering government intervention through private collaborations in the provision of social goods and other forms of infrastructural development. It has been used to improve outcomes in the health sectors in developed countries such as United Kingdom, Germany, Spain, the Netherlands, and is currently firmly applied in African countries such as South Africa, Egypt, Ghana and Botswana. Generally, Government all over are usually driven by certain key factors to use the Public-Private Partnership model for health improvements. These are:

- Desire to improve operation of public health services and facilities and to expand access to higher quality services;
- Opportunity to leverage private investment for the benefit of public services;
- Desire to formalize arrangements with non-profit partners who deliver an important share of public services;
- More potential partners for governments as private healthcare sector matures;
- Improve health education and conditions worldwide;

- Identify new and better ways of operating (Africa Health Forum, 2013:1; World Economic Forum, 2013: 2).

### **Review of Existing Framework**

The Nigerian government introduced the National Policy on Private-Partnership for Health in 2005 (Federal Ministry of Health, 2005). This was part of the reforms in the health sector embarked with a view to attaining the Millennium Development Goals (MDGs) and other National Health Policy targets. Basically, the key primary objectives of the National Public-Private Partnership Policy in Health amongst others include:

- To build confidence and trust in the public and private health sectors;
- To harness confidence and trust in the public and private sectors for the attainment of Millennium Development Goals, and other National Health Policy Targets;
- To promote and sustain equity, efficiency, accessibility and quality in healthcare provisioning through the collaborative relationships between the public and private sectors (Federal Ministry of Health, 2005, p. 6).

More than ten years after the introduction of the Policy framework, part of the major challenge remains how to form effective partnerships among different stakeholders in a way that healthcare can be served efficiently, effectively and equitably in the country. There is also the persisting issue of weak and effective co-ordination of the stakeholders and active players in the Health sector. In addition, this paper further identifies the following concerns:

- Equity financing has not been addressed in health provisioning. The non-for-profit providers and other players have not been mobilized to devote substantial part of their funds to the poor;
- Access and efficiency have not been improved in areas of exploring primary healthcare alternatives and in contracting the non-for-profit organizations;
- Low level of health promotion and advocacy in the areas of health education, consumers' awareness on health rights, contracting of Non-Governmental Organizations (NGOs) for community mobilization and outreach, and the use of mass media to promote health awareness;

- Low provision for social marketing as a means of disease prevention and control programmes e.g. in the areas of mosquito nets, condoms and other contraceptives etc.
- Training opportunities have not been expanded for different categories of stakeholders at the three levels of tertiary, secondary and primary healthcare.

### **Conclusion**

The aim of the National Health Policy and Strategy of 1988 was to “Achieve Health for all Nigerians”, however, almost three decades have passed, yet, quality healthcare has eluded most Nigerians. Nigeria has been identified as one of the 46 countries that have failed to meet the Abuja Declaration of dedicating 15% of the country’s Gross Domestic Product (GDP) to the health sector and one of the 38 countries that are off track in meeting the health-related Millennium Development Goals (MDGs). This is in addition to Nigeria continually failing to meet the World Health Organization’s benchmark of dedicating 11% of the country’s Gross Domestic Product (GDP) to the Health sector. The poor funding of the sector coupled with corruption and management issues have negatively affected health outcomes to the extent that the country’s health status is one of the lowest ranked in the world.

This paper recommended for a firm institutionalization of the Public-Private Partnership model in Nigeria’s health sector. However, the issue is not the Policy framework (which is already in existence) but in its implementation and enforceability. The virus here is corruption and mismanagement, and the monster is lack of will power to pursue the common good in the interest of all. However, the fact lies in strengthening the organizational and management capacity of the public sector to effectively implement Public-Private Partnership in the health sector. The missing link is leadership and good governance. This is the desideratum for responsible and accountable health sector governance (and in other sectors) and the effective application of the framework to improve health outcomes in the country. It is also pertinent for Nigeria to under study the successful implementation of Public-Private Partnership in other African countries like Egypt, Ghana, South Africa and Botswana.

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