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Private health care in Nigeria: walking the tightrope

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The persistently low quality and inadequacy of health services provided in public facilities has made the private sector an unavoidable choice for consumers of health care in Nigeria. Ineffective state regulation, however, has meant little control over the clinical activities of private sector providers while the price of medical services has, in recent years, grown faster than the average rate of inflation. Reforms that are targeted at reorganizing the private sector, with a view to enhancing efficiency in the supply of services, are urgently required if costs are to be contained and consumers assured of good value for money.

Introduction

Limited information exists currently on the size and structure of the private health care market in many developing countries. Various estimates put the private sector's share of total health spending at three or four times the amount of public health expenditure (Howard 1981; Akin et al. 1987), while the ratio of private to public facilities has been estimated at between 5:95 and 30:70 (WHO 1993). Information on the size and composition of the private health care subsector in Nigeria is even scantier than in many other African countries. This is partly due to the strong governmental presence in the delivery of health care prior to the 1980s and the tendency for policy-makers to view the sector as a competitor rather than partner in health development. The outcome is the concentration of local research effort on the public health sector as seen in earlier reports (Okafor 1982; Ityavyar 1988; Ojo 1990), which indeed revealed major inequalities in the distribution of health care resources nationwide.

The market for private health care is believed to have grown rapidly since the mid-1980s, a period marked by deep economic recession characterized by falling social expenditures and household incomes in real terms. The extent to which these factors have shaped the sector still remains unclear due to the paucity of data, in particular those relating to private expenditures on health care. This paper therefore examines the economic, professional, and public policy issues that are moulding the nation's health care system, but focuses largely on for-profit providers of modern medical and dental services who (along with retail chemists) constitute the most visible actors in the nation's health market place.[1]

Overview of private health care

Structure and distribution

It is difficult to ascertain the size of the private health care sector in Nigeria since a sizeable number of existing health facilities are believed to be operating without appropriate licensure by State Ministries of Health (SMOHs). Furthermore, private facilities seldom forward to the SMOH information reflecting health facility case-loads, available personnel and technologies in any given year. In particular, information on private sector personnel resources is compromised by the fact that a considerable proportion of health workers (especially doctors, pharmacists, radiographers and laboratory technicians) working in the private sector hold full-time appointments in the public sector. One study reported, however, that about 30% of all health institutions and 43% of beds in Ogun State were private while approximately half of all doctors and one-third of nurses and midwives worked privately (AHCS 1987). Data from a nationwide survey also showed that for-profit providers constitute the majority of private sector health facilities, accounting for 31% of the 11 757 facilities sampled in 1991 (FOS 1991). These are mostly small-sized clinics or hospitals (usually less than 15 beds), offering general medical, surgical, and maternity care services.

Private medical practice is essentially a solo enterprise; group practice is uncommon while investor-owned hospitals are exceedingly rare. Practices are concentrated in the industrial and commercial parts of the country, with six out of the existing 21 states (namely Lagos, Oyo, Imo, Anambra, Bendel and Kaduna) accounting for about 80% of the total number of registered facilities and beds in 1991. The distribution of retail pharmacies followed a similar pattern. But even in these states, marked imbalances in the distribution of providers existed, with the urban areas being favoured. In Ogun State, for instance, more than 80% of private health facilities were situated in urban areas (AHCS 1987). Similarly, in Lagos State about 75% of private facilities were reportedly located in the metropolis (Jeboda 1989; Ogunbekun 1992), while in Oyo State 83% of all registered physicians and 93% of specialists in private practice worked in Ibadan, the State capital, whith a population of only 41% of the entire State (Olubuyide 1994). Unlike medical practices, however, few private dental clinics exist (even in urban areas) due to the high investment cost requirement (in an economy in which

credit is not easily accessed). Less than 2% of health facilities registered in Lagos in 1991 were dental clinics.

Payment of providers

Health care is paid for directly out-of-pocket in most instances, while employers are also encouraged to provide generous medical benefits to employees and their dependants, the latter expense being fully tax deductible. About 85% of respondents in one survey reported paying for services out-of-pocket, while 10% of urban respondents (in contrast to 4% of rural respondents) claimed their medical expenses were covered by their employers (NQAI 1994).[2] An earlier survey of 2751 employers (conducted as part of the feasibility for national health insurance) showed employee medical benefits accounting for 6.5% of the payroll (FMOH 1988). These benefits are provided largely through the private market on a *fee-for-service* basis. There were no fee schedules for provider reimbursement until 1992 and cost-sharing by way of co-payments and deductibles is very uncommon under these arrangements, hence there were few incentives for restraining demand and oversupply of services. In recent years however, employers have resorted to capping employee benefits, up to specified values annually.

There is no social insurance intermediary linking up the finances of the public and private sectors, although over the last decade the government has been trying to establish a National Health Insurance Scheme (NHIS). Coverage by private health insurance is scanty and is almost totally restricted to employee medical benefits schemes. A recent study (Ogunbekun 1996) showed that not more than 0.03% of the country's population was covered by private health insurance in mid-1995.[3]

Regulation of professional practice

The Medical and Dental Council of Nigeria (MDCN) accredits degrees and training institutions, and oversees the conduct of professionals, while SMOHs license and monitor private health facilities. Professional associations within the health sector have no formal role in the regulation of provider activities. Also, formal interaction between public and private health institutions is limited, as is characteristic of many developing countries (Andreano and Helminiak 1987). For example, public institutions only rarely engage the services of registered private physicians (and only on a part-time basis), while patients cannot be formally referred from public to private facilities, even where the required service is not available in the former. There are also no private pay beds in Nigeria's public hospitals unlike the situation in Indonesia, Tanzania and Zimbabwe (Bennett and Ngalande-Banda 1994; Muschell 1996).

Market expansion

The health sector's contribution to the national economy remains poorly defined, as is the proportion of health expenditure borne by government, employers and individuals/households. Available evidence indicates that the sector accounts for just 2% of the Gross Domestic Product (GDP) (Abudu 1983; World Bank 1997). Whereas the bulk of health expenditure is believed to have been financed by government prior to the 1980s, the deep cuts in social expenditure that accompanied the economic recession and structural adjustment in the country have since shifted more of the burden to employers and households. By 1990, 60% of total health expenditure was from private sources, in contrast to government's 35% (World Bank 1994a). The private sector's share of expenditure may have further increased in recent years since only one-fifth of total health spending in 1994 came from public sources (World Bank 1997), at a time when the inflow of development assistance was on the decline.

Several factors account for this relative growth in private health expenditure. Notable among these are the contracted health budgets, the institution of cost-recovery mechanisms in public hospitals, and inconsistencies in public policy.

Shrinking health budgets

Health spending as a proportion of federal government expenditures shrank from an average of 3.5% in the early 1970s to less than 2% in the 1980s and 1990s.[4] Since 1986 there has also been marked expansion in the national Primary Health Care (PHC) programme, a measure designed to redress existing inequalities in health care provision (Ransome-Kuti 1987). This, in the face of falling per capita public expenditure, has been achieved partly by redirecting resources from acute hospital services and partly through development assistance. For instance, hospital subventions, which accounted for up to 85% of the Federal Ministry of Health and Social Services' (FMOHSS) budget prior to the mid-1980s, fell to 69% in 1986, while overall spending on health services in 1991 was only 44% of the value in 1981 (World Bank 1994b). Such shifts in resource allocation have had major implications for public hospitals, which are almost entirely financed from government subventions. The result was the near-collapse of acute hospital services, characterized by frequent drug shortages, run-down physical structures and the efflux of highly skilled but demotivated medical specialists. Meanwhile the country's population has continued to grow at about 3% annually, placing additional strain on available resources.

Cost recovery

There has also been a gradual abolition of free medical services via the introduction of cost-recovery mechanisms in public health institutions and at all levels of health care delivery. This has seen the cost of services rise steadily since 1985. For example, nominal fees for normal delivery at the Lagos University Teaching Hospital (one of the nation's largest tertiary health centres) doubled between 1992 and 1995, while charges for major surgical operations went up by 400% within the same period (Table 1). Although empirical evidence regarding the quality of care provided in public facilities is scanty, available information (from studies on reproductive health services) suggests that there has been no corresponding improvement in quality (Adewuyi et al. 1994; Adeyi et al. 1996). Consumers have become increasingly dissatisfied and

Table 1. Minimum fees for selected medical and dental services (nominal naira)

	1992		1995		% increase		Private as % of public (1995)
	Public	Private	Public	Private	Public	Private	
Registration	30	50	100	250	233	400	250
Outpatient consultation	30	50	50	200	67	300	400
Immunization*	0	450	0	1350	0	200	1350
Antenatal care	1500	1000	5000	4500	233	350	90
Normal delivery	1000	1500	2000	4000	100	167	200
Room per day (open ward)	–	150	100	500		233	500
Simple tooth extraction**	70	400	150	950	114	138	633
Simple amalgam filling**	50	400	100	950	100	138	950
Minor surgery	100	150	1500	3500	1400	2233	233
Major surgery***	2000	2750	10 000	20 500	400	645	205

Public = Lagos University Teaching Hospital; Private = GMD schedule.
* Antigens = BCG, DPT/OPV (3 doses), measles, T.Toxoid (booster).
** 1992 private sector rate estimated from ad hoc data.
*** Surgeon, anaesthetist and theatre fees.

turned to alternative sources of care. The beneficiary in this turn of events has been the private health care market, which has grown steadily to fill gaps in supply.

Policy contradictions

Of particular importance are the inconsistencies in human resource planning (vis-à-vis national health policy objectives) which have inadvertently swelled the ranks of private practice physicians. Between 1970 and 1980, medical school enrolment increased four-fold, pushing up the number of registered (Nigerian) physicians from 3000 in 1975 to 12 000 by 1985.[5,6] However, such rapid expansion in manpower supply has major cost implications which, in this case, may have been under-estimated. First, it requires that health ministries' recurrent budgets be increased proportionately to cater for the expected increase in medical school graduates. This has not been the case. Second, it implies an expansion in the volume of (necessary and unnecessary) services generated within the health system, with significant increases in overall health care costs. This is because the demand for medical care is, arguably, driven quite considerably by supply (Evans 1974; Maynard 1979). Third, a substantial increase in the demand for postgraduate medical education (an equally expensive programme financed largely by government) would also be expected.

In reality however, budgetary cuts have made it very difficult for ministries of health to absorb the large numbers of new medical graduates, while there has been no corresponding increase in the number of posts for speciality training. Physician emigration has taken care of part of the 'excess supply' created, but the bulk is believed to have drifted to the private market where remuneration is 50–100% higher than the level in public service. The resulting effect is not surprising – the number of facilities and beds in the private subsector grew by 48% and 41% between 1983 and 1989 alone, with for-profit providers accounting for 76% and 57% of the facilities and beds respectively.[7] In Lagos State, which houses the largest number of private hospitals, two out of every five beds by 1991 were situated in the private sector.

The drift to the private sector is likely to have been accentuated by a mid-career bar placed on the advancement of general duty physicians and other doctors (within the public service) categorized by the Medical and Dental Council as holding 'unregistrable' postgraduate medical degrees (Ojo 1991). The bar, introduced along with large increases in public sector health workers' pay, was aimed at encouraging specialization among physicians (Federal Ministry of Establishment and Management Services 1991); FOS statistics show that in 1991 only 12% of registered doctors were specialists, the rest being general practitioners. This policy move has since proved ineffective in stimulating specialization, with the number of training posts remaining well below potential demand.

Benefits and problems

Several benefits have been derived from the rapid growth of the private health care sector in Nigeria, the most noticeable being that it has buffered inadequacies in the public provision of services at all levels of care. For example, only 40% of the population had access to modern health services in 1985 but this had increased to 65% by 1995 (UNICEF 1996), partly through the expanded PHC programme but also as a result of the continued growth of the private sector. Half of all family planning acceptors also obtained their supplies from private outlets in 1992 (FOS 1992), while the sector is believed to have contributed significantly to the doubling of immunization coverage (for children aged one year and below) between 1980 and 1991.[8] In addition, private hospitals continue to serve as training centres for physicians in the General Practice residency, and the sector may have surpassed the public in terms of new investment in medical technology. Denton et al. (1991) observed, for instance, that inventories for all kinds of equipment were higher in private than public facilities.

Numerous problems have also accompanied this unplanned and uncontrolled expansion of the private market. Regional inequalities in the distribution of health services have widened as a result of the skewed distribution of private practices. Effective monitoring of providers has also proved very difficult with increasing reports of malpractice (Okpugie 1997), while intra-sector competition has escalated to dimensions that compromise efficiency in delivery of services.

Emerging conflict

Sky-bound prices

The crisis in Nigeria's health care system is inextricably linked to attempts at 'cartelizing' private health care earlier in the 1990s. This came in the form of new billing guidelines and fee schedules (Guild of Medical Directors 1992). The initiative was sponsored by a pressure group comprised of proprietors of select private facilities, most of whom were situated in Lagos (formerly the nation's capital and still the commercial nerve-centre). Prior to this, medical care prices were set independently by clinics and hospitals, but usually without recourse to standard accounting guidelines. Rate-setting was the exclusive preserve of the proprietor and was guided by what was considered adequate recovery for services rendered, as well as the customary fee charged by other providers within the locality. Expectedly, wide variations in the price of services existed across the country. However, there were growing fears within the medical profession that providers were resorting to charging very low fees in order to remain competitive and it was doubtful if care of good quality could be supplied under such circumstances. As Bennett et al. (1994) observed, unethical practices among providers are particularly likely to thrive in such a scenario dominated by solo practitioners.

The harmonization of fees was thus partly intended to reduce price competition to levels that posed minimal threat to ethical medical practice, but the immediate effect was a steep rise in medical care prices, reflected in a 53% increase in this component of the consumer price index (CPI) in 1992 alone – the highest singular rise for any one year up to that date.[9] The fees were further increased in 1995. Health care providers attributed these increases to the high cost of medical inputs (especially equipment and drugs which are largely imported) and the high cost of funds in a deregulated financial environment.[10] There have been equally large increases in pay within the private sector following the 1991 pay rise for public sector health workers. All of these brought about a (nominal) increase in medical care prices of more than 200% between 1992 and 1995 (Table 1). Indeed, the medical care index rose faster than any other basic need component of the CPI between 1989 and 1995 (Figure 1).

Of great importance in the cost escalation saga is the existence of multiple third-party payers, notably employers of labour who, until recently, have absorbed arbitrary increases in the price of medical services in expectation that these extra costs could be easily transferred to their customers. A review of the medical benefit scheme for a federal parastatal, for instance, showed real expenditures per employee doubling between 1988 and 1993.[11] The increase was largely attributed to high medical care prices.

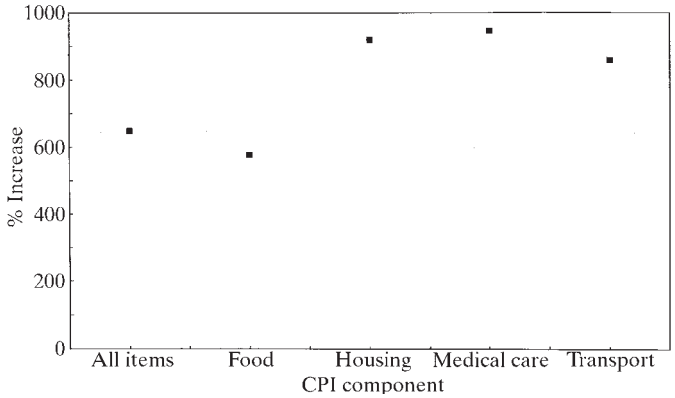

Figure 1. Change in Consumer Price Index (1985 = 100)

A major crisis in the health care market became inevitable as consumers' earnings dipped in the first half of the 1990s – about the same time that medical care prices began the upward swing. As reported by the FOS (1995), real monthly wages for senior civil servants dropped from 690 naira in 1988 to 260 naira by the end of 1994. The situation was compounded by job losses, particularly in the manufacturing and construction sectors, which meant even fewer corporate clients for the growing number of private clinics and hospitals.[12] All of these culminated in gross under-utilization of private health facilities, with bed occupancy rates in most of Lagos hospitals estimated at less than 25% by 1996 (H. Akinlade – personal communication).[13]

'Subsidization or 'embedded inefficiencies'?

Private sector providers posited that the upward movement of prices represented a *withdrawal of subsidies* rather than actual fee increases, and was consistent with the government's drive towards a subsidy-free market economy. The contentious issue, however, remains the extent to which current prices reflect the actual costs of producing services within the system. In other words, '*are consumers of health care presently receiving value for money or are they, in fact, subsidizing an inefficient supply process*?' The notion that health care consumers (and payers) may be receiving *less than a fair deal* becomes stronger when the price increases are viewed against the backdrop of existing waste in the production of services, itself rooted in the poorly organized and inefficiently financed health care system. Wouters (1993), for instance, observed high levels of technical inefficiency among health care providers in Ogun State, with high fixed costs distributed over relatively few admissions. Worse still, the level of inefficiency in the private sector was in some respects higher than the public sector – 73% of non-hospital private facilities sampled were considered technically inefficient compared with 32% in the public sector.

Such deficiencies arise partly because there is a concentration of solo practitioners within few geographical locations, each striving to capture a portion of the market, and in this pursuit,

acquiring technologies (hospital bed, laboratory and X-ray equipment) in excess of potential demand. The availability of such hardware has invariably come to be regarded as a quality index by clients, in particular corporate subscribers who have shown strong preferences for health facilities providing comprehensive services 'under one roof'. Such demand preferences have intensified the kind of competition which Light (1991) contends encourages '. . . duplication before rationalisation. . .' and invariably results in over-servicing, over-hiring and over-marketing. *Indeed, consumers of private health care in Nigeria may presently be paying for the excesses of providers under cover of 'desubsidization'.* Fierce competition among providers has similarly been observed to encourage over-supply of technologies and over-servicing in Thailand's private health care market with resultant under-utilization of installed capacities. Bed occupancy rates in the country's private sector averaged 58% in 1989 whereas government hospitals reported 99% occupancy (Nittayaramphong and Tangcharoensthien 1994).

Responding to crisis

A few studies have assessed the effect of price on the demand for medical care in Nigeria (Vogel 1994; Akin et al. 1995) but the recent changes in the health care market are yet to be empirically studied.[14] It remains unclear, therefore, to what extent the reported under-utilization of private sector capacities can be explained on account of price or income elasticities. Earlier studies suggest that consumers would be willing to pay more for medical care where they perceive significant improvement in the quality of care – reflected in improved drug supply, higher technical quality, health facility renovation, and shorter waiting times (Vogel 1994; Akin et al. 1994; Initiatives Project 1996). However, little improvement has been observed in the quality of services provided in private health facilities in Nigeria since fee schedules were introduced in 1992. Staffing patterns, for example, still reflect a heavy reliance on poorly trained auxiliary nurses (who earn only about half the salary of registered nurses). The physical state of health facilities has not seen appreciable change either, and there may well be little incentive for major quality improvements for several reasons:

1. Health care may not rank high on the priority list of the average citizen, a factor that may dampen enthusiasm for sector reforms (or improved quality of care in public and private facilities), particularly considering the absence of participatory democracy. This is indicated by the pattern of expenditures at household and national levels, with medical care accounting for just 3% of household consumption in the country in 1985. This is in sharp contrast to other sub-Saharan countries like Zambia (8%), Cote d'Ivoire (9%), and Cameroon (12%) (World Bank 1993: 256). Similarly, health expenditures in Nigeria totalled only US$5 per capita between 1990 and 1995, well below the regional average of US$42 (World Bank 1997: 38).
2. Consumers of health care, unlike the providers, are not organized into pressure groups and the existence of numerous small buyers (individuals and employers) precludes effective bargaining within the system.
3. The regulation of medical practice in the country is very weak – a product of underfunding of regulatory agencies and centralization of complaints and disciplinary processes. In essence, there is little control over providers' activities and minimal deterrence against supply of poor quality care.
4. The inadequacy of the public sector (in terms of volume and quality of services delivered) will continue to make the private sector an *unavoidable choice* for large segments of the population in the foreseeable future.
5. Private sector providers opine that limited scope exists for raising user fees in the prevailing environment of declining household incomes.[15] Returns from necessary quality improvement efforts thus may not be large enough to offset investment costs, particularly considering the high cost of credit. In other words, it is doubtful if the paradigm of *increased user fees plus improved quality equal increased revenues* (Litvack and Bordart 1993; Vogel 1994; Shaw and Griffin 1995) can hold in an atmosphere of deep economic recession.

A welcome development in the midst of this crisis emerges from private dental practitioners, many of whom have responded to falling throughput by intensifying outreach activities as an avenue for marketing their services – since overt advertizing by medical personnel and establishments is illegal (MDCN 1995). The target has been primary school children in medium to high income areas, who are offered free or highly subsidized dental check-ups as inducement for future patronage. Growing competition may thus have brought about desirable change in provider behaviour, i.e. the promotion of preventive health services. The activity, however, covers only a small segment of the population and it remains to be seen whether this can be sustained in the long term.

Reforming private health care

Given the crisis of public financing of social services in a 'cold' economic climate, it appears rational to expect continued growth of the private sector in Nigeria. It is apparent, however, that the inadequacies in the nation's health care system cannot be redressed simply by promoting private financing or private provision of services since market forces do not necessarily promote efficiency (Institute of Medicine 1986; Ginzberg 1995). Moreover, an expanded private health care market could overwhelm existing regulatory capacity and make quality control increasingly difficult, unless bold steps are taken to restructure the market. Reforms that focus on minimizing waste in the supply of services become inescapable if essential medical care is to be made more affordable and accessible to large segments of the population. Such reforms become even more relevant as the nation moves towards the institution of a NHIS with strong private sector participation (Ogunbekun 1996).

Delineating functions

One approach to achieving change is to delineate more clearly the delivery of primary care services from hospital services, in line with existing (but poorly enforced) operational guidelines for private health institutions (Lagos State Ministry of Health

1990; MDCN 1995). Emphasis should thus be placed on promoting the establishment of private *outpatient clinics* that offer general medical care (preventive and curative, including minor surgeries) rather than the current situation in which most *clinics* offer comprehensive services. Prenatal care would also be offered in these outpatient clinics, but deliveries would only be undertaken in private or public hospitals. Such differentiation of function could facilitate the monitoring of clinical activities while minimizing incentives for providers (particularly those possessing limited clinical experience) to retain difficult cases in an attempt to maximize financial returns. The supply of unnecessary services, particularly hospitalization, which is estimated at more than twice the average cost of outpatient care (Wouters 1993), should also be minimized. Group practice could be encouraged in view of the potential for higher productivity, economies of scale and better quality of care (Marder and Zuckerman 1985; Pearce 1994; Burns 1995).

The proposed arrangement is, however, better suited to urban/semi-urban locations; these are relatively well served by health services and have better transport facilities than rural areas. Another limitation is that consumers of health care, notably corporate clients, may (out of habit) be reluctant to patronize strictly primary care clinics that offer a limited range of services until the benefits of such arrangements (by way of lower costs and improved quality) become widely recognized. The proposal is thus best adopted as part of a comprehensive reform package addressing both the organization and financing of health services in the country.

The shift towards health insurance is welcome in principle, but means to achieving optimal public–private sector mix in the design of health plans remains a major challenge. The potential benefits of risk pooling are multiple. Apart from relieving employers of the burden of direct provision of services or managing contracts with numerous health care providers, the emergence of larger and more powerful buyers (health plans) could create opportunities for effective bargaining and price control (Bennett et al. 1994) – unlike the present pluralistic arrangement that allows the 'piper' rather than payer to dictate the tunes. On their part, providers would benefit from lower administrative and sales costs, and could witness shorter delays in the settlement of claims.[16] These would improve cash flows in many practices and encourage them to institute necessary quality improvements.

Health insurance could also scale down the undesirable effects of competition among providers, as health plans could guarantee a steady pool of patients for even small-sized practices, thereby providing some measure of financial security and obviating the need for costly (often ill-planned) facility expansion. The lower start-up and operating costs of primary care clinics could make this option attractive to physicians seeking to set up practices (within the framework of health insurance plans) in 'less attractive' locations, thereby facilitating the extension of basic health services across the country.

However, major obstacles confront the development of health insurance in the country. Designing a social insurance scheme that adequately protects the economic interests of the major professional groups in the health sector (i.e. doctors, nurses, and pharmacists) has proved a daunting task. For example, the model recommended to the government in 1992 is strongly opposed by pharmacists on the grounds that allowing clinics to dispense non-emergency drugs rather than filling out prescriptions (as practised in the UK before the advent of General Practice Fundholding – see Culyer et al. 1995) is prejudicial to their economic interests (Ogunbekun 1996). Furthermore, providers' associations remain unconvinced that the public sector possesses the capacity to manage and sustain an initiative as cumbersome as an NHIS. Private insurance, on the other hand, is constrained by limited information on the health care market in Nigeria, and prospects for expansion appear further dimmed by the collapse (in 1996) of the largest scheme, which covered over 17 000 enrolees and beneficiaries.

Improving quality of care

As a step towards assuring better outcomes in clinical practice, licensure of *private hospitals* could be limited only to doctors who (at the minimum) have been certified as having acquired adequate clinical experience through advanced tutelage (of 2–3 years duration) in designated teaching, general or private hospitals. Such tutelage should focus on reinforcing skills in the management of common medical conditions and ensure competence in the performance of a limited range of surgical, obstetric, and gynaecological operations, like herniorrhaphy, fracture reduction, caesarean section and salpingectomy. These valuable (surgical) services are presently provided in public and private hospitals by experienced medical officers but without formal postgraduate training or certification.

Such flexibility in graduate medical education, combined with stricter control over hospital licensure, could encourage physicians intending to move into full-time private practice to seek appropriate training and experience. This, in turn, could greatly improve outcomes of care with minimal resistance from the medical profession. *Urgent reforms are, therefore, required if postgraduate medical education in Nigeria is to be made more relevant to the needs of the populace rather than the pursuit of ideals and standards that are incompatible with her development objectives*. The current emphasis on long duration residency programmes (averaging five years) requires a radical rethink.

Strengthening regulation

Effective monitoring remains the key to achieving quality control in the delivery of health services by the private sector. Mandating private health facilities to supply information on the number and types of health facilities (as well as personnel and technologies available), as a prerequisite for annual renewal of licenses, offers an avenue for achieving greater control via better information on the sector. The availability of such information could assist health planners in identifying regions that are under-served, as well as monitoring the impact of public policy on health sector development (Ogunbekun 1992; Bennett et al. 1994). Regulatory agencies therefore need to be adequately equipped in terms of technical personnel and information technology.

The decentralization (to regional and lower levels) of complaints and disciplinary processes in professional practice is another issue that warrants consideration if effective control of the private sector is to be attained. Failure to achieve control internally could well compel consumers (who now face 'desubsidized' fees) to seek 'control' through the courts. This would not, in the long run, serve the interest of either the consumer or the provider. *Strengthening the public sector's capacity to regulate the private sector is one area of health development towards which donor assistance could be channelled.*

Lastly, the growing contribution of the private sector to social sectors' development, and the opportunities that are so presented for rapid extension of services to under-served populations (Andreano and Helminiak 1987; Sharnagat et al. 1992), need to be duly acknowledged by policy-makers. Efforts should be made to actively influence the development of the private sector via instruments such as loans assistance and tax concessions in order to influence the distribution of health care providers.[17] Further studies on the dynamics of the private health care market in Nigeria are desirable if better appreciation of the nation's health care system is to be achieved.

Conclusion

The rapid growth, since the 1980s, of the medical care market in Nigeria has been largely the unplanned consequence of public policy changes in a climate of deep economic recession. There has thus been little capacity to control the market in terms of distribution of health care providers, the scope of clinical services delivered by various categories of providers, or the quality and cost of care. Medical care prices have escalated in recent years without visible improvement in the quality of care, while the absence of virile consumerism and effective State control have served only to reinforce inefficient practices within the private sector.

The promotion of primary care (outpatients only) clinics, coupled with stricter hospital licensure, could curb waste and abuse in the private provision of health care. A shift towards health insurance also presents opportunities for more effective control of the quality and cost of care. However, designing schemes (public or private) that are affordable and adequately safeguard the economic interests of dominant professional groups within the sector remains a major challenge.

Endnotes

[1] Private not-for-profit providers (mostly mission hospitals and health centres) are observed to play a somewhat limited role in the delivery of care, although they derive considerable publicity. A nationwide survey of health facilities actually showed that less than 4% of existing facilities in 1991 were owned by missions and other voluntary agencies.

[2] Total number of respondents was 3944, of which 2096 were urban residents and 1848 were rural.

[3] Excludes Workmen's Compensation and medical care services supplied through employer-owned facilities or contracted private providers.

[4] Data source: Department of Planning, Research and Statistics, Federal Ministry of Health, 1989. More recent data on government spending is not readily available; this is compounded by the poor reporting of expenditures by the State and local governments, which are actually believed to account for the bulk of public health expenditures. In addition, budgetary allocations are not always fully disbursed.

[5] In Nigeria, undergraduate medical education lasts 5 years on the average; speciality training requires an additional 4–6 years.

[6] Data source: FOS, Lagos.

[7] Data source: FMOHSS, FOS, Lagos.

[8] Calculated from data provided in World Bank 1994(a) – see reference. These figures include coverage by non-profit facilities and nursing/maternity clinics.

[9] Computed from the Consumer Price Index, FOS, Lagos.

[10] Interest rates rose from 10% in the early 1980s to 26% in 1991. The deregulation of interest rates was a major component of the Structural Adjustment Program adopted by the Government in 1986. Data source: Central Bank of Nigeria.

[11] Data source – Nigeria Reinsurance Corporation.

[12] The Manufacturers Association of Nigeria estimated average capacity utilization for the nation's industries at less than 30% in 1995.

[13] Dr. Akinlade is the immediate past Secretary General of the Association of General and Private Medical Practitioners of Nigeria.

[14] The simulations carried out in this study were based on a 1987 data set.

[15] Information obtained from informal discussions with physicians in different parts of the country.

[16] It is not unusual for employers to delay settlement of bills from contracted providers for up to 6 months. Providers thus tend to factor 'interest' payments into employee medical bills. This often results in claims disputes and lengthy verification processes.

[17] The Peoples Bank of Nigeria, through its 'Banking for Health Scheme', made available easily accessed credit for providers serving rural or urban poor communities. The loans were given for the establishment, renovation or expansion of health facilities. The scheme was started in 1992 but its effectiveness has not been adequately researched.

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