Introduction

Developments in health are easily among the best known human development indicators. Comparisons of life expectancy, infant mortality, access to safe water and similar data indicate the positions of individual countries. The political and economic processes which these indices reflect, or which inform the nature of health policy, are often not as clear or visible. These structural factors are either frequently ignored or mentioned only in passing, as illustrated in a recent paper by Ogunbekun et al. (1999) on the private medical enterprise in Nigeria. According to the authors, the generally low quality of public health services and high user fees have combined to make private medicine the ‘unavoidable choice’ of Nigerians. They identify benefits of private medicine as higher technical efficiency and contributing to fill the gap created by inadequate public sector services and to medical training.

This paper argues that these claims are exaggerated, and that the authors seem to ignore Nigeria’s political and economic processes, the health seeking behaviour of Nigerians, as well as the prevailing causes of morbidity and mortality. It is suggested that whereas the contributions of private medicine are significant, there are also several limitations, some of which originate from its for-profit raison d’être. The ultimate aim of public health development must include improved access to services and better health status for the majority of the people. Without any form of public supported programme of payments in Nigeria, these objectives are circumscribed, especially with high fees in the private system. It is concluded that while private medicine will continue to be available for those who can afford it, it is unlikely to provide solutions to Nigeria’s morbidity and mortality problems, particularly in relation to epidemics such as the growing burden of HIV/AIDS.

The promise and limits of private medicine: health policy dilemmas in Nigeria

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I argue that the authors seemed to ignore the history of health care development in Nigeria, and the underlying political and economic processes that sustain and constrain this development. Nor do they show much appreciation for the health seeking behaviour of Nigerians and the country’s major disease burden. A case is made for a fuller contextualization by first outlining the development of health care services and the origins of the crisis in both public and private sectors. Thereafter, I examine the structure of PME, which, far from a system to be reformed to assume the wider roles suggested by the authors, is itself in a deep crisis with several negative prognoses. While the rising profile of PME is not contested, the authors seem to disregard its limitations, some of which relate to its for-profit raison d’être.

The final section discusses the implications of the suggested reforms and the limitations of private medicine in addressing the prevailing burden of disease and death in Nigeria. As part
of the current debate on alternatives to the public health care system, the roles of Christian medical facilities are also exam-
ined. It is concluded that both PME and the religious based facilities have limitations. A more functional public system is
suggested, especially in the context of current public health problems of preventable childhood diseases, the growing burden of HIV/AIDS and other epidemics.

The development of the health care system in Nigeria

Like most other institutions, the Western health care system in Nigeria is a colonial legacy. According to historical sources, private European explorers brought its rudimentary elements (Schram 1971; Ayanadele 1979; Iyyayiy 1987). By introducing quinine into their voyages of ‘discovery’, these explorers transformed the West African coast, including Nigeria, from the ‘White man’s grave’ (due to the heavy toll malaria inflicted on the invaders) into a colony. It was there-
fore no accident that the first hospital in Nigeria was a guest-
house where sick sailors lay until they recuperated (Schram 1971, p. 103). At a later date, the British Imperial Army, the
West African Frontier Force, extended medical care to the main centres of European population.

The colonial medical services were initially for the Europeans and their staff. Medical services were later extended to the general public but only as part of the colonial policy of cordon sanitaire. Often, this policy entailed forced ministrations of vaccination and other therapies for which colonial medicine was infamous (Fonot 1966; Onoge 1975; Doyal and Pannel 1976; Aidoo 1982).

Deriving from its mission of disease containment, medical care under colonialism was patently curative and was based in the urban centres close to the target population. Services were also elitist and relied on doctors and nurses rather than on aids or auxiliaries, and also on the home country for drugs, equipment and other supplies (Iyyayiy 1987). This urban based and curative system was inherited at independence (Erinosho 1982; Alubo 1985; Igun 1989).

Today, Western medical services are available in Nigeria from three parallel sources: public, private, and voluntary agencies or missionary sources. Because of the different philosophies underlying their operations, and the roles all three continue to play, a brief discussion of each is in order.

The boom and bust in Nigeria’s public health system

The public sector experienced rapid growth after indepen-
dence (declared in 1960, ratified in 1963), recording an increase in physician numbers and in bed capacity of over six-
fold in the first decade (Federal Government of Nigeria 1981). The oil boom (1971–1980) particularly boosted this growth, during which the number of curative centres doubled and training schools for personnel more than tripled (Alubo 1985a, 1987). At the time, free medical services, including food for hospitalized patients, were provided in public hospi-
tals. But, a concern during the period was the persistence of superstitions – traditional beliefs that supposedly kept people away from these free services (Onoge 1975). Olikoye Ransome Kuti (1988), a one time Health Minister, once described it as a context between science and superstition.

From about 1984, however, the public sector began to experi-
ce an acute crisis. This crisis was marked in short by the cuts in drugs, reagents, equipment and personnel. As I have illus-
trated elsewhere (Alubo 1986a, 1993; see also Stock 1985a), the crisis reflects Nigeria’s overall underdevelopment, par-
ticularly its dependency on imports (from complex medical equipment to syringes and bandages) to run medical services. Consequently, the foreign exchange difficulties attendant to the economic crisis translated to shortages in necessary sup-
plies (De Lima 1985). The medical care crisis is therefore a manifestation of the deeper structural crisis of the Nigerian economy, specifically where it fits in the overall structure of world capitalism.

With prodding from the IMF and the World Bank, and as part of the general structural adjustment package, Nigeria’s various governments since 1984 have addressed these short-
ages through a combination of ‘rationalization’, imposition of user fees, and panicky importation, such as after the 1985 doctors’ strike (Alubo 1998a). The persistent shortages and user fees have combined to discourage patronage of public facilities, and to make the private and the missionary facilities the more reliable sources.

The oil bust gave impetus to PME in other ways. Aside from the shortages, the formerly expanding public sector, which traditionally employed doctors and other health staff, began to down-size its work force. Using the slogan ‘be your own boss’, the State encouraged retrenched workers and others to become self-employed, and established structures such as the National Directorate of Employment, which runs entrepre-
neurship courses, and the People’s Bank (mentioned by Ogunbekun et al. 1999), which provides loans for self-
employment, to further support the self-employment initia-
tive. In response to the non-availability of public service jobs, which pay less than the private sector but provide scope for moonlighting and have greater job security and retirement benefits, many professionals, including physicians, have turned to private practice. To further encourage this trend, the mandatory five-year’s experience precondition for going into private practice, which was decreed during the oil boom, has now been removed (Alubo 1994a). Finally, when the new user fees in the public sector are added to the queues and insults for which the sector is notorious (Onoge 1975; Igun 1979; Alubo 1987; Iyyayiy 1988), the growing prominence of PME and missionary facilities is understandable.

This turn of events cannot be passed off, as Ogunbekun et al. (1999) have done, as inconsistent policies, or as part of the crisis of inadequate control over PME. Nor is it explained by claims that ‘the crisis in Nigeria’s health care system is inextricably linked to attempts at “cartelizing” private health care earlier in the 1990s’ (Ogunbekun et al. 1999, p. 177). The crisis, which predates the 1990s, relates to macro-level econ-
omic and structural problems and government divestment from social services, including health services. Hence, in a country that has many unemployed doctors and other highly
trained staff, almost all sectors of the public health system are understaffed. It is this complex processes that Ogunbekun et al. (1999) appropriately noted, is the dominant ownership structure of PME in Nigeria. In the absence of easy access to loans and other support, this structure accounts for the size and often sparsely equipped nature of PME facilities. Furthermore, private medical facilities are mostly urban based, with six out of the existing 21 (now 36, since 1997) states, namely Lagos, Oyo, Edo, Anambra, Benue and Kaduna States accounting for about 80% of the number of total registered facilities and beds in 1991. The distribution of retail pharmacies followed a similar pattern (Ogunbekun et al. 1999, p. 174). The authors, however, did not mention that Lagos, Ibadan, Enugu, Kaduna and Benin were old regional capitals and therefore big centres for commercial activities, including large medical centres. These cities, which are among the largest in the country, also have reputable medical schools, an important factor relating to the wide practice of employed medical staff running private clinics/hospitals on the side. PME in Nigeria is available at both the formal and informal levels. The first may be registered and would have business premises, while the second is more itinerant and less organized. Hospitals, clinics, pharmacy shops and laboratories are part of the formal system, while drug hawkers and injection doctors belong in the second category. Ogunbekun et al. (1999) focused mainly on the first level even though the two co-exist. Indeed, because the informal sector is more widespread, it may have contributed more to any rise in access to Western medicine attributable to PME.

On the basis of services provided, PME can be broadly categorized into hospitals, maternity homes, clinics, diagnostic centres and pharmacy/chemist shops. PME hospitals, which are typically strategically located in high-density areas, run the whole gamut from three to four room apartments to larger and more imposing ones. They also tend to be poorly equipped and staffed, which was why the Nigerian Medical and Dental Council certified (as of 1995) only four out of over 16 000 for purposes of internship training (Alubo 1994a: 125). There is little information to indicate that many of these hospitals train other cadres. However, it is commonly claimed that PME provides some of the first level of medical care in urban and semi-urban areas. By far the most intricate network is the business of running pharmacy/chemist shops. Activities in this category are carried out variously by medical representatives who represent government ministries of health and other big organizations, sales outlets in the shops, itinerant vendors, and injection doctors who are particularly active in market places and other places of heavy human traffic (Alubo 1985b; Stock 1985b; Iyyavar 1987; also van der Geest 1985; van der Geest and White 1986). This is due to the fact that only pharmacy shops can dispense prescription (ethical) drugs, while patent medicine dealers are restricted to common remedies or over-the-counter medicines (OTCs). In practice, however, both sell prescription drugs; others even prescribe and effectively run clinics (Igun 1994). More recently, pharmacy shops seem to have surrounded public hospitals - in apparent contravention of their own code about ‘concession’ - for strategic positioning. Beside the economic gains of the location, patients can quickly fill non-available prescriptions (popularly called o/s, meaning out of stock) from these shops at hospital gates.

There are, however, several combinations such as laboratory/clinic and pharmacy/clinic, akin to what McKinley and Arches (1985) once referred to as ‘doc-in-the-box’. Irrespective of the fact that Ogunbekun et al.’s (1999, p. 176) claims that PME has outpaced the public sector in new technology, patients and originated as doctors’ offices for consultation and simple treatment. However, many clinics have broken the mould and now provide in-patient services. Clinics again tend to be sparsely equipped, exposing them as targets for raids by government inspectorate units (Anonymous 1985). Diagnostic centres provide a range of laboratory tests, including x-rays, and also buy, sell and transfuse blood. They are, however, exclusive to urban and semi-urban areas. By far the most intricate network is the business of running pharmacy/chemist shops. Activities in this category are carried out variously by medical representatives who represent-government ministries of health and other big organizations, sales outlets in the shops, itinerant vendors, and injection doctors who are particularly active in market places and other places of heavy human traffic (Alubo 1985b; Stock 1985b; Iyyavar 1987; also van der Geest 1985; van der Geest and White 1986). This is due to the fact that only pharmacy shops can dispense prescription (ethical) drugs, while patent medicine dealers are restricted to common remedies or over-the-counter medicines (OTCs). In practice, however, both sell prescription drugs; others even prescribe and effectively run clinics (Igun 1994). More recently, pharmacy shops seem to have surrounded public hospitals - in apparent contravention of their own code about ‘concession’ - for strategic positioning. Beside the economic gains of the location, patients can quickly fill non-available prescriptions (popularly called o/s, meaning out of stock) from these shops at hospital gates.

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Fees in PME are often several times higher than in public facilities, making the ability to pay such fees a major

The origins and structure of private medical enterprise in Nigeria

The origin of private medicine in Nigeria can be traced back to the time of slavery, when medical doctors screened would-be slaves and provided medical care aboard slave ships. As Schram (1971, p. 10) has shown, an act of the British parliament made it obligatory for all slave ships to have a doctor on board. After the abolition of slavery, PME existed mostly in the emerging corporations as well as in the few proprietary hospitals and clinics, mostly in the urban areas (Iyyavar 1987). However, both colonial and post-colonial governments restricted the activities of PME because of widespread unethical practice (details are given in the next section), and to attract physicians to the then expanding public sector (Iyyavar 1987, Alubo 1994a).

Solo practice, as Ogunbekun et al. (1999) appropriately noted, is the dominant ownership structure of PME in Nigeria. The absence of easy access to loans and other support, this structure accounts for the size and often sparsely equipped nature of PME facilities. Furthermore, private medical facilities are mostly urban based, with six out of the existing 21 (now 36, since 1997) states, namely Lagos, Oyo, Edo, Anambra, Benue and Kaduna States accounting for about 80% of the number of total registered facilities and beds in 1991. The distribution of retail pharmacies followed a similar pattern (Ogunbekun et al. 1999, p. 174). The authors, however, did not mention that Lagos, Ibadan, Enugu, Kaduna and Benin were old regional capitals and therefore big centres for commercial activities, including large medical centres. These cities, which are among the largest in the country, also have reputable medical schools, an important factor relating to the wide practice of employed medical staff running private clinics/hospitals on the side.

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determinant of access (Ogunbékun et al. indicated that prac-
titioners in the Lagos area engage in collective price fixing).
The result of this is a constant high and growing poverty
in Nigeria (World Bank 1996; Federal Office of Statistics,
undated). As Raufu Mustapha (1999, p. 281) has shown, ‘the
percentage of people living below the poverty line increased
from 41% in 1992 to 80% in 1998’. Furthermore, those lucky
enough to have jobs receive on average the equivalent of
US$30 a month, an amount far less than the cost of living and
which the private sector is not obliged to pay. Rather than
address this issue of affordability and access, Ogunbékun et
al. (1999, p. 176) seem to indulge in victim blaming by
suggesting that ‘health care may not rank high on the priority
list of the average citizen’.

Because these services are priced out of the reach of most,
and for more lucrative returns, PME in the large urban
centres is sustained mainly by retainerships from big public
organizations (such as the telecommunications company
NITEL and the electricity company NEPA) and private
organizations (such as the banks, oil companies and foreign
embassies). It is this patronage by major public and private
organizations which largely determines the success and sur-
renav of entrepreneurial medicine, and hence the stiff compe-
tition among practitioners for retainerships (Ogunbékun et
al. 1999, p. 179).

This detailed explanation is necessary to situate the rising
prominence of PME in the public sector crisis, as well as to
contextualize why PME may be incapable of the wider roles
Ogunbékun et al. have suggested. I conclude this section by
noting that irrespective of source, health care development in
Nigeria is largely limited to curative services, with prevention,
promotion, rehabilitation and other aspects receiving atten-
tion only on paper (Erinmosho 1982). Consequently, the typical
Nigerian has come to equate health with medical care, and
health seeking barely goes beyond efforts to respond to acute
conditions (Igun 1979; Erinmosho 1982; Alubo 1987). In this
process, common remedies are tried first, and professional
help sought only when these fail. This process of seeking out
remedies and weighing the monetary and other costs (such as
transportation, time off work, intimidating health staff, etc.)
of attending hospitals is frequently time consuming; hence
patients are accused of presenting when the condition is
already critical (Igun 1979; Murphy and Baba 1981; Ityavyar
1988). Moreover, depending on the perceived origin of the
affliction, health care for many Nigerians goes beyond
medical services to include other activities such as rituals or
sacrifice to ‘complete’ the process (Onoge 1975). This is the
social and cultural context that private (and other) medical
care providers must factor into their practice.

Medical missionaries

Western medicine is also provided by missionaries whose
activities predate the formal colonization of Nigeria (Schalm
1971; Anyandele 1979). Through a mutually reinforcing use
of the bible and the syringe, several Christian missionaries
were engaged in a rivalry to provide medical care. At the
time, medical care was essentially an instrument of evange-
lization, a process in which it was, as in other colonies, a
reward for accepting the new faith as well as an incentive to
the non-believer (Doyal and Pennel 1976; Anyandele 1979;
Sanders 1985; Ityavyar 1987).

Unlike the public health sector, missionary facilities have
always charged fees, a factor that has remained a barrier to
greater access. In modern Nigeria, church run facilities are
numerous and seem to be distributed more evenly between
urban and rural areas than public sector facilities. This more
even spread between urban and rural areas has facilitated a
wider reach among Nigeria’s predominantly rural population.
Indeed, the wide rural network of missionary facilities has
formed the basis of collaboration in several public health
campaigns. In Plateau State, for example, leprosy services in
the southern half of the state run mostly from the health post
of the Church of Christ in Nigeria (formerly Sudan United
Mission). AIDS control activities in neighbouring Benue
State are also run in collaboration with facilities of the Roman
Catholic Church. In a similar manner, childhood immuniza-
tion services are offered in many missionary facilities.
However, their Christian origins have tended to restrict their
activities to the predominantly animist and Christian south,
and to the non-Muslim nationalities in the north (Ityavyar
1987, p. 490). More recently, the Islamic religion has begun to
establish its own medical facilities in the predominantly
Muslim areas of the country (Alubo 1994a). Because of both
the confidence that people seem to place in them (the think-
ing is that the fear of God guides their operations) and the
unabating crisis of the public system, medical missionaries
continue to be an important co-provider of western medicine.
It is therefore inappropriate to describe them, as Ogunbékun
et al. have done, as playing a ‘limited role’ (1999, p. 180). The
promised and the limits of these contributions are discussed in
more detail in the next section.

The promise, crisis and limitations of private
medicine

In this section I argue that the PME is itself in a crisis, which
is in some respects deeper than that of the public system. This
crisis relates to coverage, the fees’ regime and access, and
more importantly, to the sharp practices within the private
medical market. More than any other, this last factor is com-
pelling medicine as an institution to address its long accepted
utility.

Contrary to Ogunbékun et al.’s claims that ‘Patients cannot
be formally referred from the public to private facilities even
where the required services are not available in the former’
(1999, p. 175), there is a heavy formal and informal traffic
between the two. At the formal level, patients are routinely
referred to PME facilities to run blood and other tests, fill pre-
scriptions and to furnish supplies for surgery and dressings.
Indeed, there are suspicions that many of these diagnostic
centres and pharmacy shops to which patients are regularly
referred, might be owned by these public service health
workers, who use their positions in the latter for private
enrichment (Stock 1985b; Alubo 1990a). Patients are also
referred to private hospitals where a particular piece of
equipment, such as scanner or a renal dialysis unit, is known
to exist. Less formally, many public sector practitioners often
advise patients to go to particular private clinics for ‘better’ attention (Igun 1979; Alubo 1990a). At the informal level, drugs are sold at a ‘discount’ and thus outrageously pilfered from the public sector, such as occurred during the 1990 cholera epidemic (Renne 1997). It is thus uncertain what proportion of the claimed efficiency of PME is due to business ‘success’ or to the de facto subsidy by the public sector.

Furthermore, there is reason to suggest that the supposed shift in emphasis from curative to primary health care, which Ogunbekun et al. (1999, p. 175) blame for the crisis in public hospitals, might have been exaggerated. First, PHC had existed in Nigeria during the Third and Fourth Development Plans (1975–1985), the period that witnessed the most rapid expansion in curative care. The 1986 PHC programme, to which they referred, was only another relaunch (Federal Government of Nigeria 1986). Second, the operation of PHC has continued to have a curative basis, as its preventive and other components did not go beyond immunization shots (Alubo 1995; also Werner, undated). The claims that PME has contributed significantly to childhood immunization is also questionable, because their more organized forms are mostly urban based and do not reach the rural areas where up to 70% of Nigerians live. PME services in the rural areas are mostly through the less organized providers such as drug hawkers and injectionists, with whom the State is unlikely to collaborate. As mentioned earlier, the State is collaborating instead with missionary facilities in immunization and other public health campaigns. More importantly, immunization programmes are run mostly as campaigns through established structures, from the federal through the State and Local Government in the public health sector, without private sector involvement.

Equally doubtful are the claims that up to 65% of Nigerians now have access to Western medicine (Ogunbekun et al. 1999, p. 176). The authors attributed this 50% rise in coverage between 1985 and 1995 to PHC and the growth of the private sector. It is curious, however, that in 25 years of independence, during which Nigeria experienced oil wealth, massively expanded the public health system and provided free services, the coverage did not exceed 40%. How it could have increased rapidly during a recession, and with diminished revenue, is difficult to fathom.

Many PME practitioners in Nigeria engage in unethical practice, such as ‘surgery’ which may or may not go beyond the skin layer and ‘blood washing’. As in colonial times, many have continued the habit of indiscriminate administration of injections – with all this implies for the transmission of HIV/AIDS. There is also widespread hawking and sale of drugs with little regard for dosage or treatment regimen (Alubo 1985b; Stock 1985b; Iyyayee 1987; Iyun 1988; Pole 1989; Igun 1994). Worse still, many of the drugs imported by the private sector have been found to either contain only a fraction of the declared medicinal substance, or might contain maize flour or face powder. A former Health Minister, Ransome Kuti, who was in a position to know, once said that up to 60% of drugs in Nigeria (see Alubo 1994b) were fake. This rampant circulation of fake drugs compelled some West African neighbours to ban the importation of drugs from Nigeria in the late 1980s. A more devastating consequence, however, was the paracetamol deaths of over 100 children in 1990. This tragedy was caused by a private entrepreneur who imported a dangerous solvent for paracetamol (Alubo 1994b). These untoward practices are in addition to the use of auxiliaries as full nurses and the generally rickety nature of PME facilities mentioned by the authors.

More recently, many health care providers, including PME practitioners, claimed to have found a cure for AIDS. These claims, which a government committee has failed to be apourous (Federal Government 2000), are used to trick desperate Nigerians living with AIDS who come forward to be ‘cured’ (Abuh 2000). The most popular of these claimants is Dr Jeremiah Abalaka, a private medical practitioner, who alleges that his scientific breakthrough is being suppressed by Western pharmaceutical companies and their government to sustain markets for antiretroviral drugs (Adekeye 2000). The for-profit motive and high fees also limit access to PME services. Without any organized third party structure, patients are required to deposit money as a precondition for service, or treatment is denied or discontinued when such deposits are exhausted. In some instances, patients are held hostage until bills are paid. This unresolved problem raises questions about the limits of medicine as a business where there is no organized payment structure, and about professional responsibility as well. A recent diary of a private medical practitioner presents the issue of fee-for-service and its impact on access as a daily dilemma between saving lives (in accordance with the oath) and sustaining his business (Ati 1998).

I suggest that the high fees and health-seeking behaviour of Nigerians, rather than a supposed ‘high investment in cost requirement’ (Ogunbekun et al. 1999, p. 174), explains the low patronage of dentists. Visits to dentists are more frequently promotive and protective than for curative purposes, both of which receive little attention from Nigerian medical services consumers. Faced with this reality and the economic imperative of survival, dentists are beginning to market their services consumers. Faced with this reality and the economic imperative of survival, dentists are beginning to market their services by offering free check-ups ‘as inducement for future arrangements such as retainership can afford PME services. In any case, it is therefore inappropriate to describe PME as the ‘unavoidable choice’ because missionaries also run a functional and more moderately priced parallel system.

The fee regime means that most people cannot afford the services, in a country of high and rising poverty and unemployment. In effect, only clients covered by some third party arrangements such as retainership can afford PME services. Because of their long history, and the general trust the Nigerian public places in them, it could even be argued that church-related facilities represent a compromise between the crises of the public health system and the exorbitant fees of PME. This position is further strengthened by their fairly even distribution between urban and rural areas in their regions of operation. These strengths are being harnessed for a more
effective health delivery especially for immunization and PHC in general.

But the church-run system also has its limitations. In addition to their mostly southern and middle belt location, therefore excluding other regions, even their modest fees are higher than in the public sector. Already, the much lower fees in the public system are beyond the reach of many patients and hence are a growing exclusion (Ityavyar 1998; Alubo 1999a). Affordability of church-run facilities therefore remains a problem, which compels many to sell off livestock or go into debt. There are also questions about the extent to which public health policy can, in the Nigerian context, rely on a fee regime without also involving the same government support that divestment of the public health was designed to forestall. Perhaps the institution of a national health insurance scheme (which has been hindered for over a decade by wrangling between the various health professional groups) may increase access on which more collaboration between the two can be built. Until then, church-run services will, like PME, continue to be an important parallel source of Western medicine.

The fee regime in the PME system is also related to sharp practices because people who cannot afford the appropriate treatment seek out other PME sources in the less organized informal sector, where proprietors disregard any conceptions of dosage and where various amounts of ‘healing’ are available for various amounts of money. This unregulated practice is compelling PME, and medicine in general, to deal with its utility. There is therefore some crisis of confidence and affordability, which is pushing people to cheaper alternative sources of therapy.

This rampant malpractice contrasts sharply with the public facilities, which, despite the crisis, are generally better equipped and staffed. There are also few reports of unethical practice, such as accepting to administer the amount of treatment/healing a patient can afford. Hence, in spite of Ogunbekun et al’s claims of ‘persistent low quality’, it is the public sector (especially the teaching hospitals), rather than PME facilities, which continues to be the last resort for Nigerians who cannot afford to go overseas.

An ugly appearance is by no means a defining characteristic of PME; it also makes an important contribution to health care. Through direct services to clients and a reliance on it for the supply of drugs and other supplies, PME offers invaluable support for the public system. It is now routine for many procedures in the public system (such as tests, filling prescriptions, surgery) to rely on procurements from PME. There are also several PME facilities that have state of the art equipment and the right calibre of staff who insist of ethical practice. However, such facilities (especially in Lagos) are dwarfed by the ubiquity of drug hawkers, injection doctors and others who are part of the growing medical enterprise. Without the necessary reforms of the vast majority (more state and self-regulation for example) to make PME more useful to the Nigerian public, a typical encounter between a patient and a PME practitioner will continue to have unpredictable outcomes.

Ogunbekun et al’s suggestion to separate ambulatory services, such as antenatal care, from in-patient care may have arisen from a lack of familiarity with the health-seeking behaviour of Nigerians, and with the distribution of medical facilities. While suggested reforms might make economic sense, the typical Nigerian regards any curative activity as a ‘hospital’, which should provide all services, with referral made only for complications. The prevailing ‘market forces’ would thus seem to be pushing in the direction of comprehensive facilities, which the authors discourage. Moreover, in a country where over 60% of births are unattended (Harrison 1997; UNICEF 1997), separating antenatal care from delivery services is likely to increase cost and further discourage clients. Apparently, in the authors’ opinion, economic considerations seem to override the implications for maternal deaths, for which Nigeria’s record is already a national disgrace (Harrison 1997; Usman 1997; Wall 1998).

To conclude this section, while PME is a major source of medical care, together with the public sector and the missionary sources, it is also engulfed in its own crisis and therefore sorely in need of comprehensive reforms.

The limits of private medicine in resolving Nigeria’s health problems

Perhaps because of the general decline in public health-care services in developing countries, the private sector is frequently suggested as an alternative. Most of this debate is in response to the increased dominance of the World Bank in health policy (Ugulu and Jackson 1995; Buse and Walt 2000; de Beyer et al. 2000; Zwi 2000), and the implications of anchoring public health policy on the Bank’s formula of self-financing. The paper by Ogunbekun et al. (1999) is part of this debate, and seems to have been influenced by the World Bank’s 1987 document Financing health care in developing countries, An agenda for reform. This document signifies the Bank’s role as a major health policy-maker, which seeks to ‘revolutionize health care financing… by taking a monetarist approach and bringing health service delivery into line with its supply side recommendations in the other sectors’ (Turshen 1999, p. 122). The other issues, such as macro-economic factors which impact on supplies of essential drugs and immunizations, shortages of staff in the public sector, declining life expectancy and child survival, seem to be subsumed under the healing powers of the market.

But even the Bank has revised its earlier position by suggesting in 1993 that the government should provide some basic services for the poor, to include clinical packages for management of pregnancy, child birth and maternal-child health. The Bank also included the treatment of tuberculosis in the package, possibly because of its association with HIV/AIDS.

Ogunbekun et al. seem content with the Bank’s earlier position about private sector involvement in health and the supremacy of market forces, on the basis of which they recommended reforms (Navarro 1998, 1999; Giovanni 1999; Turshen 1999; Buse and Walt 2000). This is an important issue because in the best of times, and with free medical care, less
A further implication of the dominance of market-driven services is their lack of immediate relevance to morbidity and mortality problems of infectious, parasitic and nutritional disorders (Federal Government of Nigeria 1981, 1985; Alubo 1985a). These causes are rooted in the people’s mode of existence, reflected in access to food, safe water and other basic necessities, and in the political power, which determine, constrain and sustain such access. Nigeria’s epidemiological profile does not lend itself even to the handy packages of biomedical intervention — even with the prescribed PME reforms. Hence, in spite of supposed increased access to medical care, prevailing political and economic processes continue to lead to high infant (150:1000) and maternal (1000/1200:100,000) mortality rates and low life expectancy of under 54 years (Harrison 1997; UNICEF 1997). There is already evidence that user fees are further keeping women away from antenatal care and hospital delivery (Harrison 1997; Tursheen 1999), and thereby endangering the lives of mothers and babies. Childhood immunization and child survival are also declining as a result of poor funding of public health care (UNICEF 1999).

This issue of relevance, or the lack of it, assumes added dimensions because of the threat posed by HIV/AIDS. According to various records, the rates of HIV and AIDS are rising rapidly (Gwarzo 1998; Kuti 1998; Soyinka 1998; Federal Government 1999). As experience from other countries of Eastern and Southern Africa indicates (Singer 1998; Lanas 2000), the care for persons living with AIDS can easily overwhelm the families of the afflicted and the health care system. The new emphasis raises questions about how epidemics [including HIV/AIDS] will be controlled and monitored without a public health system (Renne 1997, p. 95).

PME in Nigeria differs from the pattern described by Andaleeb (2000) where the incentive structure propels higher quality of care than in the public sector. In the majority of PME facilities in Nigeria, the reverse is the case. But even where service quality is higher, the fee regime restricts access. The situation in Nigeria would seem to have parallels in other low-income countries which are also faced with declining funding for the public health system and a clamour for privatization and private sector involvement (Reisch 1995; Glassman et al. 1999; Mkapa 1999; Tursheen 1999; Lanas 2000).

Health care development is destined to remain a contested terrain of various professional and other interest groups. A dominant voice in the on-going debate, as represented by Ogunbekun et al., is in favour of the rising profile of PME. But this push for more private sector involvement in public health is only part of the issue; the private medical system in Nigeria has its own crisis and limitations. While PME will continue to be an important source of Western medicine, in a context of regional, rural–urban and curative imbalances, and of growing threats of AIDS and other epidemics, the needs of Nigeria and other countries faced with market-driven health reforms are perhaps better served with a more functional public health system. This is not to suggest that the public system is without problems. As preceding sections have shown, it is in crisis, some of which relates to the overall crisis of underdevelopment. I envisage comprehensive reforms to make the public health-care system more effective. Such reforms would include more prudent management of human and material resources to make the system more functional. This will require more and continued investment of public funds and the establishment of structures to ensure sustainability of such funds (along similar lines, Nigeria has an education tax fund to provide and ensure succour for educational institutions). This proposal would require ensuring regular supply of essential drugs and equipment by returning to the abandoned policy of essential drugs, and a shift in personnel development away from physicians and nurses, especially at lower levels, to aids and auxiliaries. The suggested reforms would help to resolve the present problem of exclusion and would facilitate the addressing of existing public health problems, including HIV/AIDS. The ultimate objective of health development and reforms must include improving access to services and a better health status for the majority of the people.

Endnotes

1 These are St Nicholas Hospital Lagos, Eko Hospital Lagos, Eastern Medical Centre Iju, and Salem Hospital Orelo.

2 A buka is the Nigerian street term for an eatery, which is by definition pedestrian and may not always be hygienic. Common along roadsides, bukas in Nigeria offer cheap food but quality may not always be guaranteed.

3 This is a procedure whereby dye such as laxis is inserted in drops and administered intravenously to patients. The excretion of the dye in urine is shown to the patient as proof that impurities in his/her blood are being washed off. ‘Blood washing’ and other forms of malpractice were discussed in a round-table on Ethics and Professionalism in Medical Practice in Nigeria, the African Leadership Forum, Ota, May 7–9, 1993.

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