FINANCIAL AND HEALTH REFORMS: A STRATEGIC MANAGEMENT APPROACH TO SUSTAINABLE HEALTH CARE DELIVERY IN NIGERIA

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Abstract

Financial and health reforms are discussed within the context and challenges in a complex and pluralistic Nigerian society. These major reforms are integrated and directed on health financing; with the application of strategic management principles to enhance the efficiency and responsiveness of the health service delivery. Health financing mechanisms used by some developed countries were featured. Financing mechanisms currently used in Nigeria are mainly user fees and social health insurance scheme, which benefit mainly people in the formal sector, with a vast majority of the people in the informal sector left out. Health gains and equity in distribution and use of government expenditure on health tend to elude the poor in the rural and urban areas. Implementation should build on the platform of existing systems, structures and human resources in the three tiers of government; with strategies well-adapted to drive forward the innovative activities and subsequent outcome measures. An integrative financial and health reforms model was proposed to maximize the strategic management thrust for achieving a more efficient and sustainable health care delivery in Nigeria.

Key Words: *financial & health reforms, strategic management, sustainable health care, Nigeria*

Introduction

Financial and health reforms are global phenomena which are necessitated by growing complexities in financial transactions, dwindling economic resources, aimed at enhancing cost effectiveness, and ensuring wellness and improved quality of life of the people in a dynamic world. The health sector is at the centre of global development policy, geared towards achieving economic and health security. Developing countries and the international community are improving health systems to meet the Millennium Development Goals (MDGs) and at the same time enhancing financial protection by securing long-term support for these gains. However, money alone cannot buy health gains or prevent impoverishment due to catastrophic medical bills. Well structured results based financing reforms are needed (WHO, 2010).

Financial systems are known to play a vital role in the economic development of nations through increased: domestic savings, efficiency of financial intermediation and effectiveness of the monetary policy. The increasing internationalized context of national policy making in terms of financial and health reforms is more obvious with the prevailing global financial crises. In developing countries that depend on international organizations (such as the World Bank and IMF) for aid and other support, their economic, public finance and public management

policies are very often shaped by the terms and conditions attached to such international support package (Cheung, 2002). The financial crisis in developing economies since the 1980s widened and deepened the distributive problems and slowed down the provision of goods and public services, health care inclusive. It is argued that developing economies that embarked on privatization programmes and public sector reforms, have the benefits of more effective controls, increased enterprise efficiency, and hence promotion of more effective national development (Cook and Kirkpatrick, 1995).

Financial markets, national governments and multinational corporations responded in different ways in an environment of highly mobile international capital. The intervention of the International Monetary Fund (IMF) succeeded in weakening instead of reviving many countries that fell into the trap of devaluation, downsizing and other conditionalities associated with transnational capitalism. Some countries however benefited from increased export trade that rolle[d] restructuring. The expected benefits accruable from a healthy and developed financial system are tie[d] the extent of savings mobilization and the efficiency of financial intermediation roles (Gibson and Tsakalotos, 1994).

Reformation in most developing and emerging economies is driven by the recurrent fiscal crises, globalization of the markets and the related economic-financial liberalization as well as democratic processes. Three phases of reformation were adopted by most developing countries. The first phase concentrated on the adjustments to the balance of payments and macro-economic reform and the restructuring incentives and relative prices. The second phase focused on overhauling the prevailing public sector arrangements and ensuring the privatization or contracting out a large number of state activities that could be commercialized in a market; while the third phase consists of the long term institutional adjustment required to consolidate and sustain others (Rowart, 1999).

Financial Reforms and the Health Sector in Nigeria

Health financing reforms are a core part of health sector development in low and middle income countries. Developed economies have more stable reform programmes with wider coverage. The trend is to move away from reliance on user fees or out-of-pocket payment as a source of health financing (Paul Shaw and Griffin, 1995), to a more robust system of risk pooling and health insurance schemes that tend to address inequality and good health for the poor. The existing mix of financing mechanisms and sources used in the health sector varies widely both between and within regions (Bennett and Gilson, 2001). In Nigeria, user fees are used in tax based system as well as social health insurance type system. The main objective of health financing reform is to raise more stable revenues for health care. Equity issues are secondary in some countries. In the absence of a buoyant economy, a stable financial system and employed household members, it would be very difficult if not impossible to source tax payers' funds to finance health or operate a health insurance scheme. The ability of households to pay for the costs of health care, cushioning the financial shocks associated with severe illness and accessibility of quality services to the less privileged are crucial for successful national health financing. Perceived quality of care, time and transportation costs associated with accessing care and informal charges must be favourable to the client or beneficiary. Good financial policies should be supplemented by good policies in the organization and delivery of health care (Bennett & Gilson, 2001).

The health system in Nigeria and the health status of Nigerians are in a deplorable state (Federal Ministry of Health, 2008). Nigeria's overall health system performance was ranked 187th position among the 191 Member States by the World Health Organization in 2000. Health status indicators were worse than the average for sub-Saharan Africa. Infant mortality rate and maternal mortality rate were among the highest in the world (FMOH, 2008). The situation might have improved with massive immunization efforts by the World Health Organization (WHO) and other donor agencies in the past decade. There was a general lack of transparency and fiscal discipline, as well as a complete absence of a health care financing framework to guide government's rationale for investment allocation and disbursement of resources (FMOH, 2008). This calls for urgent financial reform in the health sector to enhance the performance and free up funds for other economic development efforts.

Financing reforms are frequently embarked upon at times of economic crisis when there is financial imperative to raise more money for the health sector,

sometimes with a rush to implement reforms as a way of cushioning the situation. Hurried implementation will rarely deliver the potential benefits of such reform (Bennett & Gilson, 2001). Provision of healthcare in Nigeria is a concurrent responsibility of the three tiers of government (Federal, State and Local Governments). However, the operation of a mixed economy allows private healthcare provider participation. The Federal government is responsible for funding activities in tertiary health institutions; the state governments manage the general hospitals while the local governments (LGAs) are in charge of the dispensaries. About 4.6% of the GDP is spent on healthcare, while the federal government's overall expenditure on health is about 1.5% (Vogel, 1993).

Financial impact of health reform on medical professionals in many countries is difficult to predict. However cost reduction, increased number of patronage as more previously uninsured people are covered, and restructuring, enhanced medical informatics and job creation are likely outcomes of the reform (Qazi, 2010). A comprehensive view of health financing system has advantage over a narrow focus on particular reform instruments from marketing perspective. It was observed that over-emphasizing on the type of funding system used by countries may be conceptually inadequate, but at the same time restrict the consideration of possible policy choices or focus attention on the success or failure of particular schemes rather than on their impacts for the health care delivery system, and the entire population (Kutzin, 2001).

Health financing focuses on how financial resources are generated, allocated and used in health systems (WHO, 2010). Health financing issues address how and sourcing sufficient funds for health, how to overcome financial barriers that exclude many poor from access to health services and equity and efficient mix of health services (WHO/Health Financing, 2009). As reported earlier, developing countries in financial crisis are generally characterized by budget deficits, galloping inflation and flexible monetary policies. IMF intervention plan usually demands from such countries: balanced budgets – requiring a clean-up and stabilization of their public finances using fiscal austerity, control of inflation, and rigid monetary and fiscal policies.

Structural adjustments also created uncertainty in economic institutions, contributing to financial crises in the markets, deepening the levels of poverty, bringing more inequality and social exclusion, and making the conditions of living more precarious for the large majority of the population. Health conditions of the masses are not spared either. The social cost of implementation of these policies resulted in the reduction of public expenditure on education, health and housing, to mention a few. Nigeria is a victim.

Measures of financial sector development used to assess the effectiveness of financial reform include: growth rates of private financial assets and size of currency coupled with the growth rates and ratios of gross domestic product (GDP) that show the degree of monetization and financial market development; the flow of credit to the private sector from the financial institutions, and the growth of financial institutions' credit to the private sector relative to the growth of private sector deposits with financial institutions (Bisat, Johnston and Sundararajan, 1993). If the financial sector which stabilizes the economy fails, a cascade effect results in all aspects of the economy, health inclusive. The protection of the overall health of financial institutions through adequate regulation and supervision is crucial.

Health Financing Environment

The outcome of the financial reform has been mixed and differs from one country to another. So also is the outcome of health financing and reform. The existing mix of financing mechanisms and sources used in health sector varies greatly both between and within regions (Bennett & Gilson, 2001). The objectives are to raise more revenues for health care, encourage more efficient use of resources and promote greater accountability and sustainability. Apart from funding the health sector through budgetary allocation, other financing mechanisms have been used for the purpose. These include tax-based financing (income, corporate, value added taxes; cigarette taxes, import duties, etc.); social insurance financing which are contributions to a health fund (mandatory employer/employee contributions of percentage salary); private insurance (premiums paid are related to expected cost of service provided); user fees (clients or patients are charged according to set tariff for healthcare services rendered), and community-based health insurance (premiums are commonly fixed according to risk faced by the average member of the community, irrespective of the risk groups). Donor agencies have also played active roles in

funding health care. Health foundations owned by individuals and groups have channeled funds towards quality healthcare to communities and a number of health programmes. Such financial aids need to be monitored and integrated into the overall health package for maximum benefit to the target population. The five primary health financing mechanisms are also presented as follows: general taxation to the federal, state and local governments; social health insurance; voluntary or private health insurance; direct or out-of-pocket payments or user fees; and donations or community health insurance (WHO, 2006). Most country's systems make use of a mix of all the five models and all types of health care finance are compatible with an efficient health care system (Glied, 2008). The trend in Nigeria is a shift from tax-based to social health insurance type systems, with user fees significantly featuring in all the tiers of government, especially for the uninsured.

A conceptual framework for understanding the organization of health financing systems was used to show the relationship between stewardship of financing (governance, regulation and provision of information), health financing sub-functions (collection and pooling of funds, purchasing and provision of services) and the entire population. Issues related to the quality of health services, cost sharing/user fees, coverage/choice and entitlement/contributions to the funding system were crucial (Kutzin, 2008).

Countries may share core values and agree on the broad goals of health systems and objectives of health financing reforms, but other extraneous factors constrain the realization of these goals and values in practice. For health financing, the most expedient contextual issue is the fiscal contexts; the ability of government to mobilize tax (income, value added taxes, etc.) and other public revenues, and the need to balance them with total public spending. Fiscal context is crucial since the more buoyant the government is, the more it can commit to health financing (Kutzin, 2008).

A good assessment of the fiscal context is the ratio of public revenues (or expenditures) to gross domestic product (GDP). Richer economies tend to be more effective at mobilizing tax revenues (relative to the size of their countries). Tax collection is usually more difficult in poorer countries because more of the population are rural dwellers or work in the informal sector (Gottret and Schieber, 2006). However, the GDP per capita does not completely determine fiscal context.

The public sector must be fiscally sustainable and expenditures must be balanced with revenues. This also applies to health financing systems. Limitations of government spending on health indicate the need for implicit and explicit rationing of resources. The more governments spend on health, the less patients pay at the time they make use of services, which consequently impact on the objectives of financial protection, equity in finance, and equity in the use of health services. Governments can decide to give priority to health spending, irrespective of the fiscal constraints. Improving the efficiency of resource use is therefore very crucial, to lessen the burden of sustainability trade-offs. Apart from fiscal concerns, other contextual factors include: demographic structure and projections; rules governing the wider public finance system; and political-administrative decentralization in different tiers of government (Kutzin, 2008).

Health Financing in some Developed Countries and Nigeria

Health care reform is closely tied to financial reform because of the huge sums of tax-payers' money sunk on healthcare in most developed and some developing countries. The amount spent on health in the US represents about 16.7% of the country's gross domestic product and continues to grow much faster than the economy. Moreover, it threatens the economic future of the governments, businesses, and individuals called upon to foot the bill (Herzlinger, 2006). Health sector spending on health care research and development (R & D) was about $26 billion in 2003, only topped by the government's spending on defense R & D. Also private-sector spending on health care R & D in the areas of pharmaceuticals, biotechnology, medical devices and health services also amounts to tens of billions of dollars. Health care professionals and institutions sometimes blame technology-driven product innovators for high costs of health care system. The US spent 15.2% of GDP on health care (or US$6,347 per capita) in 2005. Approximately 45% was government expenditure. Policy prescriptions to jump-start innovations in health care financing include the use of: universal coverage where achievable, a consumer-driven system (Daley and Gubb, 2007), market-based pricing and the use of information from Securities

and Exchange Commission for health care institutions and companies providing health care (Herzlinger, 2006). The US does not have a universal health care system, although a legislation is in place to establish a fully functional one by 2014.

Other developed countries like the Netherlands introduced a successful comprehensive reform package that works not through a predominantly government-run system like in the UK, but through an insurance market that aims to be patient-focused and competitive (Dutch Health Care Performance Report, 2006). The model shows that universal coverage can be combined with the benefits of competition and individually-based care; thereby overcoming the inefficient and complex bureaucracy, lengthy waiting lists and lack of patient-orientation (Seddon, 2007). Netherlands spent 9.2% of its GDP on health care, equivalent of US$3,560 per capita, of which approximately 65% was government expendi (WHO, 2008). Sweden spent 9.2% of GDP on health care or US$3,727 per capita in the same year. In the UK, each of the four countries has a separate but cooperating public health care system.

Nigeria is still battling with the aftermath of the global financial crisis, which has the worst impact on the capital market. Channels through which the reform would have improved growth, deteriorated during the reform. Real deposit rate, real savings, efficiency and depth in financial intermediation and credit flow to the private sector became poorer during the reform. The inflation rate also worsened (Emenuga, 1994). Nigeria operates a mixed economy, with three tiers of government in place. The private sector has a significant role to play in health care delivery. The government instituted the National Health Insurance Scheme (NHIS) – a health financing mechanism involving government employees, the organized private sector and the informal sector. The Federal government expenditure on health care is about 4.6% of the GDP, while its expenditure on health stood at about 1.5% (Vogel, 1993). In 2004, there was a legislative act amending the created scheme of 1999.

Financial and Health Reforms Model

Reforms are introduced to enhance the efficiency and effectiveness of existing programmes or activities. Different economies will respond differently to reforms; with different outcomes (Monye, 2005). There are winners and losers in the race for human development and wellness (Taylor and Taylor, 1992).

The level of economic development and commitment to the course of providing quality health care to the people would play a crucial role in successful implementation of health finance. From the contextual perspective, the endemic corruption, systemic inefficiency, inequity in resource use and distribution, lack of transparency and accountability, coupled with population explosion remain the major challenges to the operation of a comprehensive reform package for Nigeria. In the three tiers of government, health financing policy is developed based on the platform of existing strategy, structure, systems and core competences. A health financing system that ensures efficient revenue collection, pooling of resources and purchasing would guarantee qualitative health care delivery. Concerted effort is made by government to introduce financial management reform in the health sector to cope with the complex operations required for success (Lawrence et al, 1994). New ways of accounting should be introduced into the financing-mix chosen to serve the Nigerian health system. Massive restructuring may be inevitable to achieve a functional and market-oriented model for the country. Methods used by developed countries discussed could be modified and adapted to create continuous quality improvement of the health system. Opposing innovation will expose the health programme to the risk of obsolescence or failure. Manpower requirements in the three tiers of government should be determined and people trained to supply the much needed human capital for sustainable health scheme.

Customer-driven health reform cannot be achieved in isolation. The financing mechanisms should be pilot tested either at local government or state level before selecting appropriate financing-mix for Nigeria. Implementation activities should be monitored by the Ministry of Health officials, the actuary, private sector participants, other stakeholders and the representatives of the people at the community level, to ensure the success of the scheme. Selection, procurement, storage and distribution of pharmaceuticals should be done by qualified personnel at all levels, bearing in mind the cost effectiveness and other pharmaco-economic parameters.

Political will is very crucial in pushing such a robust and challenging programme to a threshold that guarantees sustainable and qualitative health care

implementation activities. It would require coordination of efforts in the three tiers of government, with the Ministry of Health providing the stewardship.

The Ministry of Finance will invariably be involved especially in the budgetary allocation for health care, supporting health spending irrespective of fiscal constraints when necessary, and channeling health resources. Developments in the capital and money markets, which will affect funds flow directly or indirectly, should be monitored to ensure the sustainability of the scheme. The expected outcomes should always be matched with current performance. Outcome measures include health gain, financial protection, and degree of equity in health and financing. Gap analysis serves as a useful tool to evaluate the health financing reform (internally and externally) and to guard against the possibility of programme failure. The integrative model (Fig. 1) is a strategic management approach to achieving sustainable health care financing in an economy. The reform programmes anchor on a platform or threshold, supported by a systems-strategy-structure tripod and stabilized by core competences at the three tiers of government.

If well implemented, the malaise of rationing health care through waiting lists and lack of patient-focus would be surmounted. The inefficient and complicated bureaucracy coupled with rising costs would be improved upon. An insurer may offer different types of health plans. Tax credits could be given to low income earners. Insurers may also choose a hospital that offers quality care and dump low quality care providers. Honesty, openness and high standards must be designed into the health financing scheme if it must endure. Criteria for insurance, disease conditions to be covered, insurance criteria for the elderly and chronically ill, exemption criteria for certain disease conditions, free medicare for the under-fives, and the very poor – are all modalities to be worked out preferably during the planning/pilot stages, to have a sustainable scheme. A flexible 'tiering' system for the insured and uninsured could be adopted, aimed at narrowing the gap of health inequalities between the rich and the less privileged.

Programme planners and implementers must exert caution to avoid creating a general mistrust and power struggle between the former work force and the new staff with revolutionary approach. Nepotism and tribalism could easily erode the gains of reform programmes (Ssengooba et al, 2007). Reforms should incorporate active implementation research systems to understand the contextual dynamics and responses.

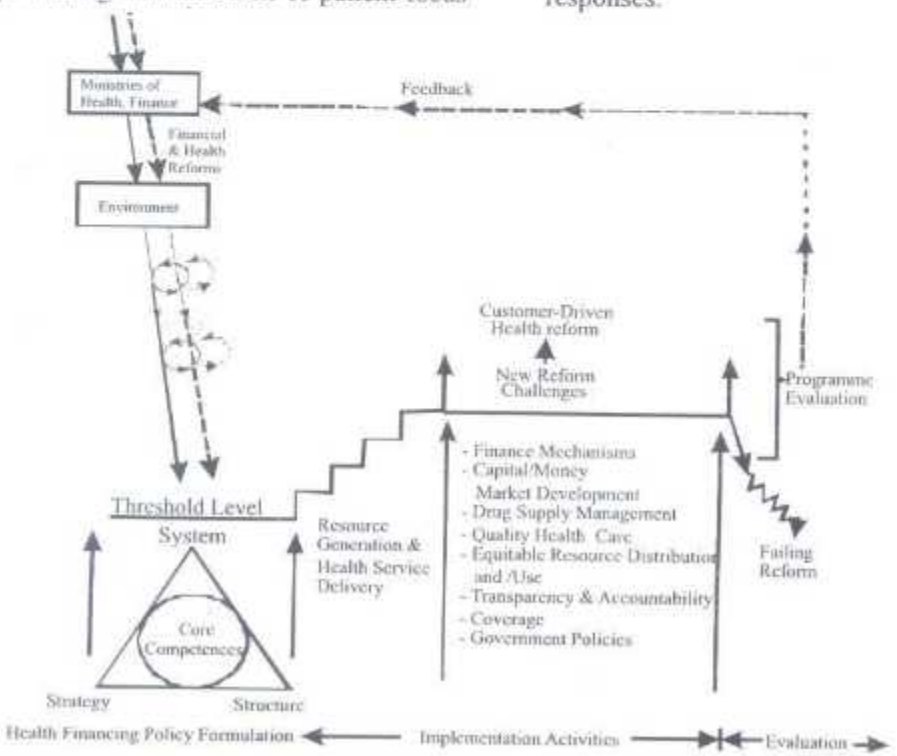

Fig. 1: Financial and health reforms: An integrative model for sustainable health care delivery

The magnitude of government subsidies to the health financing scheme should be determined and adequate resources allocated for sustainable implementation. Other health care input variables should be assessed and adequate provisions made for their availability. There is need to consult widely with various interest groups like health professionals, non-governmental organizations, religious organizations, bureaucrats, technocrats and the masses, to ensure acceptability and ownership of the scheme. Programme implementers must be part of the design; politicians, bureaucrats and external advisers do not know it all.

Health sector staff must be trained for the requisite capacity building. New forms of health care will require new skills for accurate costing, pricing and other financial skills required for a successful programme. New forms of finance incorporated into the scheme will equally require new systems as well as new skills. Lack of appropriate financial and information management systems could lead to gross inefficiency of the programme, serious financial losses and potential for programme failure. Financial systems need to be developed from the start so that revenues and premiums are channeled to the improvements in the quality of care (Bennett & Gilson, 2001). Core competences should be developed at different levels of implementation and evaluation. Developing a well articulated sequence of reform implementation is of strategic importance to complex reforms like social insurance financing. A successful financing reform will indirectly free up funds previously tied down – for other uses by government. Critics argue that reforms have unfairly transferred the burden of health care costs to the consumer (Muiser, 2007). Nevertheless, when well designed and implemented the overall gains to the society strike a balance for sustainable health care.

Conclusion

People's health status is linked to their economic status in a number of ways. With a weak economic structure, a fragile health care delivery system and unstable financial sector in Nigeria, health and financial reforms are inevitable for a sustainable health system and economic development. New policies should as a matter of urgency, be formulated and the strategic intent clearly communicated to the public and implementers - to ensure support and ownership of the programme. Structural and systemic requirements should fit the financial, human resource and administrative capacities of the three tiers of government in Nigeria, bearing in mind its gross domestic product, level of economic development, educational environment, population dynamics and socio-cultural issues, as well as the political and technological environments. Reform planners should take a closer look at the context within which health systems operate to clarify and calm down potential detractors of such reform programmes. Nigerian government should make significant financial input to health care to ensure the potential outputs of the human capital and the overall wellness of the citizenry.

The most vulnerable groups should be given adequate financial protection especially the poor and the uninsured. The people for exemption should be addressed together with the problems of access to quality health care. Reform planners would liaise with the Ministry in charge of social welfare to keep track of the very poor who need health financing most.

Integrated financing and health reforms need time to function properly. Strategies that take into cognizance the structures, systems and appropriate capacity building should be implemented to achieve step-wise and sustainable quality of care that is cost effective. The reform programmes may initially encounter resistance, skeptics and 'inhospitable' cynics resulting in cyclical and more complex reforms and outcomes. At the threshold, some level of stability is achieved to allow the systems, strategies and structures to manifest as incremental and sustainable health care (see Fig. 1). Challenges could militate against success, with potential for programme failure if contextual and systemic signals are ignored. Monitoring and evaluation systems should be built into the programme for continuous assessment of the performance and possible revision of the scheme. Constraints or challenges are jointly discussed with the planners, implementers and the wider public. The feedback mechanism to the reform committee or ministries serves to strengthen the capacity of the programme. With commitment and well managed health financing, the integrated finance and health reforms programme could engender a sustainable health care in a pluralistic and complex Nigerian health system.

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