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Healthcare Coverage and Affordability in Nigeria: An Alternative Model to Equitable Healthcare Delivery

Alex E. Asakitikpi

Abstract

Healthcare delivery in Nigeria has faced major challenges toward achieving universal health coverage. While significant progress was made in the first two decades after the country's independence in 1960, the economic downturn resulting from the plummeting of oil price of which Nigeria was dependent led to a series of twists and turns in the health sector. Health policies were subsequently influenced by external forces, and the adoption of the structural adjustment program signaled a shift from a predominantly welfare scheme to the introduction of user fee and the resultant proliferation of private healthcare provision. This paper discusses the crises that followed the turbulent health policies ever since by identifying some key factors that were glossed over by successive government regimes in formulating health policies in Nigeria. The paper concludes by suggesting a more inclusive model that will ensure equitability in the health sector and accessibility to healthcare services in the country.

Keywords: Nigeria, health policy, healthcare coverage, universal healthcare, health-seeking behavior, healthcare delivery

1. Introduction

Health policies in Nigeria have undergone tremendous evolution in the past 60 years but without the desirable quality of healthcare delivery system in place to advance the health status of Nigerians. While successive governments have made concerted efforts to promote health equity and ensure unrestrained access to health services, majority of the citizens are still grappling with various health challenges. These challenges are copiously reflected in the current World Health Organization (WHO) statistics where maternal mortality is among the highest in the world accounting for 19% of global maternal deaths [1]. The estimate of infant mortality rate in the country is 19 deaths per 1000 births with mortality among children under 5 at 128 per 1000 [2]. Furthermore, the average life expectancy of Nigerians is estimated by the World Health Organization to be 54.4 with women having a life expectancy of 55.4 and men of 53.7 [3]. These dismal health indicators have necessitated the call from researchers and other stakeholders for the Nigerian government to consider creative ways of responding to healthcare issues in the country.

In an attempt to understand healthcare problems in Nigeria, two major schools of thoughts are discernible. The first supports the neoliberal health policy that anchors its philosophy on market forces and the introduction of user fee for the provision of health services [4]. On the other hand, there are others such as the Nigerian government who promotes the continued expansion of public health centers by introducing health insurance, which is supposed to insure patients at all times, thereby expanding coverage and accessibility [5]. While these positions have their merits and, in one way or another, have been implemented in the past six decades with little success, there are some salient issues that have been glossed over which militate against the successes of health policies in Nigeria as they have evolved over the years. In this paper, we discuss the shortcomings of earlier policies and argue that the lack of a proper understanding and contextualization of citizens' health needs and their health-seeking behaviors is critical in designing appropriate health policies in the country toward the provision of quality health and access to services to the generality of the population. We identify the shortcomings that are associated with the theoretical framework of previous policies and discuss the implication of these on healthcare provision in Nigeria. Finally, we propose a model that is all-embracing toward providing universal healthcare services to Nigerians.

2. Contextualizing healthcare delivery in Nigeria

For a proper understanding of the current health situation in Nigeria, it is expedient to historicize the evolution of its healthcare system and within that framework examine some of the pitfalls that are associated with various policies. Prior to the coming of Europeans to Nigeria, the indigenous peoples that make up the country relied entirely on indigenous herbal and fauna knowledge to resolve various health conditions. The healthcare system was based on the quality knowledge of practitioners as well as defined ways of apprenticeship to qualify as a healthcare provider [6]. The medical student was expected to go through years of training both in herbal knowledge, therapeutic processes, and psychosocial relations. The underlying principle of traditional medical system was a sacred calling toward the preservation of lives and to serve as a cohesive element in the society. While traditional medical practitioners may charge "fees" (in the form of barter and general reciprocity), this did not form the bases for practice as there was no fixed and clear-cut "cost" for services rendered. Within this reciprocal framework, medical practitioners were regarded as custodians of life and were accorded the utmost respect in the society. With the coming of Europeans from the fifteenth century and the subsequent introduction of Western medicine, healthcare services became monetized so that health services were rendered for a standard fee. Although the colonial government did not overtly introduce Western medicine to rural folks, the importation of Western-trained medical doctors as well as Western medicine coupled with the influx of missionaries that used Western drugs as a means of evangelism, the seeds of drastic change in traditional medicine were sown. One key factor that led to the undermining of traditional medicine and its subsequent neglect was the missionaries' association of traditional medicine with witchcraft, Satanism, and evil. By 1960 when Nigeria gained her independence, Western medicine had been firmly established in urban centers, while missionary activities had also penetrated some rural communities. It was this skeletal framework that incipient indigenous governments built on after independence.

The underpinning philosophy of the First Republic was to ensure that Western-styled healthcare delivery became the primary source of health service in the country, and in order to achieve this, the government invested heavily in health by

awarding scholarships to indigenous students to study medicine, nursing, and other allied professions abroad. At the same time, the government of the day was also building hospitals (orthopedic, specialist, and general hospitals) both in capital cities in the states and in key urban centers. Equipping hospitals with personnel and consumables became the priority of the government. On their return from overseas, the early trained medical doctors were placed in key positions in the health sector, while the public was encouraged by the government to patronize public hospitals and Western pharmaceuticals that were provided free or heavily subsidized by the government. This welfare orientation of Nigeria's First Republic, incidentally, could not be sustained for long due to the downturn in oil price and the increasing corruption in political circles. The consequences of this development were dire: consumables became scarce commodities in hospitals, epileptic payment of salaries of health workers became the order of the day, and a deteriorating condition of service precipitated the mass exodus of medical personnel out of the country. At the same time, most health posts in rural and semi-urban communities were abandoned, and the rural folks who had initially had access to Western medicine and government generosity were left to fend for themselves. On the other hand, the patronage of Western medicine at the expense of traditional medicine had led to the dearth of highly skilled and knowledgeable traditional medical practitioners as most of them died without passing on their knowledge to the younger generation. Even if they had wanted to do so, it was difficult for them because majority of the younger generation had been introduced to Western education and religion (Christianity especially), which influenced their perception of traditional medicine as inferior to Western medicine and evil in their religious conviction. The confusion that these developments generated precipitated the rise of private medical practice both in urban centers and rural communities. The need to meet Nigeria's health challenges and the gap that was created by the exodus of qualified Western-trained practitioners as well as the dearth of skilled traditional medical practitioners paved the way for the proliferation of quacks and fake drugs from the 1980s onward [7, 8].

The introduction of private health practitioners led to the informal introduction of user fee in healthcare delivery and a concomitant rise in the cost of healthcare services. However, because of the economic downturn in the country starting from the late 1970s and the structural adjustment program that was initiated in the mid-1980s leading to the mass retrenchment in both the public and private sectors, fewer people could access private healthcare services [9]. This situation led to the massive importation of sub-standard drugs into the country. Furthermore, the breakdown of state machinery and the poor coordination of activities in the health sector encouraged unqualified personnel to set up health centers, quasi hospitals, chemist shops, and drug hawkers [10]. This situation generated an outcry for the complete overhaul of the health sector which culminated in the promulgation of Decree 34 of 1999 that established the National Health Insurance Scheme (NHIS).

3. Health-seeking behavior in Nigeria

The evolution of health policies in Nigeria has inevitably influenced the health-seeking behaviors of Nigerians. Incidentally, scholars who have examined health policies and their challenges in the country tend to lump the health-seeking behavior of the people and analyze it as a monolithic pattern [11]. On the contrary, however, patterns of health-seeking behavior in Nigeria are complex and multidirectional. Although economic analysts have classified Nigeria into two broad categories, namely, the super rich (the elites) and the masses, in reality, there are three broad groups: the upper class represented by the extremely wealthy including

politicians, the middle class consisting of the working class urbanites, and the lower class comprising urban squatters and the rural masses. Even at that, in practical terms, there are still some finer divisions in these categories. For example, among the upper class are those that are extremely wealthy and, as a rule, do not receive medical treatments in the country, and this category may be referred to as the upper-upper class category. They travel out of the country for their regular checkup and for their medication. Those that occupy the lower upper class patronize both international (foreign) medical service and, for minor ailments, exclusive local private health centers.

The working class citizens who constitute the middle class also have sub-categories. Those who occupy managerial positions in the organized private sector, directors and director general in the public sector, as well as owners of medium-scale companies usually patronize exclusive private health centers within the country, while those who occupy the middle sub-category within the middle class patronize private health services and specialized hospitals (such as orthopedic and teaching hospitals) in the country. Those who belong to the lower middle-class category primarily access private hospitals as well as general hospitals. The majority of the lower class access state general hospitals, chemist shops, drug hawkers, and traditional health practitioners that are ubiquitous in the society. Theoretically, while this categorization may be useful for analytical purposes, the reality in Nigeria is that there is a lot of crisscrossing in terms of health-seeking behaviors so that even those who occupy the upper class also combine their foreign medical services with local and spiritual means which the lower class also patronizes. This convergence in health-seeking behavior should not be analyzed as monolithic as the quality of care received by individual groups differ significantly and, thus, have bearing on their overall health status. While those who occupy the upper class use traditional health or spiritual health service merely as complimentary to the health services they receive outside the country, those who occupy the lower class sometimes use spiritual home, traditional medicine as their primary source of healthcare either due to the unavailability of other forms of healthcare services or the lack of funds to access these facilities. These patterns of health-seeking behavior are partly influenced by the health policies that have evolved in Nigeria. This recognition as well as the beliefs of the people is significant in developing a more holistic health policy that will provide universal healthcare coverage.

While neoliberal healthcare reforms have succeeded in providing healthcare services both for the upper and middle classes, they have neglected or technically excluded the lower class, which constitutes the majority in Nigeria. The reforms that were carried out in respect of revamping the ailing health sector (re-equipping government hospitals, ensuring constant power supply, provision of Western drugs and other consumables) have mainly benefitted the upper class and the upper middle class. The restructuring and commercialization of these health centers mean a higher cost of accessing them which the lower class cannot afford [12, 13]. The same is true of the NHIS, which has as its primary focus on those who work in the public and organized private sectors. Overall therefore, the neoliberal reforms in the health sector tend to privilege the upper and middle classes and disempower those in the lower class who make up over 75% of the approximately 190 million citizens.

4. The challenges of neoliberal health reforms

The philosophical underpinning of neoliberal health reforms in Nigeria as elsewhere is anchored on the logic of market forces. Although not entirely new to

Nigerians, neoliberal framework has significant constraints in its applications in the country. The African health system, with its humanistic face and barter system, still demanded some form of reciprocity from patients and their households. The missionary hospitals also had some form of market orientation in its healthcare delivery system, and through the years Nigerians are well acquainted with paying for health services [14]. Despite the welfare scheme during the First Republic, majority of the citizens were still prepared to pay for health services when the state could not sustain its welfare scheme. With the proliferation of private healthcare and the importation of sub-standard drugs, which questioned the quality of healthcare delivery in the country, most people became weary of Western medical care and resorted to other forms of healthcare services including spiritual healing. If assured of high-quality drugs as well as quality healthcare services, most Nigerians will still be prepared to pay for these services. Despite the dislocation of healthcare systems leading to eclectic health-seeking behavior in response to the proliferation of healthcare services, most Nigerians especially those in the middle and lower class still have difficulties accessing these services due to their prohibitive costs and questionable quality of drugs. The World Bank's [15] estimates of over 60% of Nigerians living below the poverty line indicate that a significant portion of the Nigerian public cannot access quality health service due to the concomitant high costs that are associated with neoliberal reforms. Within this theoretical framework, majority of the Nigerian public are faced with a dilemma: either the government subsidizes for quality healthcare services for the majority of citizens to enjoy quality healthcare or the majority of citizens must access other forms of services with questionable quality. The government's efforts at restructuring the health system by providing funds for the rehabilitation of dilapidated hospitals and ensuring uninterrupted supply of quality drugs mean that costs of health services will inevitably go up. As reported by researchers [16], there is an inverse relationship between the cost of health service and patronage with the poor responding sharply to changes in cost of service. With such neoliberal reforms, the suspicion of the public toward the government regarding health services as experienced from the late 1970s only exacerbate their suspicion of the government regarding healthcare delivery and government's conspiracy to strip them of their citizens' right to quality health. This suspicion means that increase in health cost is translated as a conspiracy between local politicians, policy makers, and global economic forces represented by the international pharmaceutical industry. This conspiracy theory reverberates in most sections of the Nigerian society.

Besides cost, access becomes an important issue in discussing healthcare delivery within the neoliberal framework. As noted in the previous section, the structural adjustment program, which led to the reduction in health personnel and the abandonment of health centers in rural areas and semi-urban centers, meant that with the introduction of user fee, the ratio of health personnel to the population as well as the ratio of health centers to the population dramatically increased. On the other hand, the restructuring and rehabilitation of health centers led to more Nigerians in the upper middle and upper class reverting to accessing health services within the country, thereby pushing away lower middle-class members who hitherto accessed health services in urban centers. This disparity in healthcare accessibility is an important consequence of the neoliberal reform which skewed significantly those who have access to quality Western medical health services and those who do not. What this means is that the reforms initiated by the Obasanjo administration starting from 1999 only favored a few who occupy the highest echelon of the society and disempowered the majority of citizens. This scenario has left the majority of the citizens to seek for alternative healthcare services both in the informal private sector and the patronage of quacks and drug hawkers. The conclusion to be drawn

from this assessment is that neoliberal reforms in the health sector did not succeed in providing universal health coverage and accessibility but succeeded in upgrading the healthcare system with a tiny minority of the population as its main beneficiary. The realization of this shortcoming prompted the federal government to initiate the NHIS with its cardinal aim of universal health coverage as well as accessibility and equity among the population.

5. Challenges of the NHIS

The philosophy behind the NHIS and its design seems promising especially in terms of equity and accessibility [10, 17]. Although a relatively new concept in the health sector in the country, insurance itself is not a novel phenomenon to Nigerians. The concept of insurance as it applies to various aspects of the Nigerian life has been in existence since the country's independence. But 10 years after the launching of the NHIS, no significant progress has yet been made. Only about 10% of the Nigerian population is covered by the scheme with the vast majority still left to fend for their health needs [18]. While the government has patted itself on the back for the modest progress in health insurance coverage, the reality is that most of the insured are private employees and government officials who are coerced to patronize the scheme. The exclusion of certain drugs and diseases such as diabetes, sickle cell anemia, HIV, cancer, and other chronic diseases also means that even those that are insured will seek alternative means to meet some of their health challenges. More importantly is the unwillingness of low- and medium-scale entrepreneurs to register their employees with the insurance scheme as stipulated by the Act. Entrepreneurs connive with their employees not to register with the NHIS as it is profitable for both parties to do so. The rationale behind this noncompliance is based primarily on the seeming benefits that both employers and employees believe they will enjoy since the Act mandates employers to pay 7.5% of the premium and the employees to pay another 7.5% of the total premium. The general belief is that registering for the NHIS would not guarantee access to quality health service due to various historical antecedents that are associated with insurance schemes in Nigeria [10, 19].

Various insurance schemes such as house insurance, education insurance, and life assurance that were introduced in Nigeria in the 1960s and early 1970s did not meet the expectations of those who embraced the schemes as their claims were not paid when the need arose. This disappointing experience led to the unofficial appellation of "pen robbers" that was associated with insurance companies. A similar case is the Nigerian pension scheme which also suffered a major scandal as a result of the nonpayment of retirees due to corrupt practices of government officials that were responsible in managing the pension funds. These historical experiences have significant bearing on the average Nigerian's perception regarding the sincerity of the government and the efficacy of its policies especially those that encourage contributions from the general public for a common good such as the NHIS. The government's alignment with global practice of neoliberal ideology is therefore seen by the middle and lower classes as a grand conspiracy by the ruling class to perpetuate the enormous gap between the elitist class and the masses. This conspiracy theory is grounded not only in the experiences of citizens in the health sector but in almost all facets of life in the Nigerian society. The gross neglect of the Nigerian public by successive regimes, starting from the mid-1980s, significantly eroded any confidence the people have in the government. It is precisely because of this disconnect between the state and its citizens that there is a lack of any meaningful social movement that forces the government to take up its responsibility and

be accountable to the people [10]. In cases where professionals such as medical doctors, nurses, and other health workers have engaged in social protests such as strikes, the government of the day had handled such social protests with a heavy hand leading to the mass exodus of highly qualified personnel in the health industry, which further compounded the problem. The near collapse of the health sector in Nigeria is one of the most important factors for the proliferation of various cadres of healthcare services and the concomitant eclectic health-seeking behavior of Nigerians.

6. Healthcare providers in Nigeria

Various scholars who have discussed healthcare provision in Nigeria although have identified key healthcare providers in the country have failed to match these various providers with those that patronize them and why. Some scholars [20, 21] correctly dissected the various providers of health services in Nigeria which can broadly be classified into two groups: government-owned health centers and those owned by private organizations and individuals. While health services were predominantly provided by the government up to the mid-1980s, private health providers have exponentially increased in the last 30 years. Government health services are generally regarded as public hospitals and those owned by other groups as private, but this nomenclature may not be entirely correct in the twenty-first century and therefore may be misleading. It is true that before the introduction of user fees in government health centers, the general public had access to these health centers. However, the transformations of various government regimes initiated in the health sector have technically excluded majority of the public making it a “public-private” health center. On the other hand, private health centers such as hospitals and maternity homes that are owned by Christian missionaries although regarded as private have become more public than government-owned hospitals primarily because of the cost differentials between government-owned and missionary-owned hospitals. Furthermore, some of these missionary hospitals and maternities are sited in rural areas and semi-urban centers giving access to rural dwellers, thereby making the missionary hospitals more accessible to underserved communities.

In addition to the abovementioned forms of health providers is the proliferation of other healthcare providers, namely, the private hospitals that are owned by qualified medical practitioners, licensed pharmacists, the unqualified and unlicensed chemist shop owners, the ubiquitous drug peddlers, traditional drug hawkers, knowledgeable traditional herbal healers, and other forms of health providers including spiritual homes and churches. The high cost of accessing government specialist hospitals as well as teaching hospitals and the bureaucratic structure of general hospitals has increased the demand for private health provision, which predominantly caters for the middle-class cadre. Because of the availability of genuine drugs and the services rendered by private practitioners, the costs are generally high and are, thus, not easily accessible to the masses. Although the licensed pharmacist on the other hand sells genuine drugs, there are instances where some have engaged in sharp practices by mixing genuine and fake drugs or sometimes leasing out their certificates to unqualified personnel to set up chemist shops [7].

Incidentally, drug peddlers fill a unique gap in the health market as they source their drugs mainly from China, Thailand, India, and other Asian countries targeting a section of the population that is made up of unskilled and manual workers. The drugs that are usually sold include energy-boosting drugs, multivitamins, blood

tonic, general pain killers, and other drugs that are associated with common health complaints associated with this group of people. The majority of customers who patronize drug peddlers are those in the low-income bracket, and although may patronize chemist shops, their major source of drug supply is through peddlers who also act as health advisers. These health “advisers” are usually strategically positioned in busy bus stops, marketplaces, and commercial busses. Traditional drug hawkers, like drug peddlers, also meet the need of specific categories of clients although sometimes the clientele spectrum cuts across economic classes. The traditional hawkers represent people who have some knowledge of traditional medicine or those who are recruited by traditional medical experts. Usually most of these traditional medicines are packaged in various forms (in bottles, wrapped in paper, nylon sachet, etc.) which are sold to the public. The illness types they target include children-related diseases (such as infections, diarrhea, skin rash, etc.), pile, eczema, dysmenorrhea, ring worm, poor sexual performance, and low sperm count, among others. This category of health providers enjoys large patronage primarily because of the low cost of the drugs and the cultural engagement the providers have with their customers. The cost of these traditional drugs is relatively cheap because they are locally sourced, while hawkers display a high level of familiarity with the drugs they sell and the diseases they are supposed to cure [22]. It is common to see these hawkers in strategic points such as crowded bus stops, marketplaces, and commercial busses (a major means of transport for low-income earners). They advertise their products with bull horns and other forms of public address systems to attract their audience. Sometimes they use patients who are suffering from ailments they claim their drugs can cure to demonstrate the efficacy of their products.

The marketing strategy of these hawkers is also displayed in commercial busses by engaging commuters first by praying in the local language and wishing everyone “Alafia” or good health. The hawker then proceeds by listing series of symptoms associated with a variety of diseases and then presenting their audience with the drugs that are applicable to cure the ailment. It is not uncommon to hear them discuss about Western medicines and their efficacy, but they are quick to also point out the high cost of purchasing them as well as the side effects they leave in the human body. This display of medical knowledge seems to be an effective way of convincing commuters to patronize their products. It is interesting to note that not only the uneducated public patronizes these traditional hawkers but the educated public also and some who belong to the middle-income class.

Often this category and the former category, namely, the hawkers of Asian drugs complement each other as it is not uncommon to see traditional medicine hawkers also selling Asian drugs. These two categories of health providers are the most common sources of healthcare service among the vast majority of low-income earners in urban centers, thereby occupying a strategic position in healthcare delivery in Nigeria. Skilled practitioners of traditional medicine although could be found in urban centers are predominantly the major source of healthcare in rural areas. They still retain the informal traditional structure of healthcare, but they have also introduced monetary rewards for the health services they render. While scholars have argued that traditional medical practitioners lack precise knowledge of diseases and have been criticized for the unhygienic environment in which they operate as well as lack of standardization of their therapy, they still constitute an important source of healthcare delivery in Nigeria. Although it is true that some practitioners do not have precise knowledge and skills to handle some form of ailments, credit must be given to them for their ability to treat common diseases and sometimes complex ailments such as mental illness, thereby creating stability in rural communities. Despite the general onslaught of medical practitioners and health scholars on traditional medicine and its practitioners, the fact remains that

very few studies have been carried out to identify areas of relative strengths of traditional health practitioners. The general tendency of discussing traditional medicine as monolithic and unspecialized is grossly misleading and gives the erroneous impression that traditional medical practitioners are static in their knowledge and do not in any way improve upon the existing knowledge they received during their training. The policies have neglected these critical areas of healthcare provision, and the need to evolve some innovative ways of incorporating them into the overall healthcare policy must be initiated, developed, and executed.

Similar to the above, very few scholars have discussed the emergence and prevalence of religious and spiritual health centers and the role they play in healthcare delivery. These centers are different from missionary hospitals that were discussed above. By religious/spiritual health centers, we mean the rise of new religious movements (such as Pentecostalism and syncretic forms) as major providers of healthcare services that rely on patients' faith and spiritual leaders' ability to manipulate spiritual elements to achieve miraculous healing. By employing religious artifacts and relying on the efficacy of prayer for healing purposes, prophets and pastors encourage their congregation to combine faith with Western medicine or to wholly depend on the supernatural for their healing and miracles. Religious/spiritual health centers began to emerge as a major alternative source of healing in the 1980s. This is not surprising as it coincides with the period when the government public hospitals began to lose their appeal as a result of their neglect by the government. The patronage of this form of healthcare cuts across all spectrum of socio-economic status. Those who patronize this form of healthcare, however, compliment the services with other forms of health provision; religious extremists completely rely on this form of healthcare for various ailments including child delivery and reproductive health more generally. These health providers may constitute a tiny minority, their influence is increasing, nevertheless, and they are attracting people from all cadre of the social strata.

7. Toward an alternative model for equitable healthcare delivery

The complex relationship between health-seeking behavior, the production and distribution of medicines, and health conditions in Nigeria requires a perceptive understanding of their interconnectedness and the development of an appropriate framework that will synthesize these patterns toward developing health policies that will reduce mortality and morbidity rates as well as improve the quality of life of citizens. The Nigerian government has not made significant progress in reducing maternal and child mortality as well as meeting the United Nations' health-related millennium development goals and the current sustainable development goals precisely because of this lack of coordination in the health sector. The neoliberal transformation in the health sector with its global perspective that anchors its principles on free market enterprise does not square with the sociocultural reality in Nigeria. While neoliberal reform took for granted basic social and economic factors in developing its structure and modalities, the neglect of these factors has far-reaching consequences in dealing with health issues in Nigeria. One of such sociocultural factors is the health-seeking behavior of citizens. In Europe and North America, response to ill health is essentially unidirectional and embraces Western medicine, but the same is not true in Nigeria as has been espoused in this paper. This is not to say that citizens in the West do not explore other forms of healthcare; what is essential is that they mostly utilize other sources such as yoga and acupuncture, among others, as complimentary medicines.

The conspicuous neglect in Nigeria's health policies in the variety of ways of seeking healthcare has greatly undermined the reality; hence the key principles of equity and coverage are severely compromised. Furthermore, the organic structure of the Ministry of Health even though has clearly defined hierarchy with local governments in charge of healthcare provision at the grassroots, state governments in charge of general hospitals in urban and semi-urban centers, and the federal government coordinating these tiers including tertiary health institutions and specialist hospitals, there is no officially recognized structure that coordinates other forms of healthcare providers. This lack of cooperation either at the federal or state government and the scattered informal healthcare providers is critical in understanding why various types of health providers with questionable skills and competence flourish in the country. This factor could be identified as the singular most important reason why mortality rates in Nigeria are still high especially in urban and semi-urban centers. On the other hand, mortality rates are also high in rural areas not necessarily because of the absence of state presence in these areas but because traditional medical knowledge has, since independence, been grossly neglected, thereby giving room for quacks to hijack by masquerading themselves as skilled medical practitioners. These traditional quacks and charlatans are primarily responsible for the high mortality rates that are recorded in rural communities. To overcome this challenge, the government needs to erect structures to coordinate the activities of skilled traditional medical practitioners and set up a formal standard to exclude quacks. In the long term, the government needs to set up research institutes that will encourage and support skilled traditional medical practitioners to document, research into the working models of traditional medicines, and explore ways of improving such knowledge. Since rural dwellers are comfortable with traditional medicine and because traditional healthcare practitioners have devised informal but effective ways of relating with patients in rural communities, government and medical research scientists need to explore these ways of patient-doctor relationship to serve as important innovations for policy implementation. Studies have shown that the formal and sometimes arrogant doctor-patient relationship in government hospitals is a significant factor why utilization is low [23–25]. Exploring this important dimension of healthcare provision and identifying alternative ways that are more culturally sensitive to the people will go a long way in achieving universal health coverage.

The recognition of African medicines and their practitioners by the WHO and its recommendation to African governments to adopt it in their health policy are in order, and there seems to be some progress made in this direction. For example, the number of African countries with national African medicine policies increased from 8 in 1999–2000 to 39 in 2010, and those with national African medicine strategic plans rose from 0 to 18. Countries' regulatory frameworks increased from 1 in 1999–2000 to 28 in 2010. Also, by 2010 eight countries had institutionalized training programs for African medicine practitioners [26].

However, despite the abovementioned progress, the issue of sustainability is still a recurring decimal in the analysis of healthcare provision in Africa. In Nigeria, as in other African countries, approach to healthcare sustainability still persistently tilts toward a global capitalist perspective which attempts to address this issue by encouraging the government to expand its budgetary allocation to the health sector for the supply of very expensive Western medicines that are beyond the reach of the average Nigerian. For example, the WHO has subscribed a minimum of 25, 18, and 14% at various times as the minimum budgetary allocation for healthcare. However, with poor economic craftsmanship, structural adjustment programs that were implemented in most African countries, corruption among government officials, and the competing needs of other sectors of the society have all undermined

the ability of the government to sustain the huge cost that is associated with healthcare delivery. User fee experience in Africa toward the purchase of Western drugs indicates varied results. For example, Gilson [14] in her review of user fee experience on the continent noted that a significant number of African countries have not benefited from this kind of healthcare reform. Similarly, the review made by Lagarde and Palmer [27] regarding user fee experience in Africa indicates varied experiences with Nigeria having recorded mixed utilization rates. One reason for these mixed results is the complete reliance of African government on the importation of Western drugs and other consumables without a concomitant framework for the production of traditional medicines. The relative economic weakness of most African countries and their low GDP make it extremely difficult for African countries to sustain this expensive enterprise. As noted above, while Nigerians, especially those in urban centers, have embraced Western medicine and some can even afford it, majority of the citizens in rural areas as well as the urban poor are still comfortable with traditional medicine, and it is within their reach. There is a need therefore for the government to include in its health policy and within the ambit of the Federal Ministry of Health to encourage the local production and fair distribution of African medicines. Such herbal production should be closely monitored to meet the basic standards that the government will set for the purpose of quality control. Such efforts will not only create jobs for indigenous citizens, but more importantly, indigenous medical knowledge will also become fully developed and contribute to global herbal knowledge. Such projects when embarked upon will trigger a series of development within the country, one of such being the need to intensify campaign for faunal and floral renewal as these are the primary sources of traditional medicine.

The pervasiveness of religion in Nigeria and the increasing use of spirituality to meet health needs are critical in the healthcare equation even if not for curative purposes, but for therapeutic processes. Studies have shown that religion and spirituality are important coping strategies that patients use as part of their therapy. Studies conducted by Koenig [28] and in an extensive review of the literature [29] revealed a positive relationship between religion/spirituality and health outcomes; these results have far-reaching implications for healthcare delivery and health policy formulation in Nigeria especially so when almost all citizens have some religious affiliation and are spiritual in nature. Although still informal in the country, there are indications that both patients and providers actively seek the spiritual assistance of religious members as part of the therapeutic package. While this is a positive development, there is a need for the government to officially recognize this form of healthcare and incorporate it in its health policy for proper coordination.

8. Conclusion

Healthcare delivery has undergone tremendous transformation since Nigeria's independence in 1960. While significant progress was made in the first two decades, the economic downturn resulting from the plummeting of oil price of which Nigeria was dependent led to a series of twists and turns in the health sector. The structural adjustment program signaled a significant shift from a predominantly welfare scheme to the introduction of user fees and the subsequent proliferation of private healthcare provision. The chaos that followed this highly unregulated private healthcare and the introduction of fake drugs into the market precipitated an unprecedented maternal and child mortality as well as a general reduction of life expectancy in Nigeria. This chaotic situation led to the launching of the National Insurance Scheme that encouraged co-payment for healthcare services.

Although these efforts have recorded some gains, the result is still far from the expected target of the federal government which was to meet the MDGs. We have argued in this paper that the neoliberal reforms in the health sector, which is today epitomized in the NHIS, are defective in significant ways leading to problems of inequity, accessibility, and sustainability. While the core of the health policy may be maintained to continue to cater for the elite group in Nigeria, there is a need to expand the boundaries of the policy to accommodate and recognize other forms of healthcare service including indigenous healing practices and religious/spiritual healing by taking into consideration the complex nature of Nigeria's health-seeking behavior. Such expansion will not only reduce maternal and child mortality due to increase in accessibility and utilization, but more importantly, it will help to address the issue of sustainability. Generating drugs locally will meet the basic health needs of citizens especially those in rural communities, empower rural folks, and involve them as important stakeholders in the process of transforming Nigeria into a healthier nation.

Conflict of interest


The author declares no conflict of interest for this article.

Author details

Alex E. Asakitikpi
Monash University South Africa, Johannesburg, South Africa

*Address all correspondence to: alex.asakitikpi@monash.edu

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