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The Nigeria Government Engagement with the Private Health Sector

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Abstract

In Nigeria, the healthcare sector is divided into primary health which is under the local government's authority that oversees the Primary Health centers, secondary health which is under the supervision of the State Ministry of Health in charge of the State General Hospitals that cater to primary and secondary healthcare. Tertiary health is supervised by the Federal Ministry of Health that oversees the Federal Medical Centres, the Teaching Hospitals, and Specialist Training Centres. Not to be excluded from Nigeria's healthcare system are the private clinics and the public-private partnership. The funding for healthcare systems is mainly budgetary allocations from the government. This systemic review was done using secondary literature, policy documents, peer-reviewed literature, and national newspapers, collected using search engines such as Google Scholar, PubMed, and Medline. The review was done over 2-month period from February-April 2024. The literature was arranged in order of relevance and the literature not used was kept aside. The World Health Organization (WHO) has recommended that 11% of a country's budget be allocated to health. African countries that make up the African Union (AU) recommended that 15% of each member African country's yearly budget should be committed to providing healthcare services to her citizens. Unfortunately, Nigeria has yet to attain either the WHO target or the AU target while committing an average, of 6% of her budgetary allocation to health. On the other hand, her neighbouring West African country Ghana, has met the average of 15% recommended by AU. The improved National Health Insurance Authority and the government's partnership with the private health sector in Public-Private Partnership (PPP) is hoped and would improve access to affordable healthcare in general and oral healthcare in particular.

Keywords

Health-Funding, Oral Healthcare, Public-Private Partnership

1. Introduction

Over the years, the government of Nigeria has developed several health policies such as the Integrated Maternal Neonatal and Child Health Strategy (IMNCH); the Oral Health (OH) policy; and the Human Resource for Health (HRH) policy [1] to mention a few. These policies have met different challenges with their implementations. As dentists, the authors are more concerned with the failure to implement the oral health policy since they share the sentiments of the researchers who reported that the health burden of oral diseases is high in Nigeria, especially in rural areas [2]. The major challenge to the OH policy implementation has been inadequate funding, however, the National Health Insurance Scheme (NHIS), an insurance scheme the government of Nigeria came up with to assist with funding health activities, has brought some relief in terms of pooling funds for the healthcare activities in Nigeria [3]. The scheme has, however, recorded failures both as a health-funding organization and as a health regulatory body [4], which necessitated the review of the activities of the NHIS, and the birth of a new organization called the National Health Insurance Authority (NHIA) with more health coverage for the populace and more authority [5]. Although dental care has been given more coverage in the NHIA by including treatment for more dental challenges, dental treatment remains at a secondary healthcare level, thereby neglecting the large rural populace that may be accessing healthcare at community health centers [6]. Ghana, a neighboring West African country, has a more generalized NHIS with better infrastructures, is well-funded, [4] and is more concerned with the attitudinal change of her rural populace to oral health issues rather than access to dental centers [7]. Besides the provision of funds by the government to the private sector in Nigeria to implement her Health policies, the government needs to regulate the private health sector on the cost of treatment charged to patients, ethical practices, and engaging only trained health personnel [8].

Oral health policy in the United Kingdom (UK) has gone beyond better dental health facilities to incorporating health promotion in the school curriculum through three main programs namely the "National Healthy Schools (NHS); Sure Start; and Brushing for Life" [9]. These oral health promotion programs in the UK may eventually help the National Health Service (NHS) to reduce the long list of patients waiting to see the dentist which is a major challenge in the UK [10]. Worthy of note is the "symbiotic relationship" between the NHS and the private healthcare sector in the UK, [10] such that the NHS can generate funds from the private sector by admitting private patients into NHS facilities where private care is given. Payment is made to the NHS [11]. Nigeria's government has also been involved in a "symbiotic relationship" known as the Public-private Partnership (PPP) with the private health sector [12].

Aims: Government engagement in the private healthcare sector.

Objectives:

1) To review Nigeria's government participation in the private healthcare sec-

tor.

2) Evaluate the responsibility and the challenges that may arise in collaborative efforts between the government and private healthcare.

3) Recommend strategies that may be utilized in the implementation of the Oral Health Policy.

2. Methodology

A systemic review comparing Nigeria's healthcare system with Ghana's and each country's relationship with the private health sector [4] [8] [13], Ghana is a West African country with a developing economy like Nigeria, and both countries run similar healthcare systems including health insurance. Secondary literature was used with grey literature, and Newspapers were collected using search engines such as Google Scholar, PubMed, and Medline. This was done using search phrases such as Oral Health policies in Nigeria, Oral health policies in the UK, Oral health policies in Ghana, Public-private partnership in Nigeria, Health financing in Nigeria, the National Health Insurance Authority (NHIA), funding healthcare in Ghana, and Public-private partnership in Ghana. The literature was reviewed, and the oral health systems of Nigeria, Ghana, and the UK were examined with more focus on Nigeria. The government's engagement with the private healthcare sector, health financing, oral healthcare policy, challenges, and ethical issues that may arise were considered.

3. Discussion

3.1. Government Engagement in the Private Healthcare Sector to Encourage the Growth of the Private Sector

Olanrewaju *et al.*, [14] reported that the population of Nigeria was estimated at 140.3 million in March 2006 and 208 million people in 2020. This sharp increase harms health infrastructures and funding [14]. According to Angell *et al.*, [15] with such an increase in population, and Nigeria ranking 12th position in health coverage in West Africa, health outcomes would be poor if plans are not made to accommodate the increase in population. Therefore, it is suggested that there should be a corresponding improvement in the water source, clean food, and better sanitary conditions because population growth usually stretches available amenities [15]. Additionally, with a rapidly growing population, Nigeria has the additional challenge of her populace residing in different regions of the country with different climatic conditions, and this may affect the implementation of healthcare policies at diverse seasons, impact health needs, and health infrastructures [16]. These various challenges create an imbalance in the healthcare of the populace resulting in the Federal Government of Nigeria (FGN) concentrating on some health policies while neglecting others like the oral health policy which has suffered exclusion from the government framework in the past years [17]. Sadly, the government's allocations in the budget for Health are not up to WHO recommendations of 11%, [18] and AU suggestion of 15% [12]. Health

allocation from the federal government of Nigeria dropped from 3.5% in the 1970s to 2% in the 1980s until the 1990s [19]. Then, in the 1990s, healthcare funds were 7.05% of federal expenditure; 4.22% in 2000; increased marginally to 6.41% in 2005; dropped to 4.3% in 2009, and slightly increased in 2010 to 4.4% [19]. More recently, it was 4.3% in 2021, an all-time peak of 8% in 2023, and dropped to 5% in 2024, [20] giving an average of 5.8%. Thus, the period covered from 1995 to 2010 averaged 5% of the health allocation in federal government expenditure, an increase from the 1980s of about 2% to the early 1990s. After 2010, the proportion of healthcare spending in Nigeria's government expenditure was 5.4% in 2011; 5.8% in 2012; 5.7% in 2013; 6.0% in 2014, and 5.5% in 2015, giving an average of 5.7% [12]. Thus, on average, below 6% of Nigeria's total budget was assigned to the Federal Ministry of Health from 2011 to 2024 and this is less than the WHO target of 11% and the AU target of 15%.

Therefore, it has become imperative to search for an alternative source of funding that would complement the government's efforts while encouraging partnership with the private sector to prevent a collapse of the health sector. An alternative was the National Health Insurance Scheme (NHIS), an insurance instrument designed to complement the government's funding in the health sector [3]. The insurance scheme was proposed as a pre-payment system whereby the employer, contributed 10% and the employee contributed 5% of his basic annual salary to a common purse the employee has access to when he/she is ill [3] [21]. The Health Maintenance Organizations (HMO) were assigned the task of operating as the middleman between the enrollee and the NHIS, and also between the enrollee and the health facilities which include private health facilities [21]. The private health sector was included to improve health indices through access to more healthcare facilities and reduce out-of-pocket (OOP) spending. Unfortunately, the NHIS failed due to numerous challenges such as poor knowledge of the NHIS program by Nigerians which led to a decrease in the number of enrolment into the scheme, enrolees were mainly federal workers since civil servants in the state and local government were excluded, poor infrastructures to operate the scheme, cumbersome enrolment into the scheme, delays of payment of claims to both public and private health facilities, and a lack of transparency in the operation of the scheme [3] [21]. Furthermore, 80% of Nigerians that were residing in rural areas had no contact with the scheme, there were only a few medical and dental illnesses covered by the scheme with no coverage at the primary care level for dental challenges, and only a few dental clinics enrolled as healthcare providers also contributed to the failure of the scheme [1] [5] [6] [21]. To address some of these challenges, the NHIS was reviewed, and her activities were expanded with more authority given to her; more medical and dental illnesses were included, although, dental treatment is still restricted to secondary health care level instead of primary health care level [5] [6]. The review and expansion gave birth to a new organization known as the National Health Insurance Authority (NHIA), which is more inclusive of the private healthcare sector as stakeholders, improved payment of claims, health coverage extending to both

the employees in the private sector and the public sector, including the states and the local government civil service, extending the scheme to cover the unemployed, aged, and vulnerable groups [5]. Additionally, NHIA has a better supervisory and monitoring mechanism for the activities of the private health sector to prevent unethical activities such as making false claims by health facilities for treatment not rendered, keeping patients waiting for long without proper healthcare, and using poor facilities. Moreover, all the stakeholders in the health sector, those in the public and private health sector including the political players were brought under one roof called "Health Insurance under one roof" (HIUOR) [5] for effective communication and cross-pollination of ideas. The schematic representation of that is shown below in **Figure 1**.

The Act creating the NHIA was signed into law on May 19, 2022, but became operational a year later, thus, it may still be too early to assess the effectiveness of the NHIA, but it is hoped that enrollment into the scheme would be easier, both public and private clinics would be able to get their payment for health services faster, there would be transparency and accountability in the disbursement of funds with better infrastructures to operate the scheme [5]. While payment to participating public and private health facilities can only be made with the availability of funds, it has been reported that the contribution made by the government of 10% is not paid promptly, and the employees' 5% contribution is less challenging [3] [21]. Nevertheless, Nigeria's neighbor Ghana, receives 70% of her funds to operate the NHIS from taxation; therefore, a large workforce may translate into more funds [22]. In addition, the Government of Ghana has met the target of allocating 15% of its yearly budget to health care, which includes the funding of NHIS [22]. The effect of this as reported by Odeyemi and Nixon is that from 2000 to 2012, [4] healthcare services were more accessible in Ghana than in Nigeria and the out-of-pocket (OOP) spending among the populace in

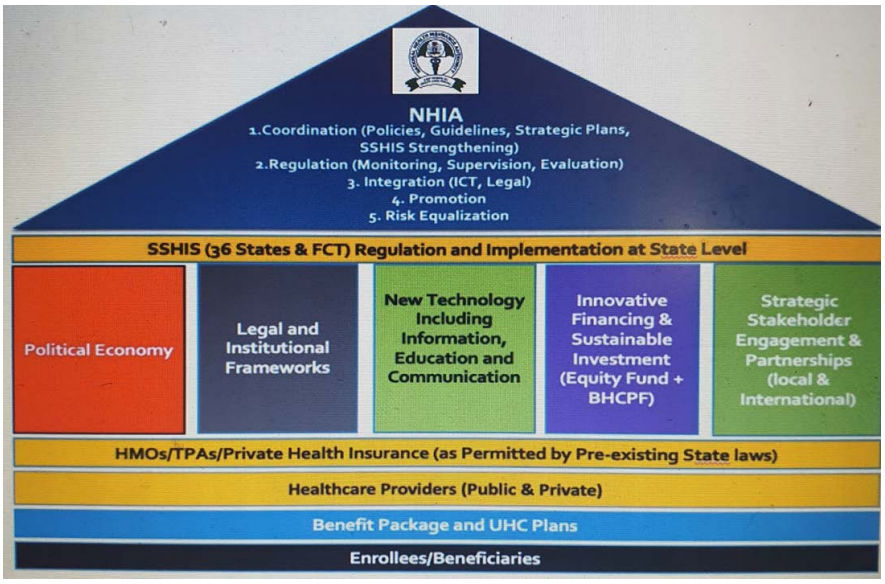

Figure 1. Framework for the HIUOR. Source: National Health Insurance Scheme [5].

Ghana was reduced by 14% while Nigeria which is already high increased further by 2% [4]. One of the objectives of the NHIS was to make health services accessible to everybody to achieve universal health coverage, Ghana has achieved 65% universal health coverage for her populace. In contrast, Nigeria has achieved only 3.5% coverage for its larger population [4]. Additionally, Nigeria needs to improve on the enrolment into the new scheme NHIA through vigorous public enlightenment programs and adding more healthcare services to the list of services offered at community health centers, such as adding oral healthcare to primary healthcare providers at the local government level, building more community health centers which would result to better accessibility to health services for the rural dwellers, [4] [6] and would attract farmers, fishermen, traders, and artisans who may not be able to afford expensive healthcare services elsewhere. This will lead to an increase in the number of enrollees making 5% contributions monthly. In addition, just like Ghana which funds its NHIS through taxation, the FGN can improve on its value-added tax (VAT) and expand its tax net to include higher taxes on alcoholic beverages, tobacco, skin-bleaching products, and luxury cars [4] [23]. More funds would further attract the private sector to work with the FGN to achieve universal health coverage for all Nigerians.

Okafor [12] reported that the number of health personnel Nigeria has in her healthcare services was not up to one-tenth of the number required by the WHO standard. **Table 1** shows different categories of health workers such as doctors, nurses, midwives, dentists, pharmacists, health extension workers, etc., and the number of these workers per 100,000 of the population in Nigeria. This report quoted a survey done by the Federal Ministry of Health in 2014, however, the steady migration of healthcare personnel to foreign countries to seek better remuneration and better working environment has continued unabated [12] [24] [25]. Ghana, on the other hand, has retained a high number of doctors in the country with better distribution of these doctors around the country by introducing in-country training where doctors are given better training and improved conditions of service [26]. Partnerships with the private health sector in Nigeria can achieve the same success as their Ghanaian neighbors.

The public sector in Nigeria is rather weak and reliance on it to operate the health system may not give the desired results [12]. To improve health services, the FGN may partner with the vibrant private sector through the Public-Private Partnership (PPP) where government hospitals would be leased to private individuals over a long period to operate and the private facility would pay a percentage of their profits to the government [12]. This leased Hospital is renovated, equipped, and upgraded to the standard of a tertiary healthcare center, training institution, or research center, and it operates with good organization [27]. An example of a successful PPP is the Garki Hospital was leased in 2007 by the Federal Capital Territory Administration (FCTA) to Nisa Premier Hospital [28]. Garki Hospital was a General Hospital located in the Garki district of the federal capital territory, Abuja. The hospital was renovated, hospital wards were

Table 1. Categories of registered health workers in 2014.

Staff Categories	Number of Health Personnel	Ratio of Health workers/100,000 of population
Doctors	53,210	35
Nurses	158,623	107
Midwives	105,979	78
Dentists	97,373	4
Pharmacists	18,187	15
Medical Lab. Scientist	5149	5
Community Health Practitioners	151,863	83
Physiotherapist	2873	2
Radiographers	1381	1
Nutritionists	1291	1
Health Record Officers	1799	1

Source: Federal Ministry of Health [12].

redesigned, and consulting rooms and medical laboratories were equipped with modern medical facilities by Nisa Premier Hospital's new owners [28]. The hospital is now a model hospital with more than 100 beds, with patients in the outpatients increasing from 17,000 in the first year to 80,000 in the third year of PPP [29] [30]. In addition, Garki Hospital is now an accredited training center for postgraduate training of doctors in internal medicine, family medicine, obstetrics, and gynecology, to mention a few specialties [29]. The experience from Garki Hospital indicates that PPP and modernization can improve any government hospital because through PPP, there is infrastructural development, and improved salaries for staff which is a major reason why doctors immigrate [25] [30]. The challenges of FGN engagement in the private health sector may include the populace claiming that the government they voted for (in a democracy) has abandoned its responsibility to its citizens and has delegated it to the private sector [31] also, when there is a change in government when a different political party comes into power, this new government may discontinue the previous government projects for political reasons [31] then, the inability of the private sector to fund projects after getting the approval from government and unethical practices that may lead to contractual disagreement [31] [32]. Nonetheless, the benefits of PPP as seen in the Garki Hospital's experience outweigh the challenges. These include the elimination of strikes by health workers, a drop in the number of doctors immigrating from the hospital to abroad since there is job satisfaction, a better working environment, better utilization of resources, reduction in cases of fraud due to transparency and accountability in the operation of the hospital, also, reduced mortality rate in all her health departments [30].

3.2. Government Engagement with the Private Health Sector in the Delivery of Oral Healthcare

Poor oral health could lead to pain which may limit the productivity of an indi-

vidual, and poor oral health challenges such as dental caries if left untreated in a large population can harm a country's economy [17]. It has been reported that between 8% to 15% of Nigerians suffer from oral health diseases with the majority of oral disease sufferers residing in rural areas where access to oral healthcare is poor or non-existent [33]. The Oral Health Policy (OHP) was approved in October 2011, after being developed through the collective efforts of dentists in the three tiers of the health system (Federal, State, and Local government), the National Primary Health Care Development Agency, the National Health Insurance Scheme and private sector [34] [35]. From the development of the OHP, the FGN recognized the role of the private sector, and successful implementation of the policy must include the private sector [35]. While the oral healthcare needs of Nigerians are enormous, there are insufficient human resources to meet the needs of Nigerians, and more of the dental personnel are concentrated in the urban areas in the southern part of the country leaving a few in the vast Northern part of the country [35]. The OHP has a framework (**Figure 2**) indicating the government's engagement with the private sector at the three tiers of government for the implementation of policy [35]. Therefore, successful implementation of the OHP requires the FGN to work with the private health sector according to the framework.

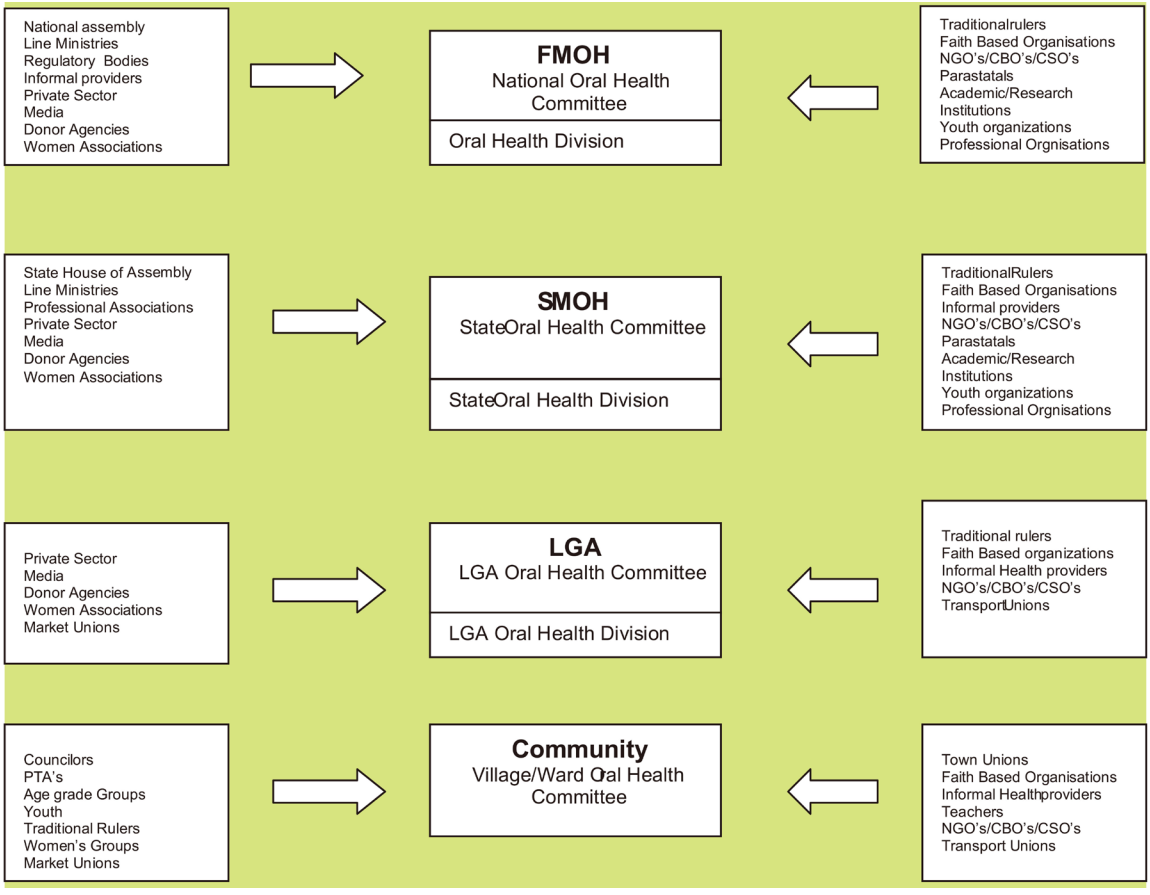

Figure 2. Framework of the Oral Health Roles at the different level of Government. Source: Federal Ministry of Health, Nigeria [35].

Nevertheless, the FGN is commended for signing the OHP after experiencing failure between 1984 and 1999 and then another failure in 2004-2009 [34]. The challenges at the formulation stages were overcome although, the implementation of the OHP has met with several challenges [33] [36]. Uguru *et al.*, *[36]* mentioned some of the challenges such as ethical issues militating against the successful implementation of OHP including inadequate funding of oral health by the FGN, the exorbitant cost of dental equipment, poor distribution of dental clinics that are more in the urban areas, and lack of health promotion initiatives to create awareness among the populace. To tackle these challenges, Amedari *et al.*, [33] recommend the use of the WHO building block framework (**Figure 3**) [37].

The FGN may consider these six building blocks seriously and work with them because they will enhance the oral health system in Nigeria [33]. The WHO health system framework could be applied in oral health as shown in **Figure 3** [33].

1) Oral Health Services delivery: The largest number of dental facilities belongs to the private sector, but according to Uguru *et al.*, [36] they are poorly distributed with more in the urban areas in the south and few or none in rural areas and the northern part of the country. Olusile *et al.*, [38] recommend that government should establish at least one dental clinic in each local government area in Nigeria.

2) Oral Health Workforce: It has been reported that the ratio of dentists to 10,000 population was 0.21 in 2017 [39]. It has been recommended that the large pool of dental auxiliaries graduating yearly from schools of dental therapies, dental surgeon assistants, and dental technicians should be trained by members of the Nigerian Dental Association (NDA) and employed in Primary Health Centers (PHC) to carry out simple treatments such as scaling and polishing, application of fissure sealants, and simple extractions under the supervision of a trained dentist who is assigned to visits PHC once a week to handle advance dental cases [39] [40].

3) **Dental information:** In the non-existence of a national oral health information system, data on oral health status is not available. Thus, strategic planning for a country's oral health needs would not be accurately done, and the effect of the OHP cannot be monitored. Therefore, the FGN should work with the dental community and the private health sector to develop an Oral Health Information System [33].

4) Dental drugs and Products: A policy document for the purchase of dental equipment was approved by the FGN, sadly, this policy only focused on tertiary dental centers neglecting the secondary and primary centers [41]. A more inclusive policy is needed to make equipping dental centers in the States and rural areas less expensive. The unethical conduct of the local pharmacists who sell dental medications, especially analgesics should be discouraged through dental health education and promotion [33].

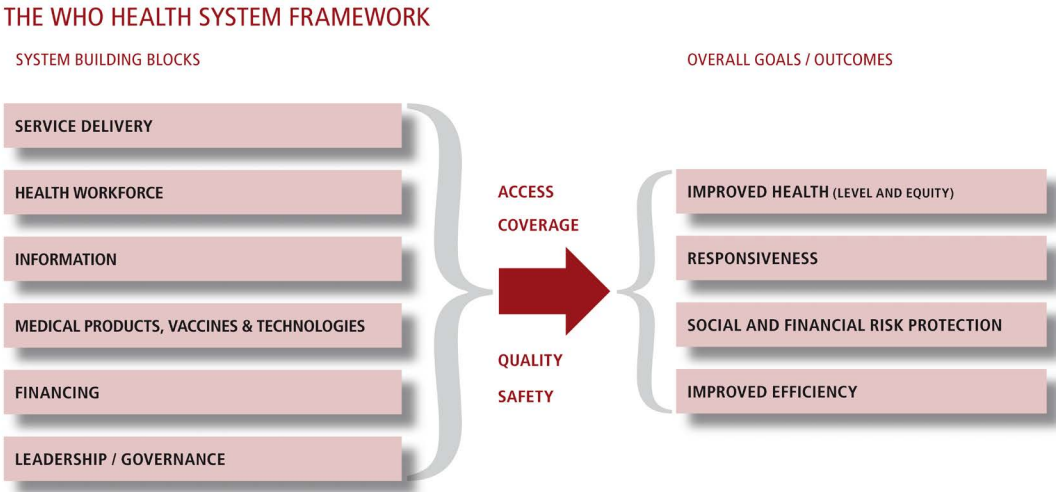

Figure 3. The WHO Health System Framework. Source: WHO [37].

5) Oral Health Financing: The FGN budgetary allocation to health is meager and the corresponding allocation to oral health is also poor [33]. Regular review of health financing and expanding the NHIA coverage of oral health challenges is encouraged [36]. Multiple taxation often experienced by private dental clinics should be abolished [36]. Since private dental clinics render most of Nigeria's oral healthcare services, FGN can collaborate with them in a PPP to establish dental clinics in rural areas [36].

6) Leadership, and Governance in Oral Health: Adeyemi, [6] has recommended the establishment of the Directorate of Dentistry in the Federal Ministry of Health (FMOH), and this would among other things provide effective leadership in strategic planning of oral health programs including monitoring and evaluation the OHP [36].

7) Community participation in Oral Health: Community participation and ownership of Oral Health programs have been reported to improve oral health outcomes in some communities in Nigeria [33] [36]. Thus, the FGN can partner with dental schools and private clinics to organize community oral health outreaches, and health promotion in communities and schools.

4. Conclusions

While universal health coverage has improved greatly in Ghana partly due to better funding from the government, improved taxation, and efficient administration of the National Health Insurance Scheme (NHIS), it is hoped that with the creation of the National Health Insurance Authority, more funds would be made available to NHIA, her activities will be more transparent, and more inclusive to cover a higher percentage of Nigeria's population. In addition, we recommend that oral healthcare be expanded and included at the primary healthcare level. The public-private partnership in Nigeria has recorded success with the Garki Hospital as a case study, therefore, the authors would recommend that the FGN should be involved in more PPP with the private health sector to ex-

pand affordable oral healthcare to the rural areas.

Furthermore, creating a directorate of dentistry in the FMoH would provide effective implementation and monitoring of OHP in Nigeria.

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Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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