

Medical Practice in the Face of Economic Meltdown: Peculiar Challenges in Nigeria and other Developing Countries

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Abstract

Background: The impact of the global economic meltdown on every sector of economic activity has been enormous, especially in the developing countries. Medical practice in these nations has been particularly challenged and stretched under this milieu. This paper thus sets out to evaluate the phenomenon of economic meltdown with its effects on the developing countries, the challenges it poses to medical practice, with Nigeria as a case study, and makes suggestions to address this scenario.

Method: A review of the literature on economic meltdown with particular emphasis on the effect on medical practice, was done, with focus on the developing countries, and specifically Nigeria. Literature search was conducted using the Medline, Google search engine, the media, as well as national and local journals.

Results: The definition and historical perspectives of global economic meltdown, as well as the geographical location of the developing countries, are set out. The peculiar economic challenges and those in the medical practice, with the concomitant glaring effects in the developing nations, with particular reference to the Nigerian situation, are outlined. Specific measures to adopt in addressing these challenges are suggested in this paper.

Conclusion: The peculiar challenges of the global economic meltdown on medical practice in the developing world, and in Nigeria particularly, must be addressed wholistically, involving every sector of the economy, with fundamental policy and structural changes put in place.

Keywords: Medical Practice, Economic Meltdown, Challenges, Developing countries.

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Economic Meltdown

The term 'meltdown' has been qualified with various synonyms, such as crisis, downturn, recession and depression. There has been a notable precedent of the

Global Economic meltdown, in the 1930's when there was the Great Depression globally¹.

Global economic meltdown means the sudden harsh economic conditions that have beset the world, globally, and affected individuals, organizations, nations, regional bodies and the entire world, as a global village. It entails various ramifications from reduced wages, reduced purchasing power (inflation), job losses to mortgage loss. It also involves declined productivity, bankruptcy, closures for companies, plummeting of gross national income per capita and decreased volume and activity of world trade².

The Developing Countries Peculiarities

The developing countries are mostly countries located between latitudes 23°N and 23°S. They are also referred to as the Global South or Third World countries (with the exception of the emerging economies of South America and Asia). Though signs of impending economic meltdown had started showing as early as the 1990's globally, they snowballed into a clear crisis by the last quarter of 2008^{1,2}.

Peculiar economic challenges

For the developing countries, most of these economic challenges had become apparent from the 1970s. Between 1990 - 2002 the gross national income per capita grew at annual average of 0.5%, and 0.02% particularly for Sub-Saharan Africa³. These nations had become faced with declining agricultural output, foreign debt burden, unemployment, poorly performing industries as well as fratricidal wars that ate deep into their economies. They were also riddled with environmental insecurity and political instability with coups, and the locust years (from the 1970's) of the jackboot military dictatorships; not to mention the emergence of HIV/AIDS scourge and deteriorating health care systems⁴.

Peculiar challenges in medical practice

The traditional values at the heart of most healthcare systems, such as **universality**- services available to all;

comprehensiveness full range of services available; and **accessibility** availability at the time of need⁵, had begun to be challenged in the last 2 decades. There was decline in these indices of standard healthcare due to reasons that included harsh economic climate, lack of maintenance culture, brain drain of well trained health workers, lack of quality services, low workers' motivation and poor quality of care⁶.

All key health indicators were at much worse levels than those in any other of the world's regions, in these developing countries. In the health sector, there had been little or no substantive progress since 1990⁷. The World Bank Group had predicted that at such rates of progress, the developing countries, especially Sub-Saharan Africa, would not achieve any of the Millennium Development Goals⁸.

At the heart of the poor state of health in these developing countries lies a failure to tackle extreme poverty. Currently, about 46 50% of their populations live on less than \$1 a day, a greater proportion than 15 years ago⁸. The failure to tackle poverty stems from inter-related factors of economic stagnation and debt crisis. The International Monetary Fund and World Bank support for these countries with crippling debt has been hinged on painful structural adjustment programmes - requiring these countries to put strict ceiling on government spending in the social sectors (health and education inclusive) and to limit public sector recruitment⁹.

THE NIGERIAN SCENARIO

Organized medical practice in the beginning

Medical practice in Nigeria has come a long way, from January 12, 1951, when British Medical Association (BMA) branch in Nigeria was formed, with late Prof Ajose as President and Dr. Brian Jones (and later, in December 1951, Dr. Majekodunmi) as Honorary Secretary. At the annual general meeting of 1960, the BMA branch matured into the Nigerian Medical (NMA)¹⁰. As at now, the NMA, as the umbrella association for other affiliate bodies, such as NARD, MDCAN, AGMPN and GMD, has 35,000 doctors nationwide¹¹. Thus 1 in every 6 or 7 doctors in Africa is a Nigerian.

Age-long welfare, systemic structural and infrastructural challenges

The challenges of the medical practice in Nigeria have dated as far back as the 1950's even predating the economic meltdown. The doctors had only been consulted by government and involved in health policy

formulation in ad-hoc manner and not on 'as of right' basis. Between the medical practitioners and government, words were traded of mutual suspicion of motives and proposals. There was persistent agitation for reorganization of the health service, addressing the shortage of medical manpower and increased resource allocation to the health sector^{10,11}.

Up to the era of economic meltdown

The challenges confronting medical practice in the Nigerian landscape rather than abating, seemed to multiply as the country advanced through the years until the dawn of the global economic meltdown in the horizon. For instance, inadequate healthcare delivery infrastructure, with dearth of working tools and diagnostic facilities, became more glaring. There was not only professional hazard among the healthcare team, but also added the political dimension, with scores of medical personnel forcefully disengaged from service at a point in time. Meanwhile the research base remained grossly under funded¹².

Added to this panorama was the infinitesimal level of training support and medical capacity building short term sabbaticals, one-year abroad programmes, exchange programmes, attendance at national and international workshops and seminars, had either been scrapped or reduced to the barest minimum¹³. Token attention was paid to intellectual capacity and professional training institutions, with residency training programmes, ICT and e-library as well as networking, glibly addressed.

The medical schools in the country that form the pool for providing the manpower base for health practice, about 34 of them now, are particularly in dire straits. Their funding is poor and their infrastructural and curricular scope, are far from desired, with many of them fledgling. The socioeconomic milieu for optimal performance and motivation of the healthcare personnel, as with many other significant players in the economy, has been worsened in the meltdown. Basic non-financial incentives and public utilities are lacking, from the little 'mercies' that had hitherto existed. Pipe borne water, regular power supply, stable telecommunication network, reasonable security of life and property (with the kidnapping saga in the South and flares of religious motivated crises and killings in the Northern part of the country) are increasingly becoming tall dreams.

In actual fact the poverty level in the country has been said to have increased from less than 40% in the 1960's

to more than 70% now. The argument for the elongation of the service tenure and improvement of the retirement social security system for medical practitioners to make for greater dedication to duty, as obtains with other cadres of professionals, is still raging¹⁴.

The brain drain phenomenon has continued unabated and has even been worsened now by the economic downturn. More than 30,000 Nigerian doctors have gone into the diaspora, and more than 780 nurses have emigrated within a period of 2 years. With the economic crisis, many more have literally been travelling in droves to foreign lands, who should have formed a vital segment of the population required for national development. The cost of training each of these highly qualified medical personnel has been put at between \$12,000 to \$184,000¹⁵.

The Nigerian health practitioners motivational factors

In a study¹⁶, carried out in one of the nation's first generation/foremost regional teaching hospitals, a survey of 149 doctors (39%) and 132 nurses (34%) of the 384 health professionals respondents was done. They were asked to rank perceived indices/factors for improved industrial harmony and patient care delivery in the hospital. It was borne out from the study that the first five ranked factors were: improved facilities; periodic interactive session with management; efforts at improving work attitude; periodic seminars and code of conduct/improved discipline.

Interestingly in this study, increased wages, as motivational factor, was ranked only in the sixth position. These five ranked motivational factors were all actualization (intrinsic) factors that provide a sense of long term satisfaction as in Herzberg's theory of motivation¹⁷; and self actualization or self-fulfilment factors as in Maslow's theory¹⁸. This compares favourably with studies in other parts of the world and demonstrates that the Nigerian health practitioner is driven by the universal motivational factors that profit the system more, rather than merely base instinct of increased salary (as often erroneously touted), even in a depressed economy.

Cost of medical care in this economic downturn

The peculiar challenge of the economic meltdown to medical practice can be graphically portrayed by the cost of managing a patient with a common cardiovascular ailment hypertension on admission in any of our tertiary health institutions. This is as shown in table 1 hereunder:

Table I: Cost Of Medical Care In A Nigerian Tertiary Hospital

PARTICULAR HEALTH NEED ACTION	COST (₦)
He pays consultation fee to get a folder	1,000
He pays for necessary investigations, such as FBC, ESR ₦300; Urinalysis ₦150; ECG ₦3,000; Chest X-ray ₦1,000; Lipid profile ₦1,250; S/E/U/Cr ₦1,500; 2D Echo ₦10,000	17,200
He pays admission fee, with nursing, feeding, bed and other charges, for _ 2/52	30,000
He pays for his medications, with some of the antihypertensives costing > ₦100 / tablet	5,000
Total	53,200

This patient has to pay out of his pocket, with an average monthly income of N20 25,000 only, since he is not part of about 10% of the population covered by the National Health Insurance Scheme. It is without gainsaying that he will not only need to borrow to meet up with this exigent need, he will likely not show up for his post-discharge check-up, neither will he remain compliant with his medications, if he has to face the current economic realities. This is quite a frustrating experience in medical practice.

Cost of Residency Training

The residency training is a necessary tutelage that every consultant will need to undergo in order to specialize in a discipline of medical practice, to be able to offer the much needed expertise in managing challenging health conditions in our environment, especially in the economic downturn. The demands of residency training include buying volumes of books, necessary instruments, tons of photocopied materials and laptop. In our socio-economic milieu he will also face the challenge of acquiring a generating set to serve as substantive power supply source (in place of PHCN) and owning a vehicle as a necessity for easy mobility. Yet in each examination season, the average resident's budget, as shown from a study in 2004¹⁹, ranged around N100,000 to N110,000 then. This comprises of the details as shown in Table II below.

Table II: Estimated Resident Doctor's Budget In An Exam Period

ACTIVITY DESCRIPTION	ESTIMATED COST (₦)
Exam application form and fee	15 20,000
Revision/update course fee	20 25,000
Accommodation, transport, feeding, photocopying, lecture handouts during a 2/52 period	25 30,000
Accommodation, feeding, transport during a 1/52 period of exam	20 30,000
Total	80 105,000

The resident doctor may need to make this pilgrimage 2 to 4 times in a year (for the National and West African Postgraduate Medical Colleges, respectively). The cost now, obviously in a more depressed economy, has definitely appreciated to the neighbourhood of more than N150,000 for each of about four exam schedules in a year! And this is exclusive of the different stages of

dissertation work, from proposal to bound copy; as well as the compulsory management course requirement for Part II Fellowship Examination. Meeting the multifaceted needs of the dependants both nuclear and extended families, as well as others in the community of course, remains an essential part of his responsibility, the foregoing notwithstanding.

Addressing These Challenges

Developing countries, such as Nigeria, face the daunting challenge of improving the performance of their healthcare systems, upgrading their health services to a level that will enable them to deliver services that are effective, efficient and equitable. A number of measures will be imperative in charting the way forward in the current precarious economic quagmire.

1. Stewardship: The World Health Report for 2000²⁰ identifies stewardship as an essential function of the health system. Stewardship assures that goals of equity, efficiency and improvement in health outcomes are achieved. The key dimensions of stewardship in the health sector, include, among others, establishing the best and fairest health system possible; defining consistent health vision and maintaining direction of health policy. This will need to be taken seriously in the developing countries.

2. Poverty Alleviation: There is imperative need for renewed focus on the determinants of poor health indices in these developing countries. This will embrace actions taken to tackle the root cause of poverty at both the global and local levels⁹. Some of these refocused actions include good governance for prudent management of resources, fighting corruption as an institutionalized policy and mounting socioeconomic conditions that allow for development. There is a definite need to institute health insurance (subsidised) policies across the board for all citizens, and not selectively, as is currently the case in a number of these countries.

3. Investment In Basic Health Care: Because of the important role in improving the quality of life and economic development in these countries, there is the acute need to critically and deliberately invest in basic healthcare, touching base with grassroot population. To be meaningful and effective this must be combined with investment in education. The 25% sectoral allocation for education in the budget stipulated by UNESCO has mainly been observed in the breach, with the Nigerian budget this year, for instance, allocating a paltry 2.3% to the educational sector.

There must also be a concomitant increased divestment from huge spendings on defence and conflicts, to the health sector. African governments committed themselves

to allocating at least 15% of national budgets to the public health sector, in the Abuja declaration of 2001²¹. Till date, no country has achieved this goal the Nigerian national budget for the health sector in the year 2009, merely averaged 2% of the total budget.

4. Improved Capacity Of The Health Workers: Implementing effective health intervention requires adequate technical capacity. Approaches to developing capacity, such as health systems research²², including policy makers and practitioners, continuing education to update knowledge, short hands-on-training courses and exchange programmes need to be instituted. Considerable funding of local research and academic institutions, including the teaching/specialist hospitals, to enable them give this commitment, is required.

5. Increase In Number Of Health Workers With Improved Function/Motivation: Retention policies for health workers, including financial incentives (appropriate salary and allowances) and non-financial incentives such as accelerated training, support to conferences, and supervision, need to be pursued. Effective mechanisms to limit or compensate for emigration of health workers need to be in place, for instance, technology and skill transfer. Attracting back nationals who are in/have specialized overseas (brain-gain, the Ireland experience²³), is a very necessary step.

6. Designated Regional Centres Of Excellence: Establishment of state of the art medical institutions in different regions with the capacity for diagnostic equipment utilization and maintenance is vital, to optimise resources. These can also serve as centres for rotational postings, short courses, hands-on-training sessions for skill acquisition. They will also engender experience building and provide refresher schedules for practising doctors in both government and private employ, as well as residents in training.

7. Decentralization Of Colleges/Examination Centres: The National Postgraduate Medical College of Nigeria and the West African College are the necessary providers of specialised manpower in the medical practice, more especially in the current global meltdown in Nigeria. There is the need to greatly reduce the financial burden of training and numerous travels as well as mitigate the hazards on the roads on "pilgrimages" to the hitherto "Mecca and Jerusalem" (Ibadan and Lagos, respectively) of professional examination centres. As well a substantial boost in psychological state of mind will be achieved, if the examination centres/institutions for instance in Nigeria, are decentralised, without necessarily compromising standards.

This arrangement is already obtaining with the Primary Fellowship Examination of the National Postgraduate Medical College. There are precedents in the Royal Colleges of London, Edinburgh and Glasgow. This

measure will, in no small measure, ensure a steady and confident pool of specialised and needed manpower to maintain standards of medical practice and good health care in this auspicious period of global economic downturn.

References

1. Swiss Think Tank KOF Index. <http://www.globalisation-index.org>. Accessed 21 June, 2009.1
2. Quest R. World Business Today: Road to Recovery. Cable News Network. <http://www.cnn.com/worldbusiness>. Accessed 21 June 2009.
3. World Bank. African development indicators 2004. Washington, DC. World Bank, 2004.
4. Sachs J. The end of poverty: economic possibilities for our time. New York. Penguin Press. 2005.
5. Spurgeon P. Health management. In Warner M(ed.). International Encyclopaedia of Business and Management. London. Routledge. 1996; 1750-1758.
6. Ali ME. Study of patient satisfaction as an evaluation parameter for utilization of primary health care services. *Journ Roy Soc.* 1992; 112 (2): 64-67.
7. Sanders D, Dovlo D, Meeus W, Lehman U. Public health in Africa. In Beaglehole R (ed). *Global public health: a new era.* Oxford. Oxford University press. 2003: 135-155.1.
8. World Bank Group. Millenium Development Goals. <http://ddp-ext.worldbank.org/ext/MDG/home.do>. Accessed 23 June 2009.
9. Sanders DM, Todd C, Chopra M. Confronting Africa's health crisis: more of the same will not be enough. *BMJ. WestAfrica Edition.* 2005; 8(4): 208-212.1.
10. Nigerian Medical Association. NMA origin. <http://nigeriannma.org/origin.htm>. Accessed 22 June 2009.
11. Nigerian Medical Association About NMA. <http://nigeirannma.org/aboutus.htm>. Accessed 22 June, 2009.
12. Uzokwe A. As Nigeria turns 41, a time for deep reflections. *October 2001*. <http://nigeriaworld.com/columnist/uzokwe/100101.html>. Accessed 23 June, 2009.
13. Ana J. Caring for older people: launching the Nigerian edition of the BMJ: implications for Nigeria's health care. *BMJ* 1996; 313: 105-106.
14. Health, Basic and Applied Sciences. Conference on Bridging the Digital and Scientific Divides forging Partnerships with the Nigerian Diaspora. Abuja. July 25-27, 2005. <http://www.utexas.edu/conferences/africa/ads/1017.html>. Accessed 23 June, 2009.
15. Ssemakula JK. The brain drain in Africa. *Africafest 2002.* Pennsylvania. [Medilinkz.org/features/articles/braindain.htm](http://medilinkz.org/features/articles/braindain.htm). Accessed 23 June, 2009.
16. Ike SO. Motivating factors for improving industrial harmony among Nigerian health professionals. *Journ of Med Sci and Hosp Mgt.* 2007; 1(1): 32-36.
17. Herzberg F, Mausner B, Synderman B. *The motivation to work.* New York. John Wiley and Sons. 1959: 1-100.
18. Maslow AH. *Theory of human motivation.* *Psych Rev.* 1942; 50: 370-396.
19. Ike SO. Problems of postgraduate medical training in Nigeria. *Nig J Med.* 2004; 14 (4): 412-418.
20. World Health Organization. *Health systems: improving performance.* Geneva. WHO. 2000.
21. World Health Organization. *World Health Report 2005.* NHA annexes. www.who.int/nha/country/whrannex/en/ Accessed 23 June, 2009.
22. *Joint learning initiative. Human resources for health: overcoming the crisis.* Boston. Harvard University press. 2005.
23. Ike SO. The health workforce crisis: the brain drain scourge. *Nig J Med.* 2007; 16 (3): 204-211.