How to Fix Nigeria: Health

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The National Health Policy has all it takes to effect a creditable fix in the health sector. It prescribes a three-tier health structure for Nigeria, with primary health care, PHC, including refined traditional medicine as the foundation, secondary health care, SHC, also known as general hospitals the supporting pillars, and tertiary health care, THC, consisting of teaching and specialty hospitals the apex
The persistence of Nigeria’s problems is not caused by lack of the knowledge of their solutions. It is often due to the dissociation of theory from practice. This is the case in health. The National Health Policy was launched in 1988. It adopted sound internationally accepted principles and adapted them to solve the health sector problems of Nigeria. It was acclaimed by the world as a good blueprint for delivery of first class health care in a developing nation, and requests for copies came from the four corners of the world. Attempts to implement it were seriously made in the first four years during the leadership of the late Olikoye Ransome-Kuti, the then minister of health, but, by the time he left office, it had not yet properly taken root. Despite the Primary Health Care Development Agency which he later returned to head, the Federal Executive Council had lost the missionary zeal he had earlier injected into its implementation, and his further efforts, he confided in me, met with several frustrations. The frequent "upgrading" of primary health care, PHC, facilities to hospitals at the State level was evidence of gross misunderstanding of the policy. The review undertaken 16 years later, when, to quote the revised document, "PHC facilities serve only 5–10 percent of their potential patient load" is ample evidence that there was not credible attempt to implement PHC. The review was therefore a purely theoretical exercise since there was little to learn from its non-implementation. Health sector reform activities closely followed this review, again all excellent but entirely theoretical, as no funds were released for implementation. The National Health Policy has all it takes to effect a creditable fix in the health sector. It prescribes a three-tier health structure for Nigeria, with primary health care, PHC, including refined traditional medicine as the foundation, secondary health care, SHC, also known as general hospitals the supporting pillars, and tertiary health care, THC, consisting of teaching and specialty hospitals the apex. The policy assigned the responsibility of implementing PHC to local government authorities, LGA, SHC to state governments, SG and THC to the federal government, FGN. The guidelines provided that each government should supervise implementation at the lower tier. But, as often quoted, the constitution places health on the concurrent legislative list, meaning that each tier of government has the freedom of action on health matters. Because of the widespread misunderstanding of PHC, the states that were to supervise its establishment at local governments have tended to rather impede the process in line with their death wish for this tier. Despite the deplorable state of SHC in the states, many have gone ahead to establish THC projects, thus thinning the available resources and leaving their health care systems with no foundation. By definition, PHC is a service easily accessible and affordable to all inhabitants of the land, whether urban or rural. Its activities constitute curative, preventive and promotive aspects of health care, requiring information, education and communication at the clinics and during home visits. When properly implemented, the people would no longer regard health as something the government or anyone else does to them. They would participate in its planning, implementation, monitoring and evaluation, adapting it to solve the problems peculiar to their communities. They would have a true feeling of ownership, and this self-reliance would go a long way to preventing illness and promoting good health-a true testimony to our belief that prevention is better than cure-definitely cheaper and much less painful than the curative jabs and operations. PHC, the first contact patients make with the health system, must also be the most efficient system of access to SHC and THC, so that any seriously sick person requiring highly skilled care, appearing at the PHC clinic would be rapidly referred up the system when necessary. Patients now avoid PHC facilities when they possibly can because its clinics constitute dangerous delay centres where non-medically registered PHC staff plays at being doctors. The system demands efficient supervisory hierarchy, adequately provided for in the guidelines, with experienced professionals participating from the higher tiers. The absence of this supervision has caused the chaos and loss of confidence by the public. The result is that the people go to the hospitals for their PHC needs, causing the doctors trained for SHC to devote 80 percent of their time conducting PHC in the outpatients’ departments of hospitals. The fix would therefore involve the reinstitution of PHC to its pride of place and its implementation in strict accordance with its guidelines. Affordable means of rapid transport for referral must be available in the form of bicycle and motorised ambulances to make PHC the quickest way to get hospital care when required. Its guidelines for supervision by qualified health professionals (doctors, pharmacists, laboratory scientists etc.) from SHC and THC must be enforced. During the colonial era, the British started a health service in Nigeria while definitive treatment was available "back home," but the services started on a development that reached the stage of training doctors at the University College Hospital Ibadan. When Nigerians took over at independence, one expected us to continue this progress that would lead to the definitive treatment also being in Nigeria, but that was not to be. Medium and high tech medical attention remained "back home" abroad as privileged Nigerians merely shifted their homes there by buying property in advanced countries and continuing to rely on their advanced health services. Nigeria has thus remained the revenue farm for harvesting the cash the privileged need for a lavish life and better health services abroad. Nigeria’s health status is deplorable. The revised health policy document admits that preventable diseases account for 70 percent of Nigeria’s disease burden and that poverty is a major cause of these problems. It admits that our maternal mortality of 1 percent is "one of the highest in the world," that some of our health indicators, such as the under-5 and adult mortality rates are higher than the average for sub-Saharan Africa. It could not have been more pathetic than that. Yet it has not, so far as we know, fired the patriotism of any head of government in Nigeria to take action to end this show of shame that no one would stomach if it were in football. Military coup makers

condemned the health achievements of their predecessors, but it was only political rhetoric to court public support. President Obasanjo’s National Conference had committees on what he regarded as the important sectors of the economy, and it did not include health. The present administration left Federal Ministry of Health without its own substantive Minister for months, and doctors are complaining that its widely publicised seven-point agenda has not recognised the importance of health. Some other sectors, feeling similarly neglected, have demanded that a state of emergency be declared for them, though health workers might argue that they are already swamped by daily emergencies; the President should just jump to the next stage and take action. The health services of the country have therefore continued to suffer from neglect by successive governments. The revised health policy document states "Public expenditure on health is less than $8 per capita, compared to the $34 recommended internationally." One would expect that, under such severe underfunding, the governments of the federation would use the scarce resources to first establish the infrastructure, but they are not looking this way—they only think hospitals. The inadequate funding causes most hospitals to spend well over 80 percent of their income on salaries and allowances, leaving little for maintenance and for running even curative services. They lack such basic infrastructures as water and power, the buildings are dilapidated and the equipment deficient, outdated and needing replacement. It was reported that a N17 billion contract for renovation of 8 teaching hospitals was awarded by the last administration, but there are widespread complaints that the company that got the job was not an accredited distributor for any manufacturer of medical equipment, that it was supplying poorly reconditioned machines that quickly broke down shortly after they were put to use. Such top-down actions rarely succeed. Before we devise the correct fix, we should consider all the factors and learn from the experience of developed countries. The greatest danger to the population of developing countries is posed by infection and infestation. Unwholesome water, malnutrition, poor housing and hygiene, and the crude standard of living and starvation all add up to reduce life expectancy, disable a good proportion of the citizens, and promote the spread of disease that appear in endemic and recurrent epidemic proportions. The priority in these countries is to provide the basic health infrastructure, otherwise known as primary health care, and also fix factors frequently placed outside the responsibility of ministries of health, like housing, water supply, environmental sanitation, nutrition, education, and employment for all and caring for the disadvantaged. Life expectancy in the United States, for example, rose from 47 to 76 years in the first half of the twentieth century because of the improvement in nutrition, housing, and hygiene. It occurred before the advent of high technology medical care, before antibiotics, and before the establishment of modern treatment and immunisation that curbed the killer diseases of measles, tuberculosis, scarlet fever, diphtheria, whooping cough and pneumonia. A study by the McKinleys’ indicated that from 1900 to 1973, less than 4 percent of the decline in mortality resulted from medical care, over 90 percent being due to public health measures. This strongly suggests that for Nigeria, public health measures, primary health care and the reduction of the level of poverty should be the priority of those who wish to improve the health of the majority of the population. Hot pursuit of high tech medicine not only makes a negligible contribution, it further dissipates the resources that might have been more effectively used elsewhere. Attempts to fix the health sector would tantamount to swimming against the tide if poverty, malnutrition, poor environmental sanitation and education are ignored. Strong inter-sectoral collaboration would have to be seriously implemented. It is necessary to discuss population to some detail, as Nigerians are very proud for being the most populous black country on earth—the Giant of Africa, never mind the rude retorts added by some unpatriotic elements. It used to be said that every fifth African is a Nigerian. That proportion has been changing to every third African. We may yet reach the point where every African is a Nigerian! However, if the rate of growth of the economy does not keep pace with that of population, mighty trouble brews, and Nigeria is already experiencing the pressure on all social services, the rise in crime rate and the loss of our trained manpower to advanced countries. The quality of life is closely correlated to per capita income of countries. The easiest explanation is that, given the same level of income, a family of five will be able to live more comfortably than that of ten. Unless Nigeria’s earnings directly applied to improve the economy grow exponentially as her population is doing, the country’s standard of living is going to plummet at an equivalent exponential rate, as there are many more mouths to feed, bodies to clothe and minds to educate without an equivalent increase in the available resources to do so. The excuse usually given that children are a gift from God will have to be countered by the explanation that intelligence is also a gift from God, and we must use it to avoid the inevitable disaster. Animals do not have enough of it to appreciate this problem, hence elephants have to be culled to prevent them from committing mass suicide through population damage to their environment. For a long time, the Chinese have been forced into the tough job of compulsory limitation of family size; such discipline is possible only under authoritarian regimes. This would be our destination if we refuse to be educated on population matters. However, it is more likely to cause our society to disintegrate even before we get there. Let us consider a WHO analysis of the effects of population on the health of nations presented in the World Health Report eight years ago: 1. WHO HS Rank: overall WHO ranking of the health services of member states 2. Pop 000: Estimated population of the country as known in 2000. 3. PGR: Population growth rate 4. Fert: Fertility, the number of children per woman 5. Depend ratio: The number of people depending on one person. 6. Over 60: the percentage of people in the population surviving over the age of 60. 7. U5M: Under 5 mortality: the number of children dying before their fifth birthday. The table shows a number of countries listed in the "three world" groups. Japan, the UK and the USA belong to the First world of wealthy countries. They have moderate populations with low growth rates less than 1.0, and the fertility of their women lies between 1.4 for Japan and 2.0 for the USA. This means that these countries will have steady populations for the foreseeable future, and their strong economies will be able to cater for the relatively small increases. They have low dependency ratios, and low under-5 death rates. Some 20 percent of their populations expect to live to ripe old age of over 70 years for men and nearly 80 for women. Their lives are relatively free of painful and disabling diseases. The first column shows the rating of their health services. While Japan is first, the USA, with equally good and in some cases better health services is at position 15 because it has a large proportion of disadvantaged citizens. The standard of living in white areas of South

Africa is higher than that of the developed world, but again the huge social differences among her inhabitants have pulled the country to position 151. Although the populations of Third world countries are moderate, they have growth rates above 2.5 except for South Africa. Fertility is high, so are the dependency ratios. Under-5 mortality is very high—around 120, again except for South Africa. Life expectancy is around only 50. The economic growth rate will not be able to keep pace with the population growth rate, meaning that the proportion of poor people will increase as the population expands. These countries are scourged by preventable communicable "tropical" diseases that make the lives of the people short and brutish. The less fortunate ones become permanently disabled. Chile, Mexico and India are examples of "Middle World" countries. They are much better off. However, big contrasts of poverty and wealth exist within them. The same contrasts also exist in the Third World, but, while the privileged class form less than 2 percent of Third World populations, it is much greater in the middle group of countries. Development is more even, and they are politically more stable than their volatile Third World sisters. The lesson from all these is that, to fix its health sector, the governments of Nigeria will have to take health more seriously than they have done so far. The gross underfunding of the sector must end. The morale of health workers should be improved by better conditions of work and incentives. There is too much callous indifference to public opinion and military attitude and language in dealing with health and other workers. We have to include the establishment of true and stable democracy whereby people in government know that the citizens’ votes can throw them out of power. This will make them more sensitive to the needs of the people. Greater investment in health would have to go pari pasu with strict budgetary discipline to ensure that the funds are applied towards the goals for which they were voted. Nigeria needs to go back to implement its national health policy with all the tiers of government using the document as guide, and putting PHC on a firm pedestal, fully developing the preventive and promotive aspects of the policy. Intersectoral collaboration is essential, bringing in the private and voluntary sectors to collaborate and maximise the use of scarce resources. It would also involve inter-ministerial activities, where provision of amenities like water and power can be prioritised in conjunction with the health development plans. The health insurance scheme is still too distant from the people that need it most, and its implementation needs radical modification. While it is true that "government cannot do it alone," in Nigeria, it is premature for government to "withdraw subsidies" on health services without first providing the basic infrastructure and raising the economic power of citizens to sufficiently enable them thrive—that was how the advanced countries did it. Britain distributed free milk to all its inhabitants well into the late seventies—several centuries after it gained independence from the Romans—to counteract malnutrition. All developed countries have in place social benefits to look after their vulnerable citizens before requiring them to pay the "correct price" for social services. Gyoh is Professor of surgery, Benue State University, Markurdi. He was director-general, Federal Ministry of Health from 1988 to 1994.

HEALTH STATISTICS SAMPLED FROM FIRST, "SECOND" AND THIRD WORLD

Life Expectancy

M

F

1st W

HI INCOME

1

Japan

126,505

0.3

1.4

46

5

22.6

77.6

84.3

9

UK

58,744

0.2

1.7

54

7

20.9

74.7

79.7

15

USA

276,218

0.9

2.0

52

8

16.4

73.8

79.7

2nd W

ME INCOME

32

Chile

15,019

1.5

2.7

56

11

10.0

73.4

79.9

51

Mexico

97,365

1.8

2.7

62

26

6.8

71.0

77.1

121

India

998,056

1.8

3.0

63

97

7.5

59.6

61.2

3rd W

LO INCOME

139

Ghana

19,678

3.0

5.0

87

118

4.9

54.2

55.6

143

Benin R

5,937

2.7

5.7

96

157

4.3

51.3

53.3

151

South Africa

39,900

1.8

3.2

63

85

5.3

47.3

49.7

163

Cameroons

14,693

2.8

5.2

90

123

5.5

49.0

52.0

184

Nigeria

108,945

2.5

5.0

87

173

4.9

46.8

48.2

Adapted from the World Health Report, WHO Geneva, 2000