

## **An Assessment of the Emergence of Organised Healthcare Services in Nigeria**

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**Abstract:** *Traditional medicine continued to play an important role in Nigeria, the country made great strides through health policies, plans and programmes to facilitate the provision of modern health care to its population in the years since 1946, World War II, after independence and currently Nigeria vision 2020. Among the most notable missions were the expansion of medical education, the improvement of public care, the control of many communicable diseases and disease vectors and provision of primary healthcare in many urban and rural areas. Health services administration refers to the process through which resource essentials for health care are effectively mobilized, controlled and utilized for the purpose of ensuring healthy living. The earliest form of western style health care in Nigeria is not available to the indigenes, but provided by doctors brought by explorers and traders to cater for their own well-being. True, the picture of our health care today is pathetic, in spite of that we have very able compatriots at home who have defied all odds and continue to carry the burden of health care delivery under holistic situations. It is against this backdrop that this paper attempts to analyze the emergence of organized healthcare services in Nigeria.*

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### **I. Introduction**

Traditional medicine continued to play an important role in Nigeria, the country made great strides through health policies, plans and programmes to facilitate the provision of modern health care to its population in the years since 1946, World War II, after independence and currently Nigeria vision 2020. Among the most notable missions were the expansion of medical education, the improvement of public care, the control of many communicable diseases and disease vectors and provision of primary healthcare in many urban and rural areas. In the late 1980's a large increase in vaccination against major childhood disease and an important expansion of primary health care became the concern of the government's health policies. Nonetheless, many problems remained in 1990, sharp disparities persisted in the availability of medical facilities among the regions, rural and urban areas, and socio-economic classes. The severe economic stresses of the late 1980's had serious impact throughout the country on the availability of medical supplies, drugs, equipment and personnel. In the rapidly growing cities, inadequate sanitation and water supply health care facilities were generally not able to keep pace with the rate of urban population growth.

### **II. The Concepts of Health Care Services**

According to Dlakwa (1996), health services administration refers to the process through which resource essentials for health care are effectively mobilized, controlled and utilized for the purpose of ensuring healthy living. Specific service involved in health administration includes the following:

- a) Proper identification of health related activities and the appropriate institutions that can carry them out. Health care can thus be organized in hospital services, health centres, clinics, dispensaries and ambulatory services.
- b) Recruitment, training and containing of professional health manpower.
- c) Formulating and implementing health care policies.
- d) Acquisition of equipment drugs and dressing for hospitals and clinics.
- e) Creating a good working relationship between the health personnel of various cadres and selling disputes that may develop between the groups.
- f) Meeting patient needs effectively and promptly.
- g) Sectors that have close bearing to health such as agriculture, water resources, works and housing, education etc.

### **The Emergence of Organised Health Care Services**

It would seem from available accounts that the earliest form of western style health care in Nigeria is not available to the indigene's, but provided by doctors brought by explorers and traders to cater for their own well-being. It was the church missionaries that first established health care services for the people. The Roman Catholic Mission, the church missionary society (Anglican) and the American Baptist Mission. The first healthcare facility in the country was a dispensary opened in 1880 by the church missionary society in Obosi and that of Onitsha and Ibadan. In 1886, the first hospital in Nigeria was the Sacred Heart Hospital in Abeokuta, built by the Roman Catholic Mission in 1885.

There are several anecdotal reports of practices within these missionary health care facilities to suggest that they were primarily used as tools for winning converts and expanding their followership. Consequently, these facilities were competitive rather than complementary. In spite of this fact, they were of such high quality that by independence in 1960, mission-owned hospitals were more than government-owned hospitals. This high quality is also evidenced by the fact that the Seventh Day Adventist Hospital in Ilesha as well as the Wesley

Guild Hospital in Ile-Ife become the nucleus of the Teaching Hospital complex of a major University in Nigeria. Even today in Nigeria, the Baptist hospitals in Ogbomosho and Eku function as referral centers in the health care delivery matrix, because of the evangelical functions of these health care facilities, it was left for the government to organize and develop policies for general health care. It is well known that towards the end of 19<sup>th</sup> century. European powers were at war with each other for ownership of the vast rich land of Africa. They established frontiers needed to be secured and so there was a powerful British military presence in Nigeria for the military, which was located in Lokoja. The British therefore established medical services there, under the Governor Lord Lugard, Lokoja was the military headquarters in 1900. Apart from military health services, civilian services were also established which is known as the first government hospital for civilians. The St, Margaret Hospital was built in Calabar in 1889.

At the end of the World War I (1914-1918) present day Nigeria was born by amalgamation of the Northern and Southern regions. These was brought along many military activities in Nigeria, including establishment of military health care facilities, some of which were left to function as civilian hospital and with time several Government health care facilities were established range from rural health centers to general hospital.

### **III. The Emergence of Centralized Control of Health Care Services**

At the last century, medical services like other services in Gambia, Sierra Leone, Ghana and Nigeria, were merged and controlled by the colonial office in London, this was first centralization of control of health services in West Africa. The colonial's office desired available service and provide manpower. As health care management become more complex, Central Administration become more regionalized, while maintaining some West African facilities such as the West African Council for Medical Research which came into being in February 1954 specifically in Nigeria was developed and expand with industrialization. Some of the medical doctors were civil servants except those who work with the missionary combine evangelical work with healing. Among the civil servants one made the Chief Medical Officer and other senior medical officer and medical officer, they form the nucleus of the Ministry of Health in Lagos.

Between 1952 and 1954, the control of medical was transferred to the regional governments as was control of other services. Consequently, each of the three region set-up their own ministries in addition to the Federal Government.

### **Nation Wide Health Care Services**

The health care services in Nigeria have been categorized of short-term planning as is the case with the planning of most aspects of the Nigerian life. The major national development plans are as follows:

1. The first colonial development plan from 1945-1955 (Decade of Development)
2. The second colonial development plan from 1956-1962
3. The First National Development Plan from 1970-1975
4. The Second National Development Plan from 1970-1975
5. The Third National Development Plan 1975-1980
6. The Fourth national Development Plan 1981-1985
7. Nigeria, five year strategic plan from 2004-2005 all of these plans formulated goals for nationwide health care services.

The overall national policy for nationwide health care services was clearly stated in a 1954 eastern Nigerian Government report on policy for medical and health services. This report stated that the aim was to provide national health services for All. The report emphasized that since urban services were well developed, the government intended to expand rural services which included rural hospitals of 20-24 beds and supervised

by a medical officer who also supervise dispensaries, maternal and child welfare clinics, prevention work such as sanitation work.

By the time the third national development plan was produced in 1975, more than 20 years after the report mentioned above, not much had been done to achieve the goals of the nation wide health care services.

This plan which was described by General Yakubu Gowon, the then head of the military government as “a monument to progress” stated “development trends in the health sector have not been marked by any spectacular achievement during the past decades this development plan appeared to have focused attention on trying to improve the numerical strength of existing facilities rather than evolving a clear health care policy.

### **The New Health Hierarchy**

The Fourth National Development Plan (1981-1985) addressed the issue of preventive healthcare services for the time, the policy contained in its plan called for the implementation of the Basic Health Services Scheme (BHSS) which deals with the establishment of three levels of healthcare facilities namely:

1. Comprehensive Healthcare Centres (CHC)
2. To serve more than 20,000 people
3. Primary health centre (PHC) to serve communities of 5,000 to 20 persons.
4. Health clinic (HC) to serve 2000 to 5000 person. Thus, a CHC would have at least 1 CHC and 1 HC in its catchment area, this institution were built and operated by state and local government with the financial aids from Federal Government.

Nigeria is currently made up of 36 states and over 500 local government areas. Each local government area is made up of between 150,000 to 250,000 people. By the scheme proposal in the fourth development plan each local government would have a minimum of 7 PHCs, 30 HCs with at least one CHC and a large local government would have more than that. Nigeria has not come close to achieve this lofty objective as a matter of facts.

Towards the end of 1983, a new military government came into being in Nigeria and one of the government's first effort was to revise the Fourth National Development Plan, the health strategy under this revised plan gradually shifted emphasis to primary health care, although, this has always been the ultimate goal of the plan, the political will did not seem, to exist for its implementation.

At the federal, the Directorate of National Health Planning had the function of coordination and implementation of the national health policy. It also had the function of developing plan for national health. At the state level, were state health advisory councils whose role is to give general advise to the Commissioner of Health in the performance of his function. At the local government level, the State Ministry of Local Government in consultation with the State Ministry of Health established local government health committees covering their area of authority for the purpose of formulating policies for providing health services to the communities. At the community level, several small communities had involved small community primary health care services with active community participation.

Presently, in Nigeria today, this goals has not been achieved. The capacities of the facilities have emerged from previous efforts have been stretched and facilities were broken beyond repair. Primary health care services only exist in name, the common man has reverted to herbalists and traditional healers for care, accessibility and affordability issues. The elites have perfect medical tourism to Indian, Singapore, etc.

### **IV. Health Care during the Struggle for Independence**

As already stated, traditional medical practices are very much a part of the health care delivery system in Nigeria today, as they were during and before the struggle for independence. Health care during independence was oriented towards curing rather than preventive care. Example, as a result of the poor attempt to establish preventive program, measles remained the greatest killer of children. By this time, WHO proven beyond reasonable doubt that proper execution of preventive programme can eradicate deadly disease and indeed, small pox was almost non-existent in Nigeria at the time. In terms of access to health care services, it is estimated that in 1960 only 10-15% of the Nigerian population was covered by any form of modern health care services. Also and these services were concentrated in the urban areas to the detriment of the rural areas. Consequently, where as more than 50% of the urban population had access to health care, less than 5% of the rural population had comparable access and 90% of the population was rural in 1960, the situation has not changed today, only urban migration has increased, further tasking the existing urban facilities, making them inadequate and ineffective. Also, today we have many quacks parading as doctors all over the country with impunity.

### **V. The Financing of Health Services**

The Federal Ministry of Health is the planning and coordinating body for health service issues. The state governments through their Ministries of health implement national programs and run state health

institutions which the local governments ensure the delivery of health care to the masses. The Federal Government pay over 90% of the money for health care services which comes directly or indirectly. It allowed the state government some independence and freedom to spend the money as they see fit and the state allows the local government some freedom in a way to spend the money.

Because federal government provides over 90% of the money for health, a look at the federal allocation to health will give a clear indication of the position that the health care occupies in the list of the government's priorities. The opening sentence of the chapter on health in the Third National Development Plan, states "development trends in the health sector have not been marked by any spectacular achievement during the past decade". In the same way, the financial allocation to health did not show any remarkable improvement in the decade that followed independence. During the Third National Development Plan of April 1, 1975 to March 31, 1980 ₦689 million naira was planned to be spent on health care out of an anticipated total expenditure of ₦43,000 million.

The Fourth National Development Plan of January 1, 1981 to December 31, 1985 was a lot kinder to health, with an allocation of ₦3,066.6 million out of a proposed ₦69,686.3 million which comes to 4.4% if we accept that 3,066.6 million naira was spent on health in that plan.

In the year 2004 federal budget 99.8 billion naira was allocated for all government services. The Federal Ministry of health got 26.4 million naira, therefore, health got nearly 26% of the total budget. Do this translate to money available for the well being of the people? A critical work at the budgetary allocations will prove otherwise. The budget deliberately mixed capital expenditure with recurrent expenditure. For example as much as ₦7 billion naira was voted to rehabilitate 8 teaching hospitals in the budget. In spite of this short coming the budget, on the surface, appears to be very kind to health. However, given the fact that the naira at that time as \$0.007 and given the fact that the population was estimated then at about 130 million, the per capital expenditure was only about \$1.42, if all of the money allocated was actually released.

## **VI. Contributions from International Organizations**

Several international organizations have played vital roles in the development and maintenance of health services in Nigeria. Unfortunately, most of these contributions pass through Federal Government, which kept very little record of the impact these contributions have made. Also, records of the exact cash amount of these contributions are sketchy. The organizations include the World Bank, United States Agency for International Development (USAID), W.H.O. UNICEF and the British Technical Assistance (B.T.A).

In collaboration with the effort of the Nigerian government, USAID and WHO launched a successful program against smallpox in 1967 and 1968 whereas USAID financed the cost of technical immunization expense, the Nigerian Government and WHO provided medical personnel and local costs. This program was so successful in Lagos in 1968, a 97% efficiency was estimated for it; with more than 90% target population immunized. The success of this program is so remarkable that the incidence of small pox has dropped from 2 to 1 case in a month in Western Nigeria among migrants. In the 1960s several projects aimed at controlling malaria (that accounted for about 11% of all mortality) were launched by WHO and UNICEF. The Expanded Programme on Immunization (EPI), Oral Rehydration Therapy (ORT) and Borehole projects for drinking water are all areas in which UNICEF's contributions are immense.

During the cholera epidemic in Nigeria in 1970-71, WHO established cholera diagnosis and treatment centres throughout the country. Today, three agencies, along with the United States Government, through the President's Emergency Plan for AIDS Relief (PEPFAR) as well as private philanthropic organizations, such as the Jimmy Carter Foundation, the Bill Gates Foundation, the Bill Clinton Foundation etc contributed to the support efforts in various sectors of the Nigerian health scene, particularly HIV/AIDS.

## **VII. Present Health Situation**

There are several indicators used in accessing the health status of a nation when these indicators were measured in African populations, it becomes clear how poorly Africa is doing. In attempting to measure these indicators, the first problem one encounters is the absence of reliable data/statistics for doing so, the value of the major indicators are shown below:

1. **Pre-natal mortality:** This is the number of stillbirths plus death within the first week of life out of a total of 1000 births (dead or alive). The pre-natal mortality rate in all of Africa, South of the Sahara, excluding South Africa, is generally thought to be 100-110 per 1000. In Nigeria, the figure is not different. At the University of Benin Teaching Hospital in Nigeria, Omene and co-workers reported that the pre-natal mortality rate was 89 in 1974 but it dropped to 33 in 1980 and by 1986 it was back up to 57. In 1990 no reliable data is available but it is estimated that the rate is near the 1974 level coincided with development of an aggressive and effective neonatology program at the Teaching Hospital which reduced to almost zero level of death within the first week of life. Today, in the same hospital, the pre-natal mortality rate is as high as 110-120 per 1000.

2. **Infant mortality rate:** This is the death of an infant before the first birthday and it is measured as the number of death per 1000 infants. In Nigeria this figure in 1960 was 190, in 1978 it was 187, 1998 range from 104-110 and a high level in 1988, because they appear to be consistent with the realities of health situation in Nigeria. However, the situation has improved over the last 20 years. The United States Central Intelligence Agency now publishes a “face book: on the state of the world’s health and it was estimated infant mortality for Nigeria since 2003 as follows. In 2003 infant mortality was 71.35, in 2004 it rose to 98.8 which was a 38.5% jump, it remained at 95.72 in 2008, 94.23 in 2009 and 2010 but credit must go to Health Care institution and health providers.
3. **Pre-maturity:** This is the birth of a baby, whose gestational age is between 28 and 37 weeks. In Nigeria, the estimated rate as of 1984 is between 5 and 7.5% because of obvious worsening health care services this value is probably higher now, today, it looks as if nobody cares enough to keep any records.
4. **Maternal mortality:** This is the death of a mother arising from complication of child birth, measured in this report, as number of deaths per 100,000 births whereas in the USA this value is about 8. In Nigeria, the 1988 value is 800, meaning that 8 out of every 1000 births is likely to result in maternal death. A figure that is 100 times higher than in the USA. The World Bank reports 1500 in 1980 but UNICEF reports 800 in 1988. It is difficult to conceive of a nearly 50% reduction in maternal mortality, when the evidence available seems to suggest a declining state of general well being. Since 1980 to today the estimated is about 1100 but the data is at best questionable. If material mortality rate is about 1100 in Nigeria, a country with a population of about 150 million, it means that about 53,000 women die from pregnancy-related complications every year in Nigeria. Given that the global pregnancy related maternal death is estimated at 529,000 it means that Nigeria contributes about 10% of world maternal deaths.
5. **Population:** Nigeria’s population at independence in 1960 was estimated at 46 million. In 30 years, the population reached 110 million. It is estimated that the population growth rate between 1965 and 1980 was 2.5%, but between 1980 and 1990, the growth rate is about 3.5%. The current growth rate is 4%, 4 times higher than in the USA and 6 times higher than in Japan. Nigeria is the tenth most populous nation in the world with a population estimated at 150-160 million.
6. **Life expectancy:** This is number of years new born children would live if subject to the mortality risk prevailing for the cross-section of the population at the time of their birth. For Nigeria, the life expectancy was 40 in 1960 and it is generally believed that it was 51 for all sexes (41 for males and 53 for females) in 1990. Today, it is estimated at 42 (thanks to the scourge of HIV/AIDS).
7. **Access to safe drinking water:** Only 46% of the Nigerian population is said to have access to safe drinking water. When this is broken down urban and rural Nigeria, it is estimated that while 100% of the urban dwellers have access to safe drinking water, only 20% of the rural dwellers have access to safe drinking water. The 100% figure for urban Nigeria is quite misleading. In the first place, water is not available 100% of the time; secondly, when water is available at least 50% of the homes do not get it. Consequently, there are modern homes in urban areas with water systems, connected to the city water lines that have never had water run through them in 10 years. Viewed against this background, therefore, the figure of 46% is exaggerated.
8. **Immunization of children and pregnant women:** For a one-year old to be fully immunized, he must have received 1 BCG (TB) 2 or 2 DPT (Diphtheria, Pertussis Tetanus) 2 or 3 OPV (oral polio vaccine) and 2 MMR (measles, mumps and rubella). In the absence of MMR, measles only. The data available for 1960 is very scanty, but the estimate is 5-10% the data for 1981 is about 23% while for 1988 it is close to 75% reaching a high point of about 50% in 1990. This represents 6-10 improvement in this health status indicator since independence. The 1983-1986 massive EPI (Expanded Immunization Programme) campaign supported by the federal and state governments with large financial and material and from UNICEF achieved enormous success in this regard. Today, there is shameful decline in the percentage of eligible children immunized.

### **Criticism**

1. **Policy formulation problems:** Poor consultation of community members in the identification of community’s problems. A public problem has to be identified through proper consultation and interaction with the target beneficiaries, properly defined, studied and understood before sound and correct policy solution can be prescribed. Failure to do this will reduce public policy at the mercy of elite’s interest, party leaders, the sycophants, the political favorites, ethnic consideration, and wealthy people and so on. Conversely, problems and demands made by disadvantaged groups such as the unemployed youth, disabled persons, poor rural dwellers, minority ethnic groups and women are the

least widely to receive attention. In effect, elitism seems to be the main catalyst of the policy formulation that results into the built-in bias in the system.

2. **Problems of implementation and evaluation:** One of the serious problems of policy performance is the issue of poor implementation and evaluation. The three (3) stages of policy monitoring and evaluation stated earlier are not properly done and in most cases are not even in existence. In some cases, the politicians are only interested in telling the public how many billions of naira, they are expanding on projects with little interest in pursuing monitoring and evaluation of these projects. At the end of the day, we are experiencing more of implementation lag than success in most of our policy implementation.
3. **Problem of transparency and accountability:** Accountability, transparency and probity are popular terms used by politicians and management experts alike (Adebayo, 1989). Nowadays, these three concepts are so frequently that it may be cored to consider them as constituting the first stanza of the anthem for good governance sang by public administrators and politicians. Unfortunately, these terms are poorly practiced among these officers. This is two fold – 1 poor wages make civil servants exposed to the temptation to be corrupt and receive bribes before contracts are awarded and (2) the politicians are hungry and in a hurry to make money by all means.
4. **Capacity of implementing agencies:** Some of the agencies discussed above that are involved in the policy formulation and implementation do not have the capacity to do what they are expected to do. The level of funding, staff and spread of the organizations make them ill-prepared to implement the policy on the provision of quality drugs for example, the Pharmacist Council of Nigeria is charged with the responsibility of regulating and controlling the practice of the pharmacy profession in all its aspects and ramifications.
5. **Disposition of implementers:** The disposition of policy implementers will affect the success or failure of a given policy if implementers willingly apply the guidelines as stated in the policy document, then the chances of success will be high. But if they deliberately refuse to abide by the guidelines, then the possibilities of failure will be great. In the implementation of the National Health Policy there are numerous cases of implementers deliberately refusing to follow the guideline. Two examples will clearly illustrate thus. First, in the guideline issued by the pharmaceutical stores, it clearly states that pharmacy (Pharmacist board of Nigeria, 1993). Another example is the guideline issued by the Federal Ministry of Health on the issuance of patent and proprietary medicine vendor's license. The guideline provides that the process should be conducted by a committee of four, the applicants be subjected to written and oral interview and that the license is actually meant for areas that do not have access to other form of health services.

### **VIII. Recommendations**

In a global sense, Nigeria's problem can only be solved by Nigerians and by the same reasoning, Nigeria's health care problems can only be solved by Nigerian health care providers. In every civilized society of the world, doctors usually lead the provision of health care, just as the credit of sound health goes to the doctor and so much the blame for abysmal health care go to doctors, therefore, the solution to our health care problems lie in the hands of doctors.

Doctors in Nigeria are organized under one umbrella, Nigerian Medical Association (NMA) with the role of promoting advancement of health and allied sciences.

- To assist and promote smooth, efficient and effective health care delivery system
- To promote the welfare and interaction of all medical and dental practitioners in the country.
- To cooperate with organizations anywhere in the world which have similar aims and objectives and to consider and express views on all proposed legislations and national issues especially those affecting health care delivery system and medical dental education in Nigeria.

Therefore, the solution to our health care problems is in the hands of NMA.

### **IX. Conclusion**

In conclusion, this paper tries to look at the emergence of organized health care system in Nigeria, it also tries to point out the changes in the health care system before and after the independence and to point a realistic picture of our health care today and try to give solution to the problem, that is, through the Nigeria Medical Association (NMA).

True, the picture of our health care today is pathetic, in spite of that we have very able compatriots at home who have defied all odds and continue to carry the burden of health care delivery under holistic situations.

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