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RESEARCH ARTICLE

PRIVATE HEALTH SERVICES DELIVERY: AN INSIGHT INTO THE EXPERIENCES OF PRIVATE HEALTHCARE PRACTITIONERS AND BUSINESSES IN NIGERIA

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ABSTRACT

Introduction: A large proportion of the public in some countries are known to patronize the private sector for their health needs, and some users even consider these services to be more attractive. Objective: The study aims to explore the experiences and issues associated with private health service delivery among private health practitioners in Nigeria. **Methodology:** A descriptive cross-sectional study was carried out among private health professional at two national events, using self-administered semi-structured questionnaires. Data obtained was formed into tables and analysed using the IBM Statistical Package for the Social Sciences (SPSS) version 20.0. **Results:** Eighty-one (48.8%) respondents used rented facility for their private healthcare practice. The net worth of private health facilities (all-inclusive in naira) was stated by 53 (31.9%) respondents to be less than 10 million (23,980.24 USD). While some new health facilities were being established, others were closing down for various reasons. There were some concerns expressed on multiple taxations,third-party mode of payment/health management organization (HMO), public power supply and security in area of private health businesses. It was the wish of 89 (53.6%) respondents that government should provide enabling environment for private health businesses to thrive. **Conclusion:** Small-and-medium-size businesses that used rented apartments with a relatively low net worth dominated the private healthcare industry. Some of such businesses have failed for several reasons. We advocate for healthcare reforms in Nigeria that should encourage growth in the private health sector.

INTRODUCTION

The health of any population is critical to its survival, and no country in the world deliberately handle issue of healthcare of its citizens lightly, as could be seen in the manner in which nations of the world managed (and still managing) the coronavirus pandemic [1,2]. The World Health Organization is a unique creation of the United Nations that work with ministries and agencies from different countries to oversee issues of healthcare in the global arena [3,4]. Challenges (both existing and emerging) abound, and multiple actors (both governmental and nongovernmental) play their roles in health systems for the public good, including the private sector [5,6]. A large proportion of the public in some countries are known to patronize the private sector for their health needs [7], and some users even consider these services to be more attractive. With a large pool of skilled health professionals domiciled in the private sector, the usual tendency of directing public health intervention strategies to public health institutions alone has been reported not to be yielding the desired result [8]Strong advocacy has been made for increase role of the private health sector [9]with low-and-medium income countries gradually showing some compliance [10, 11]. Public-private partnership has been described in the healthcare industry and embraced by governments in some climes [12, 13, 14]. The benefits of this initiative have been

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rewarding with the emergence of mega-healthcare facilities in India [15, 16,17], France and other countriesin Europe [18, 19],the United States of America [20,21],in the Russian Federation [22, 23], and some African countries. There are some reports of experiences of public-private partnership in Nigeria, detailing the feasibility thereof with proper awareness and stakeholders' engagement [26, 27]. It was severally reported, that it requires an exceptional "political will" for government-funded public sector to surmount the bureaucratic bottlenecks necessary for allocation of enough resources to the health sector, especially in the developing economy where the national health budget is usually below the benchmark recommended by the World Health Organization for public health services delivery [28,29,30]. In a document referred to as "Abuja Declaration", African Governments pledged to commit 15% of their national budget to funding the health sector [31]. However, nineteen years after that declaration, only 60% of African countries still had their budget close to 10%. A study described the relationship between the economy and the genesis of alternative therapy (traditional, spiritual and folk medicine) in Nigerian, stressing how the inadequacies of the government-financed (public) healthcare facilities – lack of drugs & dressing materials and retrenchment of staff at a time led to the emergence of the private healthcare services [32].

Emphasis in most countries is placed on providing enabling environment for the private sector to thrive, as a way of enhancing private sector participation in providing employment and rendering quality service to the citizens. Public-private partnership has also been celebrated across the globe as an avenue for health service delivery. There are reports of continuous brain-drain in the health industry, depleting our already insufficient workforce [33, 34]. How well or otherwise has the private health sector been fairing in Nigeria, in terms of the desired enabling environment to meet up with global trends? This question forms the basis for this piece of work, aimed at exploring the issues and experiences of practitioners in private health services delivery in Nigeria.

MATERIALS AND METHODS

Research Design: A descriptive cross-sectional study.

Study Area: The study was carried out at two National Conferences in Port Harcourt in Rivers State, South-South of the Federal Republic of Nigeria. **Study Sites:** The study sites were two national health sector events that held in Port Harcourt -the 7th Afri Health Expo, a National Event / Exhibition and Conference show-casing the services of Clinics, Hospitals, Diagnostic Centers, and Non-Governmental Organizations, held from 20th – 22nd October 2021, at the Atlantic Hall of Hotel Presidential, in Port Harcourt; and the exhibition center of the Annual General Meeting and Scientific Conference of the Pharmaceutical Society of Nigeria held in Port Harcourt, Nigeria in December 2021.

Study Population/Participants: Data was collected from private health practitioners

Sample Size Determination: All Conference participants at exhibition centers who gave consent were included in the study.

Sampling Method: Total population of conference attendees at exhibition centers, who gave consent was used.

Study Instruments: Self-administered semi-structured questionnaires was used.

Validity/Reliability of Instrument: The information in the study instruments was scrutinized and critiqued by all authors to ensure that they achieve the set objectives before use. The study was also be pretested in a similar study environment. The Cronbach alpha (in SPSS) was used for the validity of the study instrument.

Variables: Information on demographic characteristics, ownership status, staff strength, net worth of business, years of experience in business, patient / clients' patronage, number of similar businesses closed down, taxation, electric power supply, security, relationships with Health Management Organizations (HMO), and benefit/incentives received from Government

Bias: Opinion of participants in the two conferences who were either not present at the exhibition centres or unwilling to give consent for participation, were not captured in the study.

Data Analysis: Data obtained was formed into tables and analysed using the IBM Statistical Package for the Social Sciences (SPSS) version 20.0.

RESULTS

A 96.0% questionnaire retrieval was achieved and a total of one hundred and sixty-six (166) respondents were involved in the study.

Table (1): Socio-demographic-Category and Years of Practice of Respondents (n = 166)

Variables	Number	Percentage
Category of Health Personnel		
Medical Doctor	70	42.2
Nurse	39	23.5
Pharmacist	8	4.8
Medical Lab Scientist/Technologist	20	12.0
Technicians	4	2.4
Others	25	15.1
Years of practice (Post qualification)		
Less than 5years	48	28.9
5 - 9years	45	27.1
10 - 14years	22	13.3
15 - 19years	4	2.4
20 - 24years	10	6.0
25 - 29years	9	5.4
30years and above	28	16.9
Age		
Less than 20 years	6	3.6
20- 29 Years	50	30.1
30- 39 Years	41	24.7
40- 49 Years	26	15.7
50- 59 Years	17	10.2
60- 69 Years	24	14.5
70- 79 Years	2	1.2

Table (1) shows the categories of the respondents. Seventy (42.3%) respondents were medical doctors, 39 (23.5%) were nurses, 20 (12%) were medical laboratory scientists/ technologists, and 8 (4.8%) were pharmacists. Forty-eight (28.9%) respondents had practiced for less than 5 years after qualification, and 28 (16.9%) had spent 30 years and above practicing post qualification. Fifty (30.1%) respondents were aged between 20 and 29 years, 41 (24.7%) were between 30 - 39 years and 24(14.5%) were between the ages of 60 and 69 years.

Table (2): Staff strength and ownership status of private health practice (n = 166)

Variables	Number	Percentage
Staff strength of private health practice		
Less than 10	51	30.7
10 - 19	40	24.1
20 - 29	28	16.9
30 - 39	6	3.6
40 - 49	10	6.0
50 - 59	9	5.4
60 - 69	4	2.4
70 and above	10	6.0
No response/Don't know	8	4.8
Number of full-time health professional working in the facility		
Less than 10	86	51.8
10 - 19	31	18.7
20 - 29	21	12.7
30 - 39	6	3.6
50 - 59	6	3.6
60 - 69	4	2.4
70 and above	2	1.2
No response/Don't know	10	6.0
Number of part-time health professional working in the facility		
Less than 10	100	60.2
10 - 19	36	21.7
20 - 29	6	3.6
30 - 39	4	2.4
40 - 49	2	1.2
60 - 69	4	2.4
No response/Don't know	14	8.4
Ownership status of current facility in use for practice		
Rented	81	48.8
Private building Owned	53	31.9
Owned and built as customized health facility	32	19.3

The staff strength and ownership status of private health facilities are shown in Table (2). Fifty-one (30.7%) respondents reported a staff strength of less than 10, 40 (24.1%) respondents indicated 10 – 19 as staff strength, and 28 (16.9%) respondents asserted to 20 -29 personnel. Eighty-six (51.8%) respondents indicated that the full-time health professionals working in their facility were less than 10, while 100 (60.2%) asserted to having less than 10 part-time health professionals working in their facility. Eighty-one (48.8%) respondents opined that they used rented facility for their practice, 53 (31.9%) used their private buildings converted into health facility, and 32 (19.3%) respondents used owned and built their facility as customized buildings for private health practice.

Table (3): Business Net Worth (in Naira) and Experience in Years (n = 166)

Variables	Number	Percentage
Net worth of health facility (all inclusive)		
Less than 10 million	53	31.9
10 - 49 million	38	22.9
50 - 99 million	18	10.8
100 - 349 million	14	8.4
350 million and above	16	9.6
No response/Don't know	27	16.3
Years of operation of health facility		
Less than 1year	16	9.6
1 - 4years	33	19.9
5 - 9years	43	25.9
10 - 14years	13	7.8
15 - 19years	12	7.2
20 - 24years	16	9.6
25 - 29years	16	9.6
30years and above	11	6.6
No response/Don't know	6	3.6

Table (3) shows the Business Net Worth and Experience in Years of the private health businesses.

The net worth of private health facilities (all-inclusive in naira) was stated by 53 (31.9%), 38 (22.9%), and 16 (9.6%) respondents to be less than 10 million (23,980.24 USD), 10 - 49 million (23,980.24 – 117,503.18 USD), and 350 million and above (839,308.40 USD) respectively (using a conversion rate of 1 USD =417 Naira). Forty-three (25.9%) respondents opined that their health facilities had been in operation for 5 - 9years, while 11 (6.6%) duration of existence of 30years and above.

Table 4. Patients/Clients' Patronage and Health Facility Rentals (n = 166)

Variables	Number	Percentage
Number of patients that come to health facility per month		
Less than 20	32	19.3
20 - 39	31	18.7
40 - 59	28	16.9
60 - 99	20	12.0
100 - 199	22	13.3
200 - 299	13	7.8
300 and above	10	6.0
No response	10	6.0
Have rental services (ambulances etc.) in private health facility		
Yes	63	38.0
No	91	54.8
Not sure	12	7.2

Table (4) shows patients/ clients' patronage and health facility rentals services. Thirty-two (19.3%) respondents opined that less than 20 patients / clients patronise their health facilities per month, while 10 (6.0%) respondents did serve at least 300 patients / clients per month. Ninety-one (54.8%) respondents did not have rental services (ambulances, etc.) in their private health facilities, 63 (38.0%) respondents had rental services in their health facility. Table (5)provides information on the existence and closure of similar health facility in the neighbourhood. Forty-six (27.7%) respondents opined that more than 4 new private health facilities had been opened / established in their neighborhood within the last 5years, while 26 (15.7%) indicated that no new facility was established. Eighty-six (51.8%) respondents asserted that no health facility had shut down in their neighborhood in the last five years, 55 (33.1%) respondents indicated that they knew of one health facility shut down, four (2.4%) new about more than four health facilities that had closed business. The reasons for closure of business operations were varied: death of the owner, lack of patients, COVID-19 issue, losses on business, malpractice issue, poor management, and poor business environment.

Table (6) provides information on taxation / Health Management Organization (HMO) / power supply security / incentives from government. One hundred and four (62.7%) respondents experienced multiple taxations from government agencies in health facility. Fifty-six (33.7%) respondents felt terrible about experience with third-party mode of payment/health management organization (HMO). Fifteen15 (9%) respondents opined excellent relationship, while 63 (38.0%) were managing or coping with the situation. The respondents' experience with public power supply for business in their area was variable: 49 (29.5%) reported very poor experience; 10 (6%) felt excellent; 37 (22.3%) asserted to an average experience. Security rating in area of private health businesses shows that 61 (36.7%), 23 (13.9%) and 29 (17.5%) respondents rated security as average, poor and very poor

respectively. One hundred and thirty-three (80.1%) respondents asserted that they had not benefited from any government incentive for business.

Table (5): Similar Health Facility in the Neighbourhood (n = 166)

Variables	Number	Percentage
Number of new private health facility opened in the neighborhood in the last 5years		
None	26	15.7
1	28	16.9
2	33	19.9
3	31	18.7
4 and above	46	27.7
Don't know	2	1.2
Number of private health facility in the neighborhood that has shut down		
None	86	51.8
1	55	33.1
2	14	8.4
3	7	4.2
4 and above	4	2.4
What is responsible for the shutting down of the health facility		
Death of the proprietor doctor	2	1.2
Lack of patients	10	6.0
Covid-19 Issue	17	10.2
Losses on business	14	8.4
Malpractice issue	4	2.4
Poor management	20	12.0
Poor business environment	12	7.2
All of the above	16	9.6
Don't Know	19	11.4
No shut down	52	31.3

Table (6): Taxation/HMO/Power Supply/Security/Benefit from Government (n = 166)

Variables	Number	Percentage
Experience multiple taxations from agencies in health facility		
Yes	104	62.7
No	29	17.5
Not sure	33	19.9
Experience with Third-Party mode of payment/HMO		
Excellent	15	9.0
Terrible	56	33.7
Manageable	63	38.0
No response/No experience	32	19.3
Rate the public power supply for business in the area		
Excellent	10	6.0
Good	22	13.3
Average	37	22.3
Poor	46	27.7
Very poor	49	29.5
Not available	2	1.2
Rate the security for business in the area		
Excellent	10	6.0
Good	41	24.7
Average	61	36.7
Poor	23	13.9
Very poor	29	17.5
Not available	2	1.2
Benefited from any government incentive		
Yes	22	13.3
No	133	80.1
Not sure	11	6.6

(HMO means Health Management Organisation)

Table (7): Private health services administration (n = 166)

Variables	Number	Percentage
Professional Administrator available in health facility		
Yes	83	50.0
No	67	40.4
Not sure	16	9.6
How the private health facility is administered		
By Self	47	28.3
Use the nurses	47	28.3
Other Staff sometimes	34	20.5
There is administrator	38	22.9
Have dedicated cashier for payment made		
Yes	103	62.0
No	53	31.9
Not sure	6	3.6
No response	4	2.4
Have problem with administration/financial accountability		
Yes	62	37.3
No	81	48.8
Not sure	19	11.4
No response	4	2.4
Frequency of encountering administration/financial accountability problem		
Very often	13	7.8
Often	23	13.9
Sometimes	50	30.1
No Encounter	70	42.2
No response	10	6.0
Ever had partnership issues threaten practice existence		
Yes	39	23.5
No	115	69.3
Not sure	10	6.0
No response	2	1.2

Table (7) highlights issues of private health services administration. Eighty-three (50.0%) respondents indicated that they had professional administrator available in their private health facilities. One hundred and three (62.0%) respondents had dedicated cashier for payments made, and 62 (37.3%) had had problems with administration / financial accountability. The frequency of encountering administration / financial accountability issues was very often among 13 (7.8%) respondents, and often among 23 (13.9%) respondents. Thirty-nine (23.5%) respondents had experienced issues with co-partners that threatened practice existence.

Table (8): The future plansof the private health practitioners in Nigeria (n = 166)

	YES		NO	
	Freq	(%)	Freq	(%)
Close down and travel out	7	4.2	159	95.8
Close practice and go for specialization	4	2.4	162	97.6
Close practice and go into other business	6	3.6	160	96.4
Stay in Practice and work harder	61	36.7	105	63.3
Stay in practice and hope for improvement	51	30.7	115	69.3
Government should encourage private medical practice to thrive	89	53.6	77	46.4
Private medical practice should be liberalized	24	14.5	142	85.5
Price fixing by HMO should be abolished	43	25.9	123	74.1
Soft Loan should be available for practice upgrade	54	32.5	112	67.5
Go into partnership with others for robust practice	42	25.3	124	74.7

Table (8) show the future plans (or the way forward) for private health practitioners / practice in Nigeria. It was the wish of 89 (53.6%) respondents that government should encourage private health practice to thrive by their policies, tax drive, good business environment, etc. Fifty-four (32.5%) opined that soft loan should be made available for health practitioners to upgrade practice. Forty-three (25.9%) respondents suggested that price-fixing by HMOs should be abolished. A few respondents want to close down business, while the majority wish to stay in business.

DISCUSSION

Most respondents had been in private healthcare practice for more than 5years and were above 30 years of age, with medical doctors being the majority, followed by nurses. This demographic picture is a reflection of healthcare personnel who were in business and were present at study sites during data collection. It in no way suggests the ratio of healthcare staff population in Nigeria, as the reverse is often the case. The years of practice experience of most respondents being more than five years gives credence to their knowledge of the private healthcare business environment in Nigeria, and hence the quality of information provided for the study. This paper discussed the finding of the study using the following categorizations: size and health of private healthcare business, experiences inimical for business growth,
administrative challenges in private health business, and reasons for closure or failure of businesses.

Size and Health of Private Healthcare Business: Some findings were indicators of the size and state of health of the private healthcare industry: the staff strength of most health facilities was less than 19 workers, and the full-time workers were less than 10 as reported by majority of respondents; patients /clients patronage was variable, with about a fifth of respondents attending to less than 20 patients / clients per month; the net worth of majority of private health businesses was less than 49 million naira (117,503.18 USD);and rented apartments were used by almost half of respondents with less than a fifth of respondents using their own customized buildings designed for private health practice. Majority of respondents did not offer rental services in their private health facilities, or any other form of diversification in their business.
The implication of these findings - low staff strength, low patient/client traffic, net worth, and use of rented buildings -is that these are small or medium-size businesses whose yearly expenses included rent for the buildings.

Experiences Inimical for Business Growth: There were some experiences reported in this study that were inimical to success of private healthcare businesses: majority of respondents experienced multiple taxations from government agencies; about a third of respondents reported terrible financial experiences with third-party mode of payment/health management organization (HMO); public power supply was asserted to be very poor by about a third of respondents; and security of business environment was also rated poor by about a third of respondents. The importance of enabling environment for small-and-medium-sized businesses in Nigeria has been on the front burner for more than 20years. The findings of our study are consistent with the report of other researchers expressed in different forms: need to strengthen basic infrastructure [35],inadequacy of infra-structural facilities (water, electricity, road network, communications etc.) [36],overriding significance in moderating the relationship between entrepreneurship and economic diversification [37]. Also in the African setting, the role enabling environment for the success of public-private partnership (PPP) has been emphasized [38]. It is therefore not surprising as more than half of the respondents, strongly expressed their desire for government to create conducive environment for private healthcare businesses to thrive in Nigeria.

Administrative Challenges in Private Health Businesses: Administration / financial accountability was an issue of concern to more than a third of respondents, and only half of the private health care practitioners used professional administrators for their businesses. Professional administrators in the context of this paper, implies those who have been officially or institutionally trained and certified as financial or business administrators. Businesses grow from simple to complex situations that the untrained in such areas may be unable to handle. The use of professional administrators is therefore apt. However, issue of insincerity by professional administrators is a source of concern as seen in our study. Employee vices have been reported [39, 40], and may continue to occur as long as society exist. Control measures are therefore needed to safeguard this. Co-partners disagreements that threatened business existence was encountered by almost a quarter of study participants. Problems among partners in businesses have long been reported [41, 42].Our finding is therefore not an exception, however, the success story of the outcome of partnerships in the health sector abound in the public space [15-25]. Partnership in business is therefore a formula to be embraced, provided the contributions / duties and profit-sharing formula is spelt out at the onset of the business.

Reasons for Closure or Failure of Businesses: While some new private health facilities were being established, a few others were closing down business. The reasons for private health business closure were due poor management, poor business environment, lack of patients, losses on business, malpractice issue, COVID-19 issue, and death of the owner. A researcher in South Africa concluded in his thesis that many small-and medium-scale businesses failed because of skills shortage and lack of access to finance [43]. The cumulative issues given as reasons for closure of business in our study, could indirectly be linked to inadequacy in skills and finance. One of the principles in establishing new business is risk assessment factors – where the entrepreneur should ascertain that the business is not capital intensive and should have profit margins to sustain growth from internally generated funds [44].This is often not the case with the experiences of these private healthcare practitioners, as modern health business is capital intensive, and the profit margin is guarded. Additionally, the controlling influence of health management organizations (HMOs) leaves a sour taste in the mouth of these practitioners such that a few of them yearn for abolition of price-fixing by HMOs, while others crave for soft loans to upgrade their practice. Reforms are therefore desirable that should serve dual functions of not only protecting the public from exploitations, but also protect the private healthcare practitioners from losses in business.

Study Limitations: Although the events from which the data for this study was derived were national conferences, more

participants from Port Harcourt - the city for the event were likely to be present and may have shaped the opinion pool.

CONCLUSION

The private healthcare industry in Nigeria is dominated by small and medium-size businesses, that used rented apartments with a relatively low net worth. Practitioners experienced multiple taxations from government agencies, and about a third of respondents reported terrible financial experiences with third-party mode of payment/health management organization (HMO).Public power supply and security of business environment were reported to be very poor by about a third of respondents. Half of practitioners did not use professional administrators and some have experienced challenges with financial accountability and co-partners disagreements that threatened business existence. Some businesses have failed for several reasons, and private healthcare practitioners call for reforms to improve on practice.

Recommendations

We advocate for healthcare reforms in Nigeria that should address the issues that hinder the growth of small and medium-size businesses in the health sector, enough to result in emergence of mega-healthcare facilities to attract healthcare tourists to our shores.

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Ethical Considerations: The Research Ethics Committee approval of the Rivers State University Teaching Hospital was obtained before commencement of the study.

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