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Austerity and the challenges of health for all in Nigeria

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Abstract

The economic downturn experienced by Nigeria and many sub-Saharan African countries led to the adoption of austerity to restore the country's economy since the 1980s. Since austerity emphasizes privatization and commercialization, instead of restoration, it had, however, impacted especially the Nigerian health sector negatively. Nigeria has indeed continued to bear witness to some of the worst health and healthcare statistics in the world. Evidence from key health indicators in Nigeria also clearly shows that the country's health situation has experienced massive deterioration. Given the above, the paper argues that austerity constitutes a major impediment to the attainment of a good state of health as well as effective and viable healthcare delivery to all in Nigeria. The paper, therefore suggests: (1) reframing and recognizing health as a human right issue; (2) integration of indigenous medicine into the Nigerian national health delivery systems; (3) recognition of State investment in social services as quite necessary and important such that budget allocation to health is increased as ways forward.

Keywords: Austerity, Health and Healthcare

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1. Introduction

Agriculture was the mainstay of the Nigerian economy at independence. It provided gainful employment and satisfactory livelihood to over 90% of the country's population (NDHS, 2008). The country, at this period depended almost entirely on agricultural production for food and agro-industrial raw materials for foreign exchange earnings through commodity trade. However, with the discovery of oil in the 70s, the dominant role of agriculture began to give way to petroleum exports. This particularly translated to relative buoyant economy during the first two post-independence decades such that public spending in all sectors grew rapidly in the 60s and 70s. For instance, curative health expenditure rose by 2,850% from the N4.4million in the 70/74 fiscal year to 114million in 77/78. Expenditures in other related services, which enhanced health such as water supply, housing, education and sports, equally witnessed remarkable growth within the same period (Zwingina, 1992).

This state was, however, short-lived especially because the 80s ushered in an era of economic crisis. Indeed, the dramatic fall in oil export revenues resulting from the boycott of the Nigerian oil in the world market in 1978 led to economic recession and deterioration. By 1980s, Nigeria had entered an era of 'oil doom" and serious economic crisis. For instance, there was a dramatic fall in the country's revenue from a peak ofUS$10billion in 1979 to about US$5.161billion in 1982. The GDP also fell by 2% in 1982 and 4.4% in 1983. The consequences of these include declining growth, increasing unemployment, galloping inflation, poverty, worsening balance of payment conditions, heavy debt burden and increasing unsustainable fiscal deficits among others (Olukoshi, 1990).

To reverse the Nigeria worsening economic fortunes, the IMF-inspired austerity was adopted under the Economic Stabilization Act in 1982. The Act provided the blue print for the "tougher" austerity subsequently introduced through Structural Adjustment Programmes (SAP) in 1986. Although austerity is a set of economic reform measures designed to achieve economic recovery and growth, its adoption had particularly left both the state and the people worse off. It further threw millions of Nigerians into poverty while those already poor went below poverty line.

Evidences provided by UNDP (2000) and many other sources indicate that the incidence, depth and severity of poverty have been growing over the years. The Nigeria Office of Statistics and UNDP, for instance, show that in 1980, poverty level was 27.2%. By 1996, it had risen to 70.2%. Although, the level remained at 70.2% between 2000 -2003, some 87.5 million people were living below the poverty line of US$1 a day while 90.8% of the population or 112million people, lived on less than US$2 a day. Indeed, Nigeria was estimated to have the third largest population of the poor in the world during this period. The National policy on poverty eradication of the federal government of Nigeria also shows that while the depth and severity of poverty were 0.160 and 0.080 respectively in 1980, it increased to 0.358 and 0.207 in 1996. These had more than doubled in 2003. Also, Nigeria's per capital income of US$260 in 2000 is not only much less but just one-third of its level of US$780 in 1980 (World Bank, 2003; AFRODAD, 2005).

Moreover, since the introduction of austerity measure, unemployment and job security have equally been on the rise in Nigeria. As massive job losses occur in both the private and public sectors of the economy by

day, it is increasingly difficult to absorb hundreds of thousands of graduates from Nigerian tertiary institutions.

2. Theoretical context

This paper is anchored on a class of economic theories known as neoliberalism, which is a conservative policy aimed at enforcing stringent budget discipline on nations. The two major tenets of neoliberalism (www.wordiq.com/definition/neoliberalism) are:

- That close economic contact between the industrialized and the developing nations of the world is the best way to accelerate the transfer of technology which is germane in making poor economies rich. Hence, all barriers to international/globalised free trade should be eliminated as fast as possible.
- That governments in general lack the capacity to run large industrial and commercial enterprises. Thus, (except for key obligations such as those relating to income distribution, public-good/infrastructure, administration of justice and a few others), governments should hands off and privatise.

As a political-economic philosophy, neoliberalism had major implications for government policies beginning in the 70s and increasing in prominence since 1980s. It de-emphasizes or rejects positive government intervention in the economy. Rather, it focuses on achieving progress and even social justice by encouraging free market methods and less restricted operations of business and "development". The promoters of neoliberalism argue that the net gains for all under free trade and capitalism will outweigh the costs in all, or almost all cases (www.wordiq.com/definition/neoliberalism).

3. The problem

Nigeria has continuously adopted most of the internationally recognized health interventions to address the various problems of her health system and burden of diseases. These include eradication of small pox in 1970; expanded programme on immunization (EPI) in 1975; Primary Healthcare (PHC) in 1988; the Millenium Development Goals (MDGs) in 2001 and; Polio Eradication Initiative (PEI) in 2003 (HERFON, 2006). Nonetheless, the Nigerian health situation is far from desirable. Indeed, Nigeria had continued to bear witness to some of the worst health and healthcare statistics in the world. Evidence from key health indicators in the country clearly suggests that Nigeria's health situation have experienced massive deterioration. For instance, life expectancy at birth had remained low (HERFON, 2006, PRB, 2009). Mortality is high, with the majority of it due to infectious diseases and complications of pregnancy and child birth (HERFON, 2006; NDHS, 2008). Quite worrisome is the burden of a combination of new diseases and re-emerging old ones such as malaria, HIV/AIDS and Tuberculosis, which put the life of millions of Nigerians in serious jeopardy. There had also been significant shift in the types of predominant diseases from infectious ones to cardiovascular and degenerative diseases and cancer which currently accounts for a significant proportion of all deaths in the country. With respect to the Nigerian Health situation, therefore, the World

Health Organisation (WHO) ranked the Nigerian health system as 187th of the 191 countries evaluated in 2000. Besides, Nigeria is not only lagging behind in all Millenium Development Goals (MDGs), it is also close to the bottom of virtually every development index (HERFON, 2006; Hadi, 2007).

Since health is a state of complete, physical, mental and social well being of an individual (WHO, 1981), it is quite important in the development of every society. The importance of health as a developmental issue is better understood in terms of the components of good health which include freedom from pain, discomfort, boredom and stress; absence of illness, infirmity and diseases; balanced nutrition; qualitative and quantitative housing; water supply; good working and living conditions; education that is concerned with environmental issues and the aim of elongating a healthy or good life expectancy (ROAPE, 1986). However, the health profile of any nation depends among others on her internal social dynamics, the political choices it has made as well as her relations with the world economic system (ROAPE, 1986). Health is therefore a multidimensional matter related to economic, political and social issues in any society. It is within this context that this paper situates the health question and austerity in Nigeria. This is with a view to providing an approach for understanding why the attainment of "Health for All" had been and may remain a tall dream despite variety of relevant initiatives, strategies, and processes.

4. Austerity and the consequences for the attainment of "health for all"

A National Health Policy targeted at achieving Health for all Nigerians was promulgated in 1988. Its objective was to provide the population with access to Primary Health Care (PHC) as well as to secondary and tertiary care through a functional referral system. The policy regards PHC as the key to attaining the goal of health for all the people in Nigeria. Essentially, PHC services include health education, adequate nutrition, safe water and sanitation, reproductive health, including family planning, immunization against 5 major diseases, provision of essential drugs and disease control. Government efforts at implementing the policy provided the foundation for and shaped subsequent initiatives such as the National Health plans, the outcomes of the National vision Committee, the Health Sector Development Framework and Reform Initiative, including the efforts made at pursuing the MDGs (FGN, 1997; FMOH, 2004b; FRN, 2004). There was a comprehensive review of the 1988 policy into a new policy tagged the Revised National Health Policy, launched in 2004. The overall objective of the policy is to strengthen the national health system in order to provide effective, efficient, quality, accessible and affordable health services that will improve the health status of Nigerians and facilitate the achievement of the health-related MDGs (FRN, 2004). The revised policy also regards PHC as the framework to achieve improved health for all in Nigeria.

In spite of the laudable health objectives contained in the policies and initiatives, the performance of Nigeria on essential health indicators and PHC services, which is adjudged the key to the attainment of the "health for all" policy objectives had not been satisfactory. According to 2004 Human Development Report for Nigeria, life expectancy at birth fell from 53 years in 1990 to 50years in 2003 and 47 years by 2008 and this would probably continue to decline given the great impact of HIV/AIDS (Nigeria 2004, PRB, 2008) and other diseases such as malaria, and tuberculosis among others. Nigeria also remains one of the few countries with little improvement in both maternal and child health. International comparative data show that

Nigeria's immunization coverage rates are among the worst in the world (UNICEF, 2001). Available statistics also indicate that Nigeria has some of the worst indicators of maternal health in the developing world. For instance, 62% of births in Nigeria occur at home. Only 39% of births were assisted by a skilled health worker and 56% of women would not receive any postnatal care (NDHS, 2008). An estimated 50,000 Nigerian women die each year from complications associated with pregnancy and child birth, thus accounting for 10% of global estimates of maternal deaths. Twenty percent (20%) of global estimates of abortion-related deaths and 40% of obstetric fistulas occur in Nigeria (HERFON, 2006). Moreover, Data from 1990, 1999, 2003 and 2008 National demographic and Health surveys show that the proportion of the population collecting water from improved sources declined from 52% in 1990 to 38% in 1999 rose to 58% in 2003 but declined to 56% in 2008 with 73% of the population using non-improved toilet facilities that same year.

Reasons for the appalling situation of health in Nigeria (as shown above) can be located in the adoption of Austerity. Since the consequences of the policy are poverty, unemployment and more importantly withdrawal of subsidies, it had exacerbated health and healthcare delivery in Nigeria. Poverty, for instance, has its ramifying consequences for health. It indeed has multiplier effects on almost all aspects of living and these can impact on health. It does not only mean unequal access to health facilities, it is also a cause of ill health and impacts on treatment and the severity of the effect of illness on the victim. Generally, poor people are less likely to be able to afford the cost of treatment for most diseases and when the illness becomes protracted, and treatment becomes costly, the poor are likely to resign to fate and death. Since poverty is often a convergence of the absence of many factors and conditions required to maintain life at an appropriate level, it usually exposes poor people to diseases that hardly affect the rich. Hence, ill-health and mortality arising from malaria, tuberculosis, which had remained high in Nigeria, (HERFON, 2006) would probably be more prevalent among the poor than the rich. HIV/AIDS also has a higher prevalence among the poor than the rich (Ogundana, 1995).

A major corollary of poverty in Nigeria is high incidence of nutritional disorders. The nutritional status of the average Nigerian had remained precarious as the country consistently record deficit per capita calorie intake. Among children 0–5 years of age, 29% are underweight, nearly 3 million of them are suffering from chronic malnutrition and more than I million from stunting (UNICEF, 2009 cited in Ogunmola and Badmus n.d.). Malnutrition in the country is due partly to a high cost of living due to price increase and a high rate of food insecurity which had remained a nagging experience.

Unemployment, on the other hand, does not only intensify poverty, it also creates further health risks. Studies have also confirmed its implications for access to healthcare. (NDHS, 2003) Unemployment affects not only access to health but also the health status of individuals. It had been established, for example, that while job security increases health, wellbeing and job satisfaction, higher rates of unemployment cause more illness and premature death. Indeed, unemployment leads to both psychological and physical ill-health. It creates morale problems; increases the incidence of depression and hypertension and the propensity for suicide and early death among those affected. Unemployed people are also more likely to be unable to meet the needs of healthful living such as proper nutrition and good housing. Since massive retrenchment always means fewer employees to perform an even higher volume of work, the attendant increase in the demands and pace of work leads to higher levels of stress for the surviving workers who are often less secured on the

job. As WHO report indicates, job insecurity has been shown to affect mental health, self-reported ill-health, heart disease, and risk factor for health disease (Wilkinson and Marmot, 2003). Given the foregoing and the fact that both the employed and the unemployed suffer especially poor mental health, these factors may be accounting for the rising incidence of hypertension-induced deaths in Nigeria.

A major effect of austerity on the Nigerian health sector had been cuts in its funding. Essentially, the level of funding of healthcare in place directly affects the quality and coverage of health delivery and hence the overall status of health in a given society. The level of government expenditures in the Nigerian health sector over the years tells a story of neglect. Even the World Bank, which is the architect of austerity, in its Policy Document titled: Financing Services of Developing Countries: an Agenda of Reform in 1987 acknowledged that the problems of the sector include insufficient spending/allocation on effective health programmes among others (World Bank, 1989). In Nigeria, the average annual federal government expenditure on health is as shown in Table 1. The table shows a downward trend in the average annual federal government expenditures on health while Public expenditure on health had been less than $10 per capita compared to the minimum of $34 recommended internationally (see Table). Moreover, government spending on health recurrent and capital expenditures is a subject of worry. Between 1971 and 2004, the share of recurrent expenditures had been higher than capital (see Table). The implication of this is that expenditure is more for personnel costs with little for tools and materials and the provision of facilities in communities which have none. Besides, the distribution of existing health facilities is so inequitable such that there is concentration in urban areas, access to which is limited to about 35% of the Nigerian population. Thus, in some cases, even when one travels several kilometers to access healthcare, the possibility of getting quality service is not guaranteed because most health facilities especially at PHC level are poorly maintained. Indeed, the state of the Nigeria healthcare system is so poor to the extent that hospitals have turned into mere consulting clinics without drugs, water, electricity and functioning equipments. Perhaps most of these hospitals are not even qualified to be described as consulting clinics in that many consultants had migrated due to non-conducive working environment, and poor career prospects among others.

Statistics show that out of the 5,334 physicians from sub-Saharan Africa practicing in the United States of America, nearly 86% are from three countries namely Nigeria, South Africa and Ghana (Hagopian et al., 2004). A large proportion of these would be from Nigeria since one out of every five African is a Nigerian. Apart from USA, Nigerian doctors have migrated to destinations such as Britain, Canada, Saudi Arabia, South Africa, Namibia, Lesotho, Jamaica, and Trinidad and Tobago among others. The effect of this has especially been inadequate supply of physicians to meet the healthcare needs of the Nigerian population. There was an average of 27 physicians to 100,000 people between 1990 and 2004 (UNDP, 2005).

In recognition of the need to go round shortage of drugs in public hospitals, a scheme known as Drug Revolving Fund (DRF) was instituted about 1989. Under the scheme, large sums of money were made available to pharmacy units in public hospitals to purchase drugs to be sold to patients. Proceeds realized from such sales were ploughed back into further purchases of drugs. The scheme, therefore, essentially involves running public pharmacies as businesses (FMOH/WHO, 2005). Although DRF seems to be an ingenious strategy for addressing shortages in hospitals, it had however, failed in this regard. The scheme is plagued with “out of stock” syndrome. Erratic supplies and non-availability of some basic and essential and

specialized drugs and other health supplies are partly due to dependence on importation and currency devaluation. Since, the drugs are to be imported it must compete with other commodities for foreign exchange allocation. Partly for these, drug shortage is now compounded by the growing problem of fake, substandard and adulterated drugs, a situation which have led to the establishment of the National Agency for Food, Drug Administration and control (NAFDAC). Poor drug supply system has also led to drug resistance. The resistance to antimalaria drugs is a clear example. Perhaps more seriously, the commercialization of the DRF scheme has meant outright exclusion for those without the economic ability to pay. Hence, treatment for both out- and in-patients now requires payment before service and this many a-times result to denial of treatment sometimes with fatal consequences.

Table 1. Average annual federal government expenditures on health

	1971	1981	1991	2001	2002	2003	2004
Total FGN health expenditures In Current Price (Nm)	417.2	302.1	503.6	1,046.20	1,290.00	659.7	757.5
Total FGN health expenditures In current prices (Nm)	118.2	337.9	6,955,6	44651.5	63,171.20	39,685.50	757.5
Share of recurrent (%)	50.8	64.2	66.4	59.4	80	83.8	65.3
Share of recurrent (%)	40	556.8	441.7	45.1	20	16.2	34.7
Expenditures on health as %GDP	0.4	0.4	0.3	0.8	1	0.6	0.7
Recurrent expenditure as % total FGN health expenditure (%)	50.8	64.2	66.4	54.9	80	83.8	65.3
Total FGN health expenditure in USD (m)	196.2	219.5	124.8	400.4	524.4	311.9	411.9
Total FGN health expenditures per capital in US	3	2.9	1.2	3.4	4.3	2.5	3.2

From independence, health service was recognized as a welfare programme. However, user fees were introduced with the adoption of austerity, in spite of the endemic nature of poverty in the country, to cover the cost of drugs and healthcare services. The charging of user fees, which are periodically revised to reflect market prices, particularly led to direct competition between the cost of medical treatment and other

personal and family costs. Since the majority of health seekers at government hospitals are low income earners, the facilities were consequently deserted. This encouraged the proliferation of private hospitals and clinics, most of which does not only charge exorbitant prices but render substandard services. When clients can not afford the cost of treatment in these facilities, they would either resort to the use of herbs, self medication, healing churches and spiritual homes or simply resign to fate by adopting the strategy of 'waiting to die". Although attempts were made to regulate the proliferation of private hospitals by closing down illegal and substandard ones, this had been largely unsuccessful. Most of those that were closed down by the government later re-opened while some resume operations underground. This particularly portends great danger to the attainment of quality healthcare by the Nigerian population.

Moreover, the recognition that health systems are not just to improve people's health but to protect them against the financial cost of illness informed the government about the need to alleviate the burden of user fees (i.e. out- of –pocket payment for health) by introducing prepayment schemes such as the National Health Insurance Scheme (NHIS). Even though the package is identified as a tool for achieving health-related MDGs and thus guarantees good healthcare to the insured, the coverage had been low. It currently enrolls only workers in the formal sector and there is a limit to the number of household members that an enrollee can insure under the programme.

Given, the foregoing, it is obvious that the adoption and implementation of the IMF/World Bank prescribed austerity programme had continued to have negative impacts on the Nigerian Health Sector. It is even more so because all the major reform measures being adopted to at least reduce the problems of the sector are seemingly ineffective reason being that the measures are World Bank/donor driven. For instance, the evolution of the 1988 National Health Policy was indirectly initiated by the World Bank and its implementation had been in collaboration with external funding agencies such as the World Bank, USAID, and UNFPA among others. The formulation of the policy was in fact a condition by the World Bank for approving direct lending to health. True to it, the Federal Government of Nigeria had been enjoying the largesse of loan taking from the World Bank since the formulation of the policy. In 1989, for instance, a World Bank Loan of $60million was taken to set up a National Drug System. In 1991, a loan agreement of $78.6million from the World Bank was signed to fund population Activities such as family planning and child health, establishment of tertiary reproductive centers, health education and other related population activities in Nigeria (CBN, 1991). Also the World Bank and other international agencies had continued to provide active collaboration, technical and financial support on special programmes towards reducing the burden of diseases, water and sanitation among others. Indeed, the health sector's share of the total external assistance to Nigeria has continued to rise. It increased from 4.0% in 1994 to 21.7% in 1999, declined sharply to 3.0% in 1998 but rose to 19.8% in 1999 (HERFON, 2006).

As beneficial as the collaborations, technical and financial support from the international donor agencies seem, it could be more devastating to the Nigerian health sector. Given that austerity has become a global problem and that many of the parent nations of the donor agencies are also affected, the question then is how sustainable are their collaborations, technical and financial support? More importantly is the fact that most of the health reform and related initiatives and programmes are hinged majorly on World Bank loans. Is this not a bait to further plunge Nigeria into debt trap? Considering the fact that Nigeria is a country that is

already plagued with huge external debt and the servicing of the debt had been taking great toll on her expenditure, will the debt service burden not become more highly unbearable?.

5. Conclusion

Austerity had devastating effects on the economy and society of Nigeria. The healthcare system is not spared in this regard. Austerity ensured not only the withdrawal of government spending on the sector, but also its commercialization. These two measures as well as the high inflation that accompanied especially the SAP-induced austerity created problems of inadequate and inaccessible health services, decaying infrastructure, obsolete equipments and chronic drug shortage among others. To redress these and make health and health services accessible for all, user fees payment was introduced as a general principle. This, however, further made access to health services unaffordable, especially to the poor whose number increases by day due to the effect of austerity. Although the share of the health sector out of the external assistance to Nigeria had continued to increase, it may however become worse off eventually since most of the external assistance are loans. Given the foregoing, it can be concluded that the attainment of "health for all" in Nigeria may remain a mirage after all.

6. The way forward

To revamp the Nigerian healthcare system will require a multifaceted approach which could include the following:

(1) Reframing and integrating health as a human right issue: The need to recognize the right to health is anchored on a 1948 UN Declaration of Human Rights which states that;

> *"Everyone has the right to a standard of living adequate for the health and wellbeing of himself and of his family, including … medical care… and the right to security in the event of … sickness, disability…" (Kinney, 2001).*

Also, the UN Committee on International Economic, Social and Cultural Rights in the outline of the content to the right to health observes that the right to Health extends,

> *"not only to timely and appropriate healthcare but also to the underlying determinants of health such as access to safe and potable water and adequate sanitation, and adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions and access to health-related education and information on sexual and reproductive health" (Kinney, 2001)*.

The recognition of health as a human right could shape the policies of the IMF and World Bank such that:

- There would be reinforced efforts to protect infrastructure and provide health care services in the country even while economic development policies associated with international loans and assistance are still being imposed.

- There could also be an end to the charging of user fees for the use of publicly funded clinics and healthcare services.

(2) Full integration of indigenous medicine into national health delivery systems: In this sense, both convectional and traditional medical practitioners should be able to render their services freely and legally in parallel. This should, however, be with clear understanding of each other and in close collaboration at all levels of the healthcare delivery system, thereby providing the chance for the patient to make an informed choice.

(3) The framework of unequal economic and political relations between Nigeria and the advanced capitalist countries must be addressed. Specifically, the neoliberal economic policies of Nigeria (privatization, deregulation, free trade, commercialization, massive retrenchment of employees in the public sector) which are dictated by the global unequal framework must be rejected in favour of policies that would advance the true interests of Nigerians, including their health interests. Thus, austerity, which is a product of the neoliberal ideology can not, therefore, answer the critical challenges posed by the Nigerian health sector and the people's health needs. Hence, investment by the state in social services such as education and health becomes quite necessary and important. In fact, the Nigerian government should increase the budgetary allocation to health and ensure that it meets the WHO acceptable minimum.

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