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A Critical Appraisal of Modern Healthcare Delivery in Nigeria

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Abstract
The modern healthcare delivery was introduced in Nigeria by Missionaries and was advocated by the colonial administration. In its years of existence, it was effective and actually met the health needs of the populace. However, in the last few years the quality and services in the country had declined to the extent that citizens with complicated health problems are now compelled to travel outside the shores of the country for proper medication. The paper examines the history and structure of modern health care delivery in Nigeria and as well examines its importance on the wellbeing of the people. It also examines some of the challenges that have bedevilled modern healthcare delivery in the country. Significant of these challenges are poor funding of the health sector; dearth of qualified health personnel, inadequate health facilities, prevalence of corrupt practices within the health sector among others. The paper recommended amongst others, an increase in budgetary allocation for the health sector, training and re-training of health personnel in Nigeria for effective service delivery.
Keywords: *Healthcare Delivery, Modern, Nigeria*

Introduction

The provision of effective healthcare services to citizens globally is one of the cardinal roles of government; especially as it relates to the provision of quality modern health care delivery (Ogidi, 2013). This is predicated on the belief that "health is wealth," it is only when the people are healthy that any meaningful development can take place (Ogye, 2019). The forbearers of the Nigeria people invented their own art of health care systems from the earliest period of their existence. This is to say that health care system is not alien to the Nigerian people, but modern medical practice as we have it today in Nigeria is a colonial legacy. At its inception the religious missions had played significant role in modern medical practice. It started when the missionaries established the Sacred Heart Hospital in the 1860s in Abeokuta. Then other missions outreach followed, like Baptist Mission, Presbyterian Mission, Sudan United Mission and Sudan Interior Mission. Mission-based health facilities were concentrated in certain areas, depending on the religious and other activities of the missions. The British colonial government provided formal medical services with the construction of several clinics and hospitals in Lagos, Calabar, and other coastal trading settlements in the 1870s (Oke & Owumi, 2010 and Ogidi, 2013). Government hospitals and clinics further expanded to other areas of the country as western activities increased (Tile, 2016).

Most of the public medical centres that were established functioned relatively well in terms of the provision of essential drugs and the availability of qualified medical personnel and other paramedical that were needed to render services to the citizenry (Alubo, 1986). In 1980s, adequate funding was made for the health sector both at federal and state levels. It is important to note that at this time Nigeria's health care system compete favourably with those of Western countries like US and UK. This was because at that time, annual budgetary allocations from both the federal and state governments met the operational expenses of health ministries and agencies.

And this was also regular even if not always sufficient due to competing demands from other sectors of the economy (Alubo, 1986).

The mismanagement of public funds by political elites undermined the quality of health care delivery in Nigeria. The implications of this development are the constant devaluation of the nation's currency and rise in cost of governance. These stringent economic measures have affected the running and funding of modern healthcare delivery in the country. In this circumstance, government was left with no other option but to always cut its annual budget, thus exacerbated the conditions in healthcare services. The menace is characterized by decayed infrastructure in the health sector with an unprecedented demand for modem healthcare that far outstripped its availability. In most health centres in the country, it has become increasingly difficult to get the necessary equipment that could aid the treatment of most diseases like cancer, kidney failure and stroke in the country due sharp practices as well as diversion of funds and resources made for healthcare (Ogidi, 2013 & Ogye, 2019).

Succinctly, many Nigerians have expressed high hopes for an improvement in modem health care delivery in the country. This is because there have been numerous policies and commitments by different governments in recent times to revamp the health sector. The reality on ground is that modem healthcare delivery in the country continues to deteriorate. This explains the reason an increasing number of Nigerians, especially the wealthy consistently seek medical care in overseas and even some neighbouring African countries. The situation is not only pathetic but a national embarrassment to the nation called Nigeria that pride itself as the giant of Africa, and the sixth largest production of crude oil in the world (Alubo, 1986). It is following from here that this paper undertakes to explore the relevance and some of the challenges affecting the provision of universal healthcare delivery in Nigeria.

Significance of the Study

The study has both practical and scientific significance. Practically, the study would help the government and policy makers to improve modern healthcare delivery in Nigeria. The health users will also benefit because it will improve their knowledge on identifying qualitative health services. Scientifically, the study will help to fill the void that currently exists in this topic area.

Methodology

In order to draw out the maximum amount of relevant information from the topic, this paper reviewed secondary data through cross-referencing of secondary information collection and content analysis.

Conceptual Review: Modern Healthcare Delivery

In today's healthcare delivery system, the people are at the centre of an intricate network of clinical, medical facilities, and other elements of the system. For citizens to enjoy optimal health as individuals and as a population, they must have the benefit of high-quality healthcare services that are effectively coordinated within a strong public health system. The capacity of the healthcare delivery system is to serve the population in terms of cultural competence, quality, professionalism, funding, information system and emergency preparedness. Orthodox (modern) medicine came with the specialization and a rational, scientific approach to disease. Its advantage to other medical systems rests on its association with other modem sciences, its intellectual ethics of free inquiry and precise observation, its spirit of humanism and its status as an enlightened liberal profession. A major feature of modem health care system is that, it is closely tied to cost or monetary value, notwithstanding the political ideology of the society. And this has hindered the ability of many citizens both in Western and non-western societies to enjoy quality health care. Another feature of healthcare in modem societies is limited access to competent medical care. Often times, this problem is a reflection of dearth of qualified physicians and other health

professionals in ratio to the sick population especially in many developing countries (Umar, 2006).

According to Olugbenro (2011) healthcare delivery is the services of looking after the health of all the people in the country or area hence, health care delivery is the activities or services of promotion and maintenance of a state of optimal physical, emotional and social wellbeing; the prevention of diseases and rehabilitation, aimed of enabling Nigerians live productive lives. Similarly, Doob (2000) describes health care as the variety of public and private organizations that support an individual's effective physical, mental and social adaptation to his or her environment. Ozo-Eson (2011) sees health care as an aspect of health services that involves institutional tools developed for repairing and preventing illness in society. Healthcare is often a matter of persuading or educating people to change certain kinds of behaviour that affect their health (McMahon, Barton and Piot, 1992).

Theoretical Framework

The Political Economy Theory of Health

The theory is derived primarily from the works of Marx cited in Schaefer (2008) and his followers. Navarro (1970) was identified as one of the foremost proponents or theorists of the political economy theory. The political economy of health concentrates on issues of economy and state policies, and how it relates to health and medicine. The theory denotes economic production and distribution of scarce resources in human society. It explains economic systems and particularly class relations among people as well as between genders in the society. According to political economy theorists, accessibility to health care in human societies is greatly determined by social class, gender and ethnicity which is caused by differences in wealth, income, and living/working conditions of members of the society (Haralambo, Holborn & Heald, 2004).

Many works on the political economy of health indicate a link between the political economy of some developing countries like Tanzania, Ethiopia, Mozambique and Nigeria in relation to their health service organization and distribution (Ozo-Eson, 2011). Studies have shown that the problem of health services in these countries is directly influenced by wide spread inequality in the distribution of economic, social and political resources (Ozo-Eson, 2011Alubo, 1995; Onoge, 1975). This explains the position of Alubo (1995) that in Nigeria, even after independence, and with much revenue made from the oil boom, the state of ill-health and poverty has remained the lot of the populace. The relevance of the political economy theory in this paper rest on the premise that since independence, health care has been politicized to favour of the very few rich in the society. This demonstrates the fact that in spite of all the numerous policies and programmes in the health sector executed by successive governments in Nigeria, majority of the populace have been denied fundamental basic health needs (Eboh, 2008).

The goal of the political class is to ensure that they enjoy some form of exclusive rights and privileges in medical care by consciously neglecting public health institutions in the country; and at the same time vote huge resources for themselves to regularly engage in foreign medical trip. It is the political power and social status they occupy in the society that influenced them to make policy that favoured the capitalist principles, since most political class owns private clinics. However, this is at the detriment of the common man or poor citizens who do not have any other alternative but to patronize the ill-equipped, neglected and deplorable health institution in the country. Poor funding of health sector as a social phenomenon in Nigeria has become both social and medical indicators for political elites and upper class to distinguish themselves from the common man or poor in the society. The economic and political structures of the Nigerian society create social divisions, classes, hierarchies, antagonisms and conflicts that produce and reproduce inequalities.

The History of Modern Healthcare Delivery in Nigeria

Modern healthcare practice was introduced into Nigeria in the 1860's, when the Sacred Heart Hospital was established by Roman Catholic missionaries in Abeokuta. Mission based establishments were centred in certain regions, depending on the religious and other animations of the missionaries. Catholic hospitals particularly were concentrated in the south-eastern and mid-western regions. While the next largest sponsors of mission hospitals and other aids respectively were placed side by side with mission work by the Sudan United mission, which centred on middle-belt region, and the Sudan Interior Mission, which worked in the Islamic northern region of the country. Together, they operated twenty-five hospitals or other facilities in the northern part of the country. Many of the mission hospitals remained central components of the healthcare outreach in the north till 1990s (Ogidi, 2013). Pearce (1982) points out that colonial administration later converted these emergent medical systems into colonial service. The missions also played significant role in medical training and education. They provided training for nurses and paramedical personnel and sponsored basic education as well as advanced medical training, often in Europe, for many of the first generations of Western educated Nigerian doctors. In addition, the general education provided by the missions for many Nigerians helped to lay the groundwork for a wider distribution and acceptance of modern medical care (Ogidi, 2013cited in Ityavyar, 1985).

It was followed by British colonial government which began providing formal medical services with the construction of several clinics and hospitals in Lagos, Calabar, and other coastal trading centres in the 1870s to take care of their health needs. Unlike the missionary facilities that served the larger population, the colonial medical services were at least initially, solely for the use of the European. Services were later extended to African employees of European concerns. Government hospitals and clinics expanded to other areas of the country as European activity increased there. The hospitals in Jos, for example, were founded in 1912 when tin mining activities began (Ogidi, 2013 cited in Ityavyar, 1985).

Then after the end of World War I in 1918, medical facilities were expanded substantially, and a number of government-sponsored schools for the training of Nigerian medical assistants were established by colonialists. In addition, after World War II, partly in response to nationalist agitation, the colonial government tried to extend modern health and education facilities to most of the Nigerian population. In this regard a ten-year health development plan was announced in 1946. In 1948 the first full-fledged medical school, University College Hospital (UCH) Ibadan was founded (Erinosho, 1998). This further boosts the training of medical professionals in the country. By 1960 a number of nursing/midwifery schools were established, as well as two schools of pharmacy. The 1946 health plan established the Ministry of Health to coordinate health services throughout the country (Ogidi, 2013).

During the post-civil war years in the country, ownership of health establishments was divided among federal, state, and local governments, and there were privately owned facilities. Whereas the great majority of health establishments were government owned, there were growing numbers of private institutions through the 1980s. By 1985 there were 84 health establishments owned by the federal government (accounting for 13 percent of hospitals beds) 3,023 owned by state governments (47 percent of hospital beds) 6,331 owned by local governments (11 percent of hospital beds) and 1,436 privately owned establishments (Providing 14 percent of hospital beds (Ogidi, 2013 cited in Ityavyar, 1985).

The Importance of Modern Healthcare Delivery in Nigeria

The advent of modem medicine coincided with the age of scientific discovery. The period witnessed breakthrough in combating many hitherto incurable diseases like yellow fever, chicken pox, tuberculosis and leprosy. The invention of modem medicine was also a period of

advancement in human surgery and therapeutic healing. It has no doubt improved the economic, social, psychological and physical wellbeing of people and most significantly increased life expectancy in many countries of the world, including Nigeria. The importance of qualitative modem health care delivery in Nigeria is outlined below.

i. There will be reduction in maternal and infant mortality in the country. More expectant mothers and their infants will have access to quality health care services in the country.
ii. A country with functional and quality health care system will experience increase in standard of living of its citizens.
iii. Effective and functional modem healthcare will increase life expectancy of ordinary citizens.
iv. An effective and functional healthcare system in the country will discourage health "tourism". In the last few decades, the moribund nature of our health care's system has increased the population of Nigerians, both wealthy and poor to seek quality healthcare in foreign countries. It is very common in Nigeria today to see certain individuals and their family members applying for visa to foreign countries like India, Germany U.S.A, and UK with the hope of seeking cure for chronic ailment/diseases. The availability of qualitative and functional health care in the country will help to reduce such foreign trips. And this will in tum save a lot of foreign exchange for the country.
v. Quality health care system in the country will drastically reduce untimely death in Nigeria. The pitiable state of most health institutions in the country depicts a situation where in times of emergencies, there was non-availability of blood, oxygen ambulance, health specialists or ordinary drip to save a life. Functional and quality health institutions with such facilities or requirement will help to save lives and in times of emergencies will help to overcome psychological crisis associated with untimely death of spouses, children, relatives, neighbours and friends (Ogidi, 2013).

The Challenges Associated with the Provision of Modern HealthCare Delivery in Nigeria

In recent times the state of health care delivery in Nigeria has deteriorated to a level that calls for concern by stake holders and academicians. Ayodele (2008) observed that even ordinary Nigerians now seek for medical care in neighbouring African countries. One major challenging factor in ensuring qualitative modem health care delivery in Nigeria in the last few decades is inadequate medical professionals. There are many areas of medical specialization the country is experiencing dearth of qualified and experienced hands. And notable among them are plastic surgeons, cardiologists, obstetricians and psychiatrists. For example, Fasubaa (2001) reported that in Nigeria and other third world countries, many of the clinics have insufficient members of staff, many of who are over-worked, under-paid and poorly motivated. The dearth of qualified health professionals is more acute in the area of mental health care in Nigeria. As far back as 1975 the World Health Organization (WHO) had observed that the most important constraint in meeting mental health needs in the developing countries is the extreme scarcity of mental health professionals (Gurege, 2003). The deplorable state of inadequate health professionals as it affects mental health is made worse with brain drain among few Nigerian psychiatrists who had moved to foreign countries where condition of service is better than Nigerian

The dearth of health professionals, especially physicians is even more acute in many rural communities in the country. Many primary health care centres in the country can hardly boast of resident doctors or registered staff nurses that attend to both in-patients and out-patients. The readily available health workers in many rural communities are usually health technicians, social workers and auxiliary nurses (Alubo, 1990 & Abubakar, 2003).

Furthermore, the issue of inadequate and poor state of health facilities in the country calls for concern. It is common knowledge that sub-Saharan Africa in general and Nigeria in particular is in dire need of a robust health care delivery system. In the last few years Nigeria was rated very poorly when its health services were assessed by WHO and other external agencies (Adetokumbo 2002). Abubakar (2003:96) noted that In respect of health facilities and

infrastructure, the picture is not encouraging; facilities are generally inadequate, concentrated in the urban areas where only a relatively small percentage of the population live. The rural areas are completely neglected and where health services and facilities exist, they are few, far apart and away from users, under staffed with little or no essential drugs.

Most health institutions in the country have experienced decay in the recent times due to lack of maintenance and inadequate budgetary allocation to maintain existing ones or build new ones. The problem of inadequate health institutions and facilities has been with us for many years. Otuchikere (2008) investigation revealed that, in most general hospitals in Nigeria, there was absence of some of the essential equipment needed for the treatment of patients. For example, there were instances of non-availability of oxygen in hospitals- a gas necessary to aid respiration. Another core issue confronting modem health care delivery in Nigeria is alleged corruption among management staff in health sector. The corruption as a social problem has plagued Nigeria's health sector in recent years. This involves mismanagement of funds at local levels; extortion of patients by health officials; and the abuse of procurement contracts for hospitals supplies (Ayodele, 2008). The level of corruption in Nigeria's health sector also involves the mismanagement of funds from government budget and international donor agencies funding. According to studies undertaken by World Health Organization and the Centre for Global Development, donor nations rarely know what happens to their funds after they hand it over to a recipient government (Ayodele, 2008). Similarly, Abubakar (2003) observed that the decay in Nigerian's health care delivery is compounded by widespread corruption and outright embezzlement of public funds by government functionaries and their allies. It is often alleged that, apart from embezzlement of yearly budgetary allocations for health ministries and agencies, foreign aid and loans collected by many Nigeria leaders are either shared by corrupt officials and their allies within and outside the country or the monies remain in the developed countries, as all of it is used for the purchase of drugs and equipment or the payment of salaries and allowances of foreign expatriates (Abubakar, 2003).

Beside this lack of trust or apathy, the non-cordial relationship between doctors and patients in many hospitals also exist. This frosty relationship is influenced by the prevailing ratio of doctor to patient's population in the hospitals. Otuchikere (2008) admitted that most government hospitals, including teaching hospitals have become mere preliminary consulting rooms. This is because doctors and other health professionals are often faced with the challenge of attending to great number of patients in our hospitals. Otuchikere (2008), further narrated the situation in the hospitals this way It is more deplorable in most of the general hospitals, where patients have lamented that doctors in these hospitals have a habit of keeping patients waiting for long than usual before attending to them. And when they turn up, they are in a hurry to discharge the patient. This attitude is often compounded due to the fact that doctors and other health professionals have too many patients to attend to in the hospitals, apart from their commitments at their private hospitals (Ogye, 2019).

It is equally important to state that population explosion in the country has undermined qualitative modern health care delivery. The 2006 Population and Housing Census puts Nigeria's population at 140,431,790, with a national growth rate estimated at 3.2 percent per annul. The country is the most populous country in Africa (Nigeria Demographic and Health Survey, 2008). Rapid population growth is one of the most popular explanations for the many problems facing Nigeria and other sub-Saharan African countries. According to Omonu (2000) rapid population growth in the last three decades has resulted in overcrowding, poor environmental sanitation, increased pressure on social and health infrastructure, especially in urban areas. In spite of the huge annual budgetary allocations to Nigeria's health sector by successive governments, uncontrolled population growth tends to have worsened the state of qualitative and functional health care service. The implication is that the average sick person in the country will hardly enjoy quality health services (Ogidi, 2013 and Ogye, 2019).

Conclusion/Recommendations

Quality health care delivery in Nigeria has been affected in recent times due to poor funding, corrupt tendencies among health personnel, and recurrent industrial disputes among other factors. These factors have greatly undermined the quality of health care services available to the citizens. To ensure an improvement in the modem healthcare delivery system in the country, the following recommendations are hereby put forward:

i. There should be adequate funding of healthcare. The annual budgetary allocation for the health sector in the country should be increased.
ii. The provision of health services, especially in the rural communities need to be intensified. In this regard, the National Primary Health care Delivery Agency (NPHDA) in collaboration with states and local governments should build at least one Primary Health Centre (PHC) in all electoral wards in the country. The (PHCs) should be staffed with qualified doctors, nurses, pharmacists and other health professionals.
iii. Quality and affordable drugs should be made available to patients in all government health institutions. Also, localities where primary health clinics (PHCs) are located should have modem amenities like housing estate, electricity, pipe-borne water, motorable roads. This will motivate qualified health professionals to live and work in local communities.
iv. For health care to be effective and functional in present day Nigeria the much orchestrated fight against corruption need to be intensified. Those found guilty of such dubious crimes should be punished so as to serve as deterrent to others. The fight should be holistically and effectively tackled in the health sector.
v. There should be health development plans that will serve as a blue-print for the development of the health sector. Problem of inconsistencies in health care policies and programmes by new administrations in the country should be discouraged.

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