Cash for health care: the unending search

In Nigeria an autonomous health fund would help to stop the deterioration in standards of care associated with underfinancing of the public sector and poor regulation of the market.

After nearly a decade of gross underfunding in Nigeria’s health sector, a new remuneration package has been proposed for medical and allied workers, while extrabudgetary sums of 550 million naira (US$55 000 000) from the federal government and over 700 million naira ($70 000 000) in foreign grants have been secured for the improvement of hospital services. Machinery for improving cost recovery in public health care provision has been set in motion while alternatives to the financing of services by taxation are being considered.

Reforms

In 1986 a primary health care initiative was launched with a view to redressing imbalances in the distribution of resources between rural and urban areas. The programme now appears to be firmly rooted in the local communities, supported by their councils. However, successful primary care programmes do not necessarily reduce workloads at the secondary and tertiary levels of care. Indeed, they tend to uncover more patients with costly requirements at the higher levels, patients who might otherwise have died or sought alternative care, probably from the traditional system.

The extra funds made available to the health sector are timely, considering that hospital services have been gradually run down over the last decade. It is expected that the new measures will boost morale in the sector, check the manpower drain, and generally enhance the effectiveness of the public health care system.

Unfortunately, the political will to sustain and improve on the present level of funding is questionable, given that the health sector has traditionally been regarded as one of low priority by both military and civilian administrations. Federal government budgets for the health sector declined from around 3.5% of total expenditure in the early 1970s to an average of 2.5% for the second half of the decade, and to less than 2% in the 1980s. Furthermore, the country’s structural adjustment programme, begun in 1986, has subjected the health sector to market forces. There are no obvious political pressures compelling government to provide additional grants, and a further decline in

Dr Ogunbekun is Medical Adviser in the Medical Unit, Nigeria Reinsurance Corporation, Reinsurance House, 46 Manna, PMB 12766, Lagos, Nigeria.
public health spending cannot be ruled out in the near future. Inconsistency in funding has greatly impeded health service planning and has led to poor utilization of the sector’s meagre resources.

Risk-sharing perhaps offers the best chance of improving access to and sustaining growth in Nigeria’s health care system.

Tax-financed health services are at risk in periods of recession, and foreign aid is an unreliable source of funds. The health care system should be better protected against adverse trends in the economic environment.

Market approach

Some policy-makers have sought to reduce the impact of cash shortages by promoting market concepts in health care delivery, particularly with respect to hospital services. The rationale is that improved efficiency of resource management allows a greater volume or better quality of service without increased funding. Two alternatives that appear to be highly favoured in this regard are:

- charging patients the true cost of clinical services;
- privatization of ancillary hospital services.

Most tertiary centres have already cut back substantially on financial support for patients. The absence of adequate social protection, for example through national health insurance, has made the cost of care excessive for the poor and the chronically sick.

There is little evidence to suggest that the quality of care has improved in these institutions. Waiting times appear to have lengthened for both outpatient consultations and elective surgery. Drug supplies are erratic, especially in general hospitals, despite the establishment of revolving drug funds. Laboratory throughput has remained low, largely as a result of the scarcity of reagents. Worse still, the lack of managerial expertise in most public hospitals means that consumers could be helping to pay for the survival of an inefficient system. The situation is exacerbated because poor medical auditing and health systems research impose severe restrictions on the ability to identify and quantify waste in the public health services.

The privatization of ancillary hospital services could bring about improved efficiency without putting additional costs on patients and would also be in keeping with the government’s wish to allow market forces to operate in public sector activities. It is assumed that competition between private contractors leads to better quality service, and that privatization, by reducing hospitals’ recurring expenses, frees resources for vital capital programmes and gives managers additional time to concentrate on matters that are more directly related to the care of patients. Improvements in the quality of support services could induce more patients to use government facilities, thereby attracting funds that would otherwise go to the private sector. However, the overall effect is likely to be minimal since ancillary services may account for no more than 5% of recurrent expenditure in public hospitals; the bulk of their costs comprise medical staff emoluments.
Moreover, hospital managers would still be required to monitor and evaluate contractors' performances, and, where necessary, review or terminate contracts. This may not be an easy task in a politicized public service environment. It could also expose the system to underhand practices. In the long run it might well be more efficient to retain in-house provision of these services and to overhaul public hospital management systems.

**Strengthening private health care**

With the public sector seemingly incapable of meeting growing consumer demands, it is logical to encourage the growth of private medical care. This could be done by providing soft loans to those wishing to establish or expand private practices, and by granting additional tax concessions to employers in respect of expenses on staff medical benefits.

Private financing, which can be seen not just as a resource substitution strategy but also as a means of widening consumers' choices, is worth considering for the following reasons.

- Public health expenditure seems unlikely to rise beyond the present level unless there is a major shift in the economic adjustment process; inflation-adjusted figures actually reveal a fall in annual per capita health spending from 3.4 naira in 1981 to 2.6 naira in 1988 (from US$5.2 to $0.58 at the prevailing exchange rates).
- Money spent on private health care is out of the immediate reach of government and would therefore make the sector better insulated against future cuts in social expenditure.
- Most employers and employees in the organized private sector, as well as those in government institutions, seem to prefer private health care and already have contracts with private providers.
- Unused beds and equipment are believed to exist in the private sector. The utilization of these resources could be enhanced through policies favouring private health care; for example, employers could be encouraged to buy services from the private market rather than to operate their own facilities, and the development of a private health insurance market could be promoted.
- Given the right incentives, the private sector could facilitate the extension of health care services to underserved communities. The experience of China, where 70% of private doctors work in rural areas, lends credence to this view (1). The opportunities for private doctors to earn attractive incomes through fee-for-service payments and voluntary health insurance schemes may have brought about this distribution of physicians, unusual in a developing country (2).

The advocacy of expanded participation of the private sector in health care delivery can, however, be faulted on the following grounds.

- The private sector does not necessarily use resources more efficiently than the public sector. How else could one...
interpret unused capacities when consumer demand appears to be rising and standards of care in public facilities are declining?

- The private sector would further weaken government services by draining them of skilled manpower. The public sector has already witnessed an exodus of specialists to the West and the Middle East.

To what extent this unregulated growth can boost the supply of health services without undermining the equity objectives of national health policy remains to be seen. But if health for all is to be attained the vast majority of the populace must have ready access to essential services, and this should depend on social, not individual, financing (3).

**Striking a balance**

Alternative approaches that would make the health sector less dependent on government funds and reduce financial barriers are clearly required if economic decline is not to erode the gains made in funding. An autonomous health fund that pools financial resources and has a redistributive component could guarantee a more predictable flow of money. Modalities for the implementation of a national health insurance plan are already being worked out by the Federal Ministry of Health (4). There could not be a more appropriate time for establishing such a scheme, considering that a proposed pay rise for public sector health workers will probably have a knock-on effect in the private sector, pushing services further beyond the reach of the poor, the unemployed, and even those employed people lacking employer-sponsored medical benefits.

Apart from making it easier to ascertain the proportion of gross national product committed to health care delivery—a more accurate indicator of overall spending than the health share of federal government budgets—a health insurance fund would probably be a more prudent purchaser of health services than most individuals and corporate bodies, and could provide a more effective means of collective bargaining, thereby moderating inflation in the medical care market. Furthermore, it could, through
resource redistribution, create a more socially acceptable environment within which the option of charging patients the true cost of clinical services could be fully pursued while opportunities are afforded for better control of the private sector.

Very considerable resources would undoubtedly be required to set up and manage such a fund. The potential problems, such as cost escalation and the widening of inequalities, are formidable. Another worry is that the availability of this additional financing option might encourage the government to cut or freeze its health budget. Nevertheless, risk-sharing perhaps offers the best chance of improving access to and sustaining growth in Nigeria’s health care system.

* * *

Nigeria’s health services have fared badly in recent times, largely as a result of expenditure cuts associated with the economic crisis. The injection of more funds by the federal government is desirable but would probably be insufficient to make a lasting impression on the performance of public health care institutions.

Alternatives to the financing of the health sector by taxation are needed if services, particularly at the secondary and tertiary levels, are to withstand the extra load which the growing population and the current efforts in primary care are bound to generate. By charging patients the true cost of clinical services and privatizing ancillary services, public health institutions may be able to improve both cost recovery and efficiency. However, the former option raises the question of equity while the latter could make hospital administration more complex.

The expansion of private medical care provides an avenue for boosting health spending. Adequate controls should, however, be established in order to promote uniform distribution of private providers and to protect patients against care of poor quality. Such controls might well be best effected if a single buyer of services, e.g., a national health insurance plan, managed the bulk of health care finances. This could facilitate the redistribution of resources while ensuring increased efficiency in their utilization.

Acknowledgement

I am grateful to Dr F. A. O. Olopade for his kind assistance.

References