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The Place of Healthcare Service in National Development Plan: An Assessment of its Impact on Nigeria's Health and Economic Development

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Abstract

The need for planning is underscored by the fact that resources are scarce and human needs are insatiable. Health has been regarded all over the world as a treasure, and it is believed that investing in health produces positive outcomes in human capital that have long term impact on economic development of every nation. Disease and illness usually disrupt the production process and by implication, the production capacity is always greatly affected by the poor condition of health. In Nigeria, the need to effectively manage the scarce resources to meet the healthcare needs of the citizens has resulted in several development plans over the years. However, although attention was given to healthcare services in the plans, shreds of evidence indicate that Nigerians continue to live in a poor condition of health that negates the country's economic development. Therefore, in this paper, qualitative content analysis of the existing literature is utilized to analyze the place of healthcare services in Nigeria's development plans. The paper also assesses the extent to which the plans impacted on the public health in Nigeria and the country's economic development as well.

Keywords*: Development Plan, Healthcare Service and Economic Development*

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Background to the Study

Generally, it is observed that development plans have been instrumental in the diagnosis and remedy for development. Successive Nigerian governments accepted development plans as strategies to address development challenges in the country (Iheanacho, 2014: 49). Health on the other hand, is important because it is an intrinsic element of human welfare. As a component of human capital, health is also a key factor in the creation of wealth. It is believed that the development of any nation depends on the sound health of its people and without which, the material production of every society is impossible (Arewa House Archives Kaduna/SNP/19/23/A.396). As an intrinsic element of well-being, health is a good summary indicator of human development. Health development is a process of sustained improvements in health status, should thus be an important target of development policy (Mwabu, 1998: 1). The only means through which diseases and illnesses are controlled to preserve health is the provision of adequate, effective and accessible healthcare services. In Nigeria, provisions of healthcare services are usually made in development plans. The country has gone through four development plans since its independence as well as the fifth one that did not materialize.

Objective of the Study

The main aim of this paper is to assess the provision of healthcare services under the plans concerning economic development in Nigeria.

Methodology

In this study, qualitative content analysis is utilized to analyse both primary and secondary sources on theoretical issues in the linkages between health and economic development, Nigeria's development plans and the provision of healthcare services as well as the state of Nigeria's public healthcare system and economic development. The primary sources include archival materials that are deposited in Arewa House Archives Kaduna (AHAK) and National Archives Kaduna (NAK). The data contained in the materials was perused, analysed and interpreted. Secondary sources such as textbooks, journal articles, seminar papers, theses and dissertations that raise some issues on the subject matter were consulted and utilized.

Health and Economic Development: A Theoretical Framework

This section presents the theoretical framework that should guide the submission of this paper. In other words, the section is a highlight of different possible channels through which health can impact the economy. The close connection between health and wealth was emphasized by Pritchett and summers that explored a causal relationship between the two phenomena and had concluded that wealthier nations are healthier nations. According to them, wealthier nations are in a stronger position to provide better health to the population. Better health in turn, increases labour productivity, thereby enhancing wealth (Pritchett and Summers, 1996).

The major contribution to our understanding of health as an integral part of human capital was provided by Grossman (1972), who was the first to construct a model of the demand

for health applying the human capital theory. He distinguishes between health as consumption good and health as a capital good. As consumption good, health enters directly into the utility function of the individual, as people enjoy being healthy. As a capital good, health reduces the number of days spent ill and therefore increases the number of days available for market activities. Thus, the production of health affects an individual's utility not only because of the pleasure of feeling in good health but also because it increases the number of healthy days available for work and income. Health is not only demanded but also produced by the individual. Individuals inherit an initial stock of health that depreciates with time, but they can invest to maintain and increase this stock. Many inputs contribute to the production of health. Healthcare service is one of these factors (Grossman, 1972). Specifically, the following are the channels through which health is believed to influence the economy:

Channels of Influence between Health and the Economy

The need to understand the link between health and economic development in low-income countries like Nigeria is yet to receive adequate attention from scholars. Since human capital matters for economic outcomes and since health is an important component of human capital, health also matters for economic outcomes. At the same time, economic outcomes matter for health. Health is determined by genetics, economic, social, cultural and environmental factors. These determinants of health condition can be influenced positively by development plans. But the health of a population may also, in return, influence the economic context. Thus, health could contribute to economic outcomes; at both the individual and the country level through four channels: high productivity, high labour supply, and high skills resulting from education and training, as well as more savings available for investment (Bloom, Canning, and Sevilla, 2001).

Productivity

Healthier individuals could reasonably be expected to produce more per hour worked. In other words, productivity could increase directly due to enhanced physical and mental activity. This is because; more physically and mentally active individuals could make better and more efficient use of technology, machinery or equipment (Suhrcke, Mckee, Stuckler, Sauto, Tsolova, and Mortensen, 2005: 22).

Labour Supply

Good health reduces the number of days an individual spends sick, which consequently increases the number of healthy days available for work. But health also influences the decision to supply labour through its impact on wages, preferences and expected life horizon. The effect of health on labour supply through each of these factors is not always obvious. If wages are linked to productivity, and healthier workers are more productive, health improvements are expected to increase wages and thus the incentives to increase labour supply. How health affects individual preferences also affects whether and how health determines economic outcomes. One can imagine that, as health improves, working becomes less cumbersome, and therefore the individual might be ready to take up more work in exchange for leisure time. However, one can also imagine that a health

improvement reduces the needs for the consumption of medical treatments, and therefore reduces the relative preference for work, leading to a reduction of working time and an increase in leisure time. Finally, if good health changes neither preferences nor wages, but raises life expectancy, the individual's needs for lifetime consumption would increase, leading to a higher labour supply (Suhrcke, Mckee, Stuckler, Sauto, Tsolova, and Mortensen, 2005: 22).

Education and Training (Skills)

According to human capital theory, more educated individuals are more productive and obtain higher earnings. Since healthy children tend to achieve higher educational attainments and suffer less from school absenteeism, improved health at early ages indirectly contributes to future productivity. Moreover, if good health is linked to higher life expectancy, healthier individuals would have higher incentives to invest in education and training, as the depreciation rate of the skills acquired would be lower (Suhrcke *et al*, 2005: 22). Not just that, but education inculcates health behaviour. Educated individuals tend to have better health and well-being. Education is,thereforean important mechanism for enhancing the health of individuals; it reduces the cost of healthcare at individual and aggregate levels and also helps save earnings (Feinstein, Sabates, Anderson, Haindo, and Hammond 2006: 173).

Savings and Investment

The state of health of an individual or a population is likely to impact not only upon the level of income but also the distribution of this income between savings and consumption and the willingness to undertake investment. Healthy individuals are likely to have a wider time horizon and their savings ratio may consequently be higher than the savings ratio of individuals in poor health (Suhrcke, Mckee, Stuckler, Sauto, Tsolova, and Mortensen, 2005: 22).

The Place of Healthcare in Nigeria's National Development Plans

Nigeria's planning experience began with the Ten-Year Plan of Development and Welfare for Nigeria, introduced in 1946 by the Colonial Government (1945-1956). The ulterior motive of the Plan was to meet the perceived needs of the Colonial Government rather than any conscious attempt to influence the overall performance of the Nigerian economy. Health-wise, the primary interest of the Colonial Government was to preserve the health of the colonial officers and the colonized to sustain exploitation. Consequently, the Government decided to develop healthcare services with an emphasis on rural areas in the following ways. Firstly, directing and encouraging local authorities to develop the existing medical institutions to standard; secondly, giving capital and recurrent grants to the local authorities for the construction, renovation and maintenance of new institutions; and thirdly, through direct involvement by constructing and maintaining some medical institutions. The plan paid no attention to the socio-economic root causes of poor health in the country (NAK/SOKPROF/1210).

With regards to the British colonial motive behind the provision of healthcare services in the Plan, the views of several medical historians guide the direction of this paper. In their submissions, they advanced that colonial healthcare services served the ambitions of colonial masters rather than the interest of the colonized (Bivins, 2012; Davidovitch and Greenberg, 2007; Marks, 1997; Anderson, 1998; Arnold, 1993 and Arnold, 1988). They have shown that colonial efforts to deal with the health problems of developing regions were always closely linked to the economic interests of the British. Colonial healthcare services were concerned primarily with maintaining the health of the Europeans living in the colonies because they were viewed as essential to the success of colonial exploitation. The health of the colonized was only considered when their ill-health threatened colonial economic interest. Accordingly, the success or failure of health interventions was measured in terms of the colonies' production than by measuring the condition of health among the indigenous population. In this regard, Vaughan says:

> *Epidemic diseases posed a constant threat to the economic viability of the colonial state. The rise of tropical medicine was an outcome of the continuing threat posed by epidemic diseases to the entire colonial enterprise* (Vaughan, 1991: 37-38).

Basically, the intended healthcare services in the first Ten-Year Development Plan by the British in Nigeria was the economic oriented for exploitation rather than driven to the well-being of Nigerians. Thus, the services were designed for economic development of the British, not Nigerians. Irrespective of the imperialistic nature of the Plan, it became the basis upon which the subsequent national development plans and healthcare policies in Nigeria were formulated (Iheanacho, 2014: 51).

After Nigerian independence and consequently the termination of the Second Colonial Development Plan, 1956-1962 (WJHCB/SOKPROF/ACC/2), healthcare policies and services in Nigeria were enunciated in various forms; either in the national development plans or as government decisions on specific health problems. Most of the healthcare development plans; schemes; projects; declarations and decisions in independent Nigeria were dictated by colonial healthcare policies. Some of the post-colonial plans included the First National Development Plan (1st NDP), 1962-1968 and the Second National Development Plan (2nd NDP), 1970-1975. The latter Plan aimed at correcting the deficiencies of the former Plan (www.oauife.edu.ng/Dr.-K.-T.-Ijadunola).[1]

However, the most ambitious plans in terms of healthcare services were the Third and Fourth National Development Plans (3rd and 4th NDPs) in 1975-1980 as well as 1981-1985 respectively. The 3rd NDP attempted to draw up a comprehensive national healthcare policy dealing with such issues as health manpower development, provision of a comprehensive healthcare system based on the Basic Healthcare Service Scheme (BHSS)

[1]Although the National Health Policy and Strategy for Health for All Nigerians were published in 1988 and revised in 1998 and 2004 by the Federal Ministry of Health, it is noteworthy that the actualization of the 4th NDP was within its period between 1981 and 1985. Therefore, the publication in 1988 was a spill-over and a sign of continuity with the provision of the 4th Plan that aimed at providing health services for all Nigerians.

and efficient utilization of health resources. By the time when the Plan was produced in 1975, more than 15 years after independence, not much had been done to achieve the goals of both 1st and 2nd NDPs. Therefore, the Plan tended to improve the numerical strength of the existing health facilities rather than evolving a clear healthcare policy (www.oauife.edu.ng/Dr.-K.-T.-Ijadunola). Upon the termination of the 3rd NDP, the 4th NDP came into being. The major aim of the Plan was reflected in the National Health Policy and Strategy to achieve health for all Nigerians (Emuakpor, 2010: 55). [2]The Plan addressed the issue of preventive health services for the first time in the history of Nigeria's development plans. The policy statement contained in the Plan called for the implementation of the BHSS that was first addressed in the 3rd Plan (www.oauife.edu.ng/Dr.-K.-T.-Ijadunola).

In the post-Fourth National Development Plan period, the Nigerian Federal Government embarked on many strategic plans, schemes and actions to improve the health condition of Nigerians for economic development. For instance, in 2005 National Health Insurance Scheme was introduce to ensure among others, universal provision of healthcare, control of arbitrary increase in the cost of healthcare services, adequacy and equitable distribution of healthcare facilities within the country as well as adequate flow of funds for the smooth running of the health sector in general (National Health Insurance Scheme Decree No. 35 of 1999). Other strategic programmes that have linkage with healthcare are Millennium Development Goals, Federal Government's 7-Point Development Agenda and Vision 20:2020. These programmes and actions have underscored human capital development as the bedrock of national agenda with explicit reference to the health sector (TWG-NSHDP, 2009: 11).

From the foregoing, it became clear that development planning has been a consistent phenomenon in Nigeria's administrative system. However, it is worrisome that the plans have not yet achieved the expected results in the health sector. This is evident from the high morbidity and mortality rates that beset the country (Iheanacho, 2014: 49-50). A review of the various plans clearly shows that the country is still very far from where it was envisaged it will be today health-wise (Iheanacho, 2014: 50). This could simply be a result of either faulty implementation of the plans, distortions or even non-implementation.

Development Plans, Strategies and the State of Health in Nigeria

This segment reveals the failures of national development plans and other strategies to improve the health of Nigerians for economic development. Theoretically, health is seen as one of the key determinants of economic development in Nigeria. This has helped pave the way for health to be included in the country's development plans and strategies. Beginning with the state of health, despite the provision of funds for the health sector in

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the development plans, Nigeria's health system has continued to deteriorate remarkably. There had been high morbidity and mortality rates. The morbidity and mortality rates are across the people of all ages even though child and maternal mortality record the highest incidences. Of all the plans, the most ambitious in terms of healthcare services were the Third and Fourth National Development Plans in which the policy contents of Primary Health Care were made (TWG-NSHDP, 2009: 11). Thus, the discourse of the section begins with the 4thPlan and other subsequent strategies.

Primary Health Care (PHC), which forms the bedrock of the national health system since the 4th NDP, remains in a prostrate state due to gross underfunding, mismanagement and lack of capacity (TWG-NSHDP, 2009: 11). After the period of the Plan in 1985, Nigeria in her strategy to secure the health of Nigerians collaborated with the World Bank to finance her health sector. As at 1998, the Bank had funded five health projects in the country, namely Sokoto Health Project; Imo Health and Population Project; the National Essential Project; The National Population Project; and the Health System Fund Project (Kajang, 2004: 41-42). Likewise, the Bank embarked on the HIV/AIDS Programme Development Project and the Health System Development Project II from 1998. In the same vein, there was the announcement of the National Health Policy in 1998, as well as the declaration of the slogan that there will be good health for all Nigerians by the year 2000 (Kajang, 2004: 41-42).

Unfortunately, the Plan and the World Bank interventions, as well as the National Health Policy to achieve health for all Nigerians by the year 2000, have not changed the gloomy situation of the Nigerian health sector. For example, among the 191-member states of the United Nations whose overall health systems 'performance was assessed by the World Health Organization in 2000, (the targeted year of the declaration of health for all), Nigeria was ranked number 187. The country's performance came ahead of only the Democratic Republic of Congo, Central Africa Republic, Myanmar and Sierra Leone (WHO, 2009). It is pertinent to note that those three countries below Nigeria in the ranking were pre-occupied with civil wars and political instability for close to three decades. Nigeria, on the contrary had had relative stability within the same period (Kajang, 2004: 40-41).

Moreover, the report of the assessment revealed that the country's health status indicators with respects to maternal mortality rate is 948/100,000, the infant mortality rate is 115/1000 and the under-5 mortality rate is 205/1000. The results were worse than the average for Sub-Saharan Africa (WHO, 2009). It is also reported in the National Health Policy that the mortality rates in Nigeria are one of the highest in the world (Federal Republic of Nigeria, 2004: 3). Similarly, the 2003 Nigerian Demographic and Health Survey indicate immunization coverage of twenty-three percent as well as six percent of under-five sleeping under insecticide-treated nets (ITNs). Moreover, it is revealed that less than half of childbirths were attended by skilled health personnel in the year (TWG-NSHDP, 2009: 11). The report and survey confirmed that Nigeria's health status instead of becoming better is worsening despite the pieces of evidence that the

country's health sector is being captured under development plans and other strategies. It is also exposed that Nigeria's health sector was below the country targets and internationally-set benchmarks. Currently, Nigeria's health sector is characterized by fragmented health service delivery, inadequate financing, weak health infrastructure and mal-distribution of the workforce (TWG-NSHDP, 2009: 2). The following sub-heads depict the situation of the sector at the service level.

Health Institutions and Supplies: Nigeria's healthcare institutions are poorly lit, the roofs often lick, there is never running water, there is no back-up power supply, there are no facilities for anti-sepsis and sometimes, the walls are cracked and falling. Generally, the institutions established in the country were so inadequate and poorly executed to meet the minimal service package required to combat the prevailing disease burden. Likewise, the institutional environments provide no motivation or incentives for health workers. The problem of equipment and supplies in Nigeria's public healthcare institutions is very common. There is hardly any supplies and equipment commensurate with the patient turnover at the institutions (www.oauife.edu.ng/Dr.-K.-T.-Ijadunola).

Healthcare Staffing: At this juncture, the paper considers maternal and children health aspect since it records the highest number of mortality. It is pertinent to note that the global best practices have identified that the single most important factor that determines the outcome of any pregnancy and delivery is the availability of skilled birth attendants (midwives and doctors) (www.oauife.edu.ng/Dr.-K.-T.-Ijadunola). However, many public healthcare institutions, for example, general hospitals and health centres in Nigeria lack skilled health workers in the correct numbers and mix. It is very common to find an institution providing antenatal care, delivery and child health services without midwives let alone doctors. Instead, what is usually found is a large number of unskilled attendants and aids (cleaners and health assistants) who man the facilities and continue to provide supposedly technical services without the necessary training. Wrong judgments abound many times; they cannot even identify complications let alone treat or refer them. The shortage of skilled personnel takes a toll on the health and effectiveness of the few ones that are available in the facilities. For instance, it is commonplace to see many pregnant women attending a clinic where there were not more than two doctors. This explains why health workers always complain of the burden of work, while patients, on the other hand, complain about the poor attitude of the health workers towards them. The workers refer to what the patients call poor attitude as the staffs' reaction to the stress and pressure of work (Labbo, 2013: 323). Whichever way, the patients are on the receiving end of all the shortcomings.

Conclusion and Recommendations

As the popular saying goes 'Health is Wealth', it is clear from the theoretical discourse in the paper that, the health sector is critical to economic development with ample evidence linking productivity, labour supply, education (skills) and savings with healthcare. Although the total health expenditure of Nigeria as a percentage of the Gross Domestic Product, public health expenditure as a percentage of total public expenditure per capita

for Nigeria are below the average for Sub-Saharan Africa, and far below the recommendation by the WHO, Nigeria's development plans and strategies paid fair attention to healthcare services. However, the major problems are with the formulation and implementation of the plans. Specifically, the paper emphasized the modelling of national plans on colonial policies, poor implementation and corruption. Beginning with the 1st and 2nd NDPs, the Plans failed because they were designed based on colonial development plans. The problem is that colonialism was a dictatorship in which the views of Nigerians were not important in every sector. The formulation of colonial plans as related to healthcare was taken by the British officers and indigenous people were consulted. Therefore, the Plans could not address the underlying health problems in the country. Thus, the 1st and 2nd NDPs were designed on that model without consultation of the general public.

With regards to implementation, there has been a mismatch between the designed plans and the political will as well as commitment to the implementation of such plans by the authorities concerned. This is because even when there was implementation, most of the healthcare services executed were politically motivated rather than targeting improvement in the health of the citizens. Therefore, although the projects were designed in the development plans, they lack proper planning in the execution and were of very poor quality and inadequacy. In the same vein, hardly, examples can be drawn from having the officials of the ministries of finance, works, environment, budget and planning as well as that of health engaging in analysis about how the implementation of proposed healthcare services can guarantee economic development. Such discussions could have enhanced other health interventions like environmental safety, provision of clean drinking water, construction and maintenance of good roads among others for the sake of improved health for economic development. However, what is commonplace among those officials is corruption. Funds meant for healthcare institutions, drugs and other healthcare-related projects are being siphoned away making Nigerians vulnerable to premature death and consequently lack of economic development in the country.

Finally, there is need to acknowledge the fact that, unlike in the developed countries where technological advancement rendered manual labour less important factor in generating outputs, in Nigeria agriculture and other primary extractions are the most important within the economy. Therefore, labour is predominantly manual. It heavily influences how ill-health impacts on labour market outcomes. So, there should be a timely investment in health to reduce the burden of diseases on individuals who supply labour for them to lead healthier and more productive lives.

References

Arewa House Archives Kaduna/SNP/19/23/A.396/Annual Report of the Ministry of Health, Northern Nigeria for the Year 1957-1959

Anderson, W. (1998). Where is the postcolonial history of medicine? Essay Review, *Bull History of Medicine,* 72.

Arnold, D. (1993). *Colonizing the body: State medicine and epidemic disease in Nineteenth-century India,* Berkeley (C A): University of California Press

Arnold, D. (ed.), (1988). *Imperial medicine and indigenous societies* (Manchester: University Press)

Bivins, R. (2012). Coming home to (Post) colonial medicine: Treating tropical bodies in Post-War Britain, *Social History of Medicine,* Oxford University Press

Bloom, D., Canning D., & Sevilla J. P., (2001). The effect of health on economic growth: Theory and evidence' *NBER, Working Paper 8587*, Cambridge: National Bureau of Economic Research, available at www.nber.org/papers/w8587

Davidovitch, N. & Greenberg, Z. (2007). Public health, culture, and colonial medicine: Smallpox and Variolation in Palestine during the British Mandate, *Public Health Reports,* 122.

Emuakpor, A. S. (2010). The evolution of health care Systems in Nigeria: Which way forward in the twenty-first century, *Niger Medical Journal,* 51 (2)

The Federal Republic of Nigeria, (2004). *Revised national health po*licy, Federal Ministry of Health Abuja.

Feinstein, L., Sabates R., Anderson T. M., Haindo A. S., & Hammond C., (2006). What are the effects of education on health, *measuring the effects of education on health and Civic Engagement: Proceedings of the Copenhagen Symposium.*

Grossman, M. (1972). On the concept of health capital and the demand for health, *Journal of Political Economy*, 80 (2).

Iheanacho, E. N. (2014). National development planning in Nigeria: An endless search for appropriate development strategy, *Internal Journal of Economic Development Research and Investment, 2* (5).

Ijadunola K. T., Free Health Services in Nigeria: How beneficial to the poor? Available at www.oauife.edu.ng/.../Dr.-K.-T.-Ijadunola.

Joseph, O. A. (2014). National development strategies: Challenges and options, *International Journal of Humanities and Social Science Invention,* 3 (4).

Kajang, D.R. (2004). *Organization and management of health services in Nigeria: 1960-2004, (A Case of the Federal Ministry of Health, Abuja, Nigeria).* PhD Dissertation, St Clements University.

Labbo, A. (2018). *A history of modern medical and healthcare services in colonial and Post-Colonial Sokoto Province, 1920-1986*'. *PhD Thesis*, Department of History, Usmanu Danfodiyo University, Sokoto, Nigeria

Lawal, T. & Oluwatoyin, A. (2011). National development plans in Nigeria: Issues, challenges and prospects, *Journal of Public Administration and Policy Research,* 3 (9).

Marks, S. (1997). What is colonial about colonial medicine? And what has happened to imperialism and health, *Social History of Medicine,10*.

Mwabu, G. (1998). Health development in Africa: *Economic Research Papers Series,* (38). National Archives Kaduna /Sokoto Provincial File/1210/Kangiwa Dispensary.

National Health Insurance Scheme Decree, (2009). No. 35 of 1999, part II: 5; NHIS

Pritchett L. & Summers L. H. (1996). Wealthier is Healthier, *Journal of Human Resources*. 30 (4)

Suhrcke, M., Mckee M., Stuckler D., Sauto Arce R., Tsolova S., & Mortensen J., (2005). *The contribution of health to the economy in the European Union,* Luxembourg: Office for Official Publications of the European Communities.

TWG-NSHDP/Health Sector Development Team, (2009). *The National Strategic Health Development Plan Framework (2009-2015).* NCH ADOPTED.

Vaughan, M. (1991). *Curing their Ills colonial power and African illness,* Stanford University Press, 1991.

WHO, (2000). World health organization assesses the world's health systems, *World Health Report*, June.

Waziru, J. (1958). History and culture bureau/Sokoto Provincial File/ACC/2/Five *Year Plan Medical and Health*, 1950 – 1958.