NIGERIAN HEALTHCARE SERVICES: FIXING THE HEALTHCARE CHALLENGES THROUGH PRIVATE SECTOR PARTICIPATION

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According to a study conducted by the IFC with assistance from McKinsey & Company in 2009, only a few countries in Sub-Saharan Africa are able to expend the WHO-determined average of US$35-US$50 (N5,250 - N7,500) per year per person on healthcare despite the surge in foreign assistance from several multilateral agencies and donors during that decade. The study estimated that over the next decade (2010 - 2020), US$25 billion – US$30 billion (N3.7 trillion - N4.5 trillion) in new investment will be needed in healthcare assets, including hospitals, clinics, and distribution warehouses, to meet the growing healthcare demands of Sub-Saharan Africa. The World Health Organisation (WHO) estimates that about 50% of Sub-Saharan Africa's total health expenditure is financed by out-of-pocket payments from its largely poor people. It is therefore understandable that Sub-Saharan Africa with about 11% of the world's population accounts for about 24% of the global disease burden in human and financial costs despite commanding less than 1% of global health expenditure. Globally, almost 50% of the deaths of children under five take place in Africa. In Nigeria, the Ministry of Finance reported that the resources available for delivering the essential health care package is about N3,848.00 (US$25.65) per capita. Low public spending on healthcare provides a huge opportunity to leverage the private sector in ways that will improve access and increase financing and the quality of healthcare goods and services throughout Africa.

The private sector already dominates the healthcare sector in Africa

In a region where public resources are limited, the private sector is already a significant player. About 50% of healthcare financing in Africa comes from private sources, and about 50% of total health expenditure goes to private healthcare providers since the vast majority of the region's poor people, both urban and rural, rely on private health care. In addition, increased attention from external donors has resulted in some remarkable initiatives that funnel billions of dollars to help combat the worst health scourges of the region, HIV/AIDS,

tuberculosis (TB), and malaria. However, most of the area lacks the infrastructure and facilities necessary to provide and deliver minimal levels of health services and products.

The region also faces a severe shortage of trained medical personnel, with just 3% of the world's health workers deployed in Sub-Saharan Africa. Furthermore, improving economic performance in Sub-Saharan Africa means that demand for healthcare is poised to increase further in the region. Hence there is a major role for the private sector in enhancing access to affordable healthcare services in Africa.

Health Expenditure and Resource Adequacy Indicators	Nigeria	Africa Average	Low to Middle Income Countries Average
Govt. Expenditure on Health (% of total)	36.7	49.8	45.4
Private Expenditure on Health (% of total)	63.3	50.2	54.6
No. of Physician (Per 10,000 People)	4.0	2.3	10.1
No. of Nurses & Midwives (Per 10,000 people)	16.1	10.9	16.8
No. of Dentist (Per 10,000 people)	0.3	0.3	0.9
No. of Pharmacist (per 10,000 people)	1.3	0.8	3.5

Source: WHO Health Statistics 2011

The Nigerian healthcare sector shares the same attributes with its African peers

Infrastructure decay, brain drain, incessant workers' strikes and low investments in the sector characterise healthcare services in Nigeria. Collectively, all tiers of the healthcare system have suffered. In 2011, national spending on teaching hospitals and federal medical centres is estimated at N204 billion; approximately 79% of the government's health expenditure. However, only N20.25 billion (10% of total hospital expense) is allotted to capital expenditure in spite of insufficient medical equipment.

Key Health Statistics	Nigeria	Africa Average
Life Expectancy at Birth (Yrs)	54	54
Maternal Mortality Rate (Per 10,000 Birth)	840	620
Birth Attended by Skilled Personnel (% of Birth)	39	48
Under 5 Mortality Rate (per 1000 Birth)	138	133
Prevalence of HIV in Adult (15-49yrs)	3.6	4.7
Malaria Mortality Rate (Per 100,000 Birth)	146	94

Source: WHO Health Statistics 2011

The structure of Nigeria's public healthcare system is multi-layered

Public health care delivery system in Nigeria consists of a network of primary, secondary, and tertiary facilities. In 2005, the Federal Ministry of Health estimated a total of 23,640 health facilities in Nigeria of which 85.5% are primary, 14% secondary and 0.2% tertiary health care facilities. 38% of these facilities are owned by the private sector. This has not changed significantly since then. Primary care was largely provided through health clinics and dispensaries spread throughout the country. Secondary care is provided through general hospitals and maternity centres while tertiary care is handled through the university teaching hospitals.

Inadequate infrastructure and poor staff morale lead to poor service delivery in public hospitals

The target areas for mass procurement of medical equipment are the teaching hospitals. The absence of proper facilities and inadequate remuneration of public sector healthcare workers have resulted in the coexistence of privately-owned hospitals which cater to those who can afford them side by side with the public healthcare centres. In public funded hospitals, physical facilities are often decaying, and equipment is either obsolete or non-operational as a result of power challenges. The irony however, is that the few highly skilled medical professionals are often found in public employment but are almost always providing consultancy services in privately funded firms or in their own personal clinics.

Nigerian Health indicators are very poor

According to the Federal Ministry of Health, the health indicators for Nigeria are among the worst in the world. Nigeria shoulders 10% of the global disease burden and is making slow progress towards achieving the 2015 targets for the MDGs on healthcare. The health indicators in Nigeria have largely remained below country targets and internationally-set benchmarks due to weaknesses inherent in the system. Hence the government is convinced that a purposeful reform of the National healthcare delivery system is necessary. The government, thus, initiated a process that led to the development of the National Strategic

Health Development Plan 2010-2015 (NSHDP) which was developed in a highly participatory manner in 2010.

…But the National Strategic Health Development Plan 2010-2015 has not taken off yet

The NSHDP 2010-2015, developed to strengthen the national health system and to vastly improve the health status of Nigerians, estimates that a total amount of N3.99 trillion (US$26.6 billion) would be required to reposition the Nigerian Health system over the 6 year period. Funding sources are limited largely to government spending at all levels, development partners via Official Development Assistance (ODA) and Non-Governmental Organisations (NGOs) and Philanthropists.

More importantly, significant funding of the plan is expected via the recently passed National Health Bill currently awaiting Presidential assent. The National Health Bill proposes a major paradigm shift in health financing in Nigeria through the establishment of a Fund to be known as the National Primary Health Care Development Fund. The Fund would be financed from the consolidated fund of the Federation, at an amount not less than 2% of its value; with grants by international donor partners and funds from other sources serving as additional funding.

Over the 6 year implementation period of the NSHDP, the estimated annual spending requirement is N666.16 billion. Unfortunately, in the first year of implementation in 2011, the total health sector budget is only N257.87 billion. This represents 5.75% of the total budget and less than half of the required annual spending. In addition, the National Health Bill upon which the spending is based is yet to become law. The rising competition for government resources continues to make it difficult for any sector to get the kind of guaranteed allocation that is proposed in the bill as well as potential increase in government expenditure to the sector in the future. The plan was delivered in August 2010 which was already eight months into its first implementation year. Therefore the plan already had a bad start and is unlikely to deliver results as intended.

Even the National Health Insurance Scheme has not delivered optimally

The National Health Insurance Scheme (NHIS) is one of several attempts by the government to improve access to quality healthcare for the Nigerian people. In 1999, the government established the scheme which is a federally funded social health insurance scheme. The scheme is designed to facilitate fair financing of healthcare costs through risk pooling and cost-sharing arrangements for individuals. The scheme has enormous potential to improve the financing of healthcare in Nigeria, thereby encouraging the development of higher-quality, more organised private sector providers. The implementation of the scheme began in 2005.

In 2010, five full years into the scheme, it was estimated that only 5.3 million Nigerians (3.73% of the population) were benefiting from the scheme, the majority of which were individuals working in the formal sector leaving large gaps among the poor and informally employed. Even in the formal sector, it is arguable that the scheme has not achieved the level of progress expected. The factors responsible for its slow growth include the non-universal enforcement of the scheme, inadequacy of medical facilities in many areas, poverty and low level of awareness.

Unstable global economic outlook might affect future donor assistance to healthcare

Another source of financing for healthcare is donor assistance. Overall, approximately 10% of Africa's health care expenditure was financed directly by donor aid in the decade of 2000 to 2010. The challenging global economic scenario in recent times as well as the unstable outlook suggests dwindling aid in the coming years making donor aid a potentially unsustainable source of healthcare financing. This suggests a need for the private sector to play a bigger role in the development of the health sector in Nigeria.

The sector requires provision of physical assets and training of additional health workers

The biggest area for private sector involvement will be in building and improving the sector's physical assets. A large number of additional hospital beds will need to be added to the existing base especially in under-served areas. In addition, the number of physicians, nurses, and community health workers required exceeds the number that will graduate from existing medical colleges and training institutions in Nigeria. Demand for better distribution and retail systems and for pharmaceutical and medical supply production facilities will also be strong.

The private sector has been involved in every facet of Nigeria's healthcare sector

Existing elements of the private sector involvement in the healthcare sector consists of non-public entities that include for-profit commercial companies, non-profit organisations, and social enterprises. Individual public sector health workers provide private sector services, both formally and informally, and an informal health sector of healers, midwives, and individual medicine sellers also exists. The private sector is often perceived as serving only the rich, but the opposite is often the case. In fact, private sector providers, including for-profit and social enterprises, play an important social role i.e. meeting the medical needs of the poor and rural populations underserved by the public sector. In addition, the private sector frequently provides services or products that might otherwise not be available, such as advanced medical equipment and procedures.

Funding challenge is limiting government's provision of healthcare services; hence the need for private sector participation

Obviously, funding the healthcare system in Nigeria has become burdensome to the government even as clamours for increases in health workers remuneration continue to persist. The well-being of the citizenry should be very important to any leader, as a healthy labour force will be more productive and will aid economic growth. Given the tightening fiscal policy regime, and an increasing willingness of the present government to embrace private participation in the provision of critical infrastructure such as highways and airports,

we recommend an application of the public-private partnership approach to the country's health sector.

Nigeria's experience with Public–Private-Partnership (PPP) in the healthcare sector has been considered successful

In March 2007, the PPP model was successfully implemented at the Garki Hospital Abuja, where a concession agreement for its management and operation was signed between the FCTA and NISA Medical Group after a competitive bidding process. Sector-wide adoption of the PPP model would have numerous upsides for the country including: improved quality of healthcare services provided, updated medical facilities, increased staff efficiency and a more reliable medical diagnosis and treatment process.

Successful implementation of PPP arrangements could be beneficial to Nigeria

Partnering with the private sector can have substantial benefits for the public partner and the health sector. Potential benefits include reduced government spending as large up-front investments of scarce public funds are eliminated, greater efficiency from private partners' operational efficiency, and better management of hospital services and infrastructure. In the health sector, partnering can also be particularly valuable as a method of leveraging technical or management expertise (for example, performance-based monitoring and incentives), and spurring technology transfer, all of which can lead to quality improvements. Partnering can also reduce or better allocate risks since the private partner may be better able to manage costs and schedule overruns.

PPPs can be beneficial for the health sector when they are well justified, prepared, implemented, and monitored, including being adjusted when necessary, in an appropriate and timely manner. PPPs should include well-defined objectives, clear division of roles and responsibilities, risk allocation, and other transaction elements to be agreed upon between the partners in advance. In that regard, the quality of contracts between the public and private partners and, in some cases, between partners and third parties is critical to the

success of a PPP. Most importantly, all parties in a PPP should bring adequate expertise and experience to the contracting process.

However, there are also important risks to consider

Leveraging partnerships and collaborations with the private sector to address the challenges governments face in healthcare today may not be easy. Public-Private-Partnerships and Collaborations may take a long time to establish and bring to fruition, and in some cases may not be the most effective or efficient option available. Planning an effective PPP involves careful review of the allocation of financial risks and rewards, decision-making processes and responsibilities, and the applicable regulatory and contractual framework.

Therefore careful evaluation of the conditions for success and sustainability is required

Accordingly, an accurate up-front evaluation of the likely trade-offs and benefits are required to appropriately design and pro-actively manage a PPP. This can uncover risks stemming from inadequate regulatory framework or low institutional capacity, which may need to be addressed either through special provisions built into the contract or through separate reforms undertaken by the government. These may include enhancing accreditation systems, updating patient rights policies and enabling transparency in health providers' performance.

Appropriate monitoring and management of quality and performance are particularly important in healthcare PPPs. Monitoring and evaluation mechanisms, performance indicators, targets and outputs, as well as any performance bonuses should be discussed upfront, built into contracts, and refined at the pilot stage, if possible. It is critical that the public partner has sufficient capacity for oversight and for making timely adjustments as needed. External oversight methods can also be utilised (for example licensing to practice or to operate a facility or a specific health technology, and accreditation according to agreed quality standards) in ensuring continuity in the monitoring and management of quality and performance.

HEALTHCARE DELIVERY SYSTEM FOR PILOT STATES

BAYELSA STATE	2010	2011	2012
Healthcare Budget (N)	3.79 billion	N/A	6.37 billion
Population	1,998,349		
Population density/sq.m	94.71km2		
HOSPITALS IN BAYELSA STATE			
Federal Government Owned Hospitals		Federal Medical Centre, Yenagoa	
State Government Owned Hospital		General Hospital, Olugbobiri	
		Odi General Hospital	
		Police Clinics, Bayelsa	
Private Medical Centres		St Peter's Hospital	
		Crest Consultant Clinic	
		Glory-Land Inri Hospital	
		Everly Medical Centre	
		Asueifai Clinic	
		Kuro Specialist Hospital	
		Glory-Land Inri Hospital	
		Alev Hospital	
		Alfa Clinic	
		Asueifa New Life Clinic	
		Believers Faith Medical	
		Bosek Clinic	
		Crest Consultants Clinic	
		DSS Clinic	
		Magcol Clinic	

	Mieye Medical Centre
	Opueze Mat.& Nursing Home
	Our Saviour's Clinic
	Palen Hospital
	Trinidex (Trinity) Medical Centre
	Tobis Clinic
	Pretoro Hospital

AKWA-IBOM STATE	**2010**	**2011**	**2012**
Healthcare Budget (N)	13.86 billion	9.456 billion	16.9 billion
Population	2,920,208		
Population density/sq.m	330/km2 (860/sq mi)		
HOSPITALS IN AKWA-IBOM STATE			
Federal Government Owned Hospitals		University of Uyo Teaching Hospital	
State Government Owned Hospital		General Hospital, Ikot Ekpene	
		General Hospital Etinan	
		General Hospital, Ikot Okoro,	
		General Hospital, Oron	
		General Hospital, Oron	
		General Hospital, Ikot Okoro	
Private Medical Centres		Emmanuel Hospital, Eket	
		Mary Slessor Hospital, Itu	
		Methodist Hospital, Ituk Mbang, Uruan	
		St. Luke's Hospital, Anua, Uyo	
		Mercy Hospital Abak	
		Imaobong Missionary Medical Centre, Mbak kpe	
		Palmer Memorial Mission Hospital, Ibiono Ibom	
		Eye Centre, Mercy Hospital, Abak	
		Gateway Clinic, Uyo	

DELTA STATE	2010	2011	2012
Healthcare Budget (N)	7.99 billion	3 billion	9.28 billion
Population	3,098,391		
Population density/sq.m	150/km2 (380/sq mi)		
HOSPITALS IN DELTA STATE			
Federal Government Owned Hospitals		Federal Medical Centre, Agbor	
		Federal Medical Centre, Asaba	
		Federal Medical Centre, Onicha-Olona (under construction in 2006)	
State Government Owned Hospital		Delta State University Teaching Hospital, Ogharra	
		Central Hospital, Sapele	
		Central Hospital, Warri	
		Comprehensive Health Center, Idumuje-Uno	
		Ekpan Government Hospital, Warri	
		General Hospital, Ibusa	
		General Hospital, Onicha-Uku	
		Government Hospital, Okwe-Asaba	
Private Medical Centres		Anointing Medial Centre Enerhen Warri	
		Agori-Iwe Memorial Clinic, Ughelli	
		Baptist Medical Centre, Eku	
		Baptist Medical Centre, Warri	
		Glory to God Hospital, Issele-Uku	
		Grace and Mercy Clinic/Maternity, Ughelli	
		Lily Hospital, Warri	
		Lonia Clinic and Maternity, Warri	
		Mariere Memorial Central Hospital, Ughelli	
		Midland Clinic, Anwai Road, Asaba.	
		Norhor Clinic, Ughelli	
		Pilgrim Baptist Hospital, Issele-Uku	
		Temple Clinic, Anwai Road, Asaba	
		Twins Clinic and Maternity, Off Deco Rd., Warri	
		Ufor Hospital, Uloho Avenue, Ughelli	
		Sunrise Hospital off Airport Rd. Warri	
		St. Rebecca's, Nnebisi Road, Asaba.	
		Eloho clinic and Maternity, Oviri, Agbarho	

EDO STATE	2010	2011	2012
Healthcare Budget (N)	(N/A)	1.8 billion	4 billion
Population	3,218,332		
Population density/sq.m	121.326/km2 (314.233/sq mi)		
HOSPITALS IN EDO STATE			
Federal Government Owned Hospitals		University of Benin Teaching Hospital, Benin City	
State Government Owned Hospital		Central Hospital, Benin City	
		Irrua Specialist Teaching Hospital, Irrua, Ekpoma	
Private Medical Centres		Aimiuwu Hospital, Benin City	
		Benoni Hospital, Benin City	
		Enofe Medical Centre, Eyea, Benin City	
		Evangel Hospital, Benin City	
		Faith Medical Centre, Benin City	
		God's Care Hospital, Benin City	
		Greenhill Radiological Centre, Ekpoma	
		Igbinedion University Teaching Hospital, Okada	
		Narrow Way Clinic, Benin City	
		Osionmo Hospital, Orhionmwon LGA, Edo State	
		Osula Royal Hospital, Benin City	
		Royal Crown Clinic, Benin City	
		St Margaret's Hospital, Benin City	
		St. Philomena Hospital, Benin City	

IMO STATE	2010	2011	2012
Healthcare Budget (N)	(N/A)	(N/A)	12.725 billion
Population	2,934,899		
Population density/sq.m	710/km2 (1,800/sq mi)		
HOSPITALS IN IMO STATE			
Federal Government Owned Hospitals		Federal Medical Centre (FMC), Owerri	
State Government Owned Hospital		Imo State University Teaching Hospital	

	Aboh Mbaise General Hospital
	General Hospital, Umuguma Road, New Owerri.
Private Medical Centres	Amanda Hospital Inc.
	Chidicon Medical Centre, Owerri
	Chinyere Clinic, Onumonu, Owerri
	Chidiebere Clinic 17 Ajiaku Street Owerri
	Christina Specialist Hospital, Egbu
	Holy Rosary Hospital, Emekuku
	Jacksman Hospital,Udo Ezinihitte Mbaise
	Joint Hospital, Amaigbo
	Joint Hospital, Mbano
	Jude Udokwu Memorial Hospital,amaifeke orlu
	Life Spring Specialist Hospital, Ikeneggu Owerri
	Oriegbu Clinic, Eziudo Mbaise
	Salvation Christian Hospital, Owerri
	St Damian's Hospital, okporo orlu.
	St Marys Children & Community Hospital, Orlu
	St. Vincent's Clinic, Orji
	Umezuruike Hospital, Owerri

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