ETHICAL PORTRAIT OF THE NIGERIAN HEALTH SECTOR

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The Christopher Kolade Centre for Research in Leadership and Ethics (CKCRLE) commissioned this study.

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Author: Yetunde Anibaba
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CHRISTOPHER KOLADE CRLE
At LAGOS BUSINESS SCHOOL

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Abbreviations

BHCPF	Basic Health Care Provision Fund
FGN	Federal Government of Nigeria
FMoH	Federal Ministry of Health
GDP	Gross Domestic Product
HFR	Nigerian Health Facility Registry
HMOs	Health Maintenance Organisations
HRH	Human Resources for Health
LGA	Local Government Areas
NCD	Non-Communicable Diseases
NHIS	National Health Insurance Scheme
NSHDP	National Strategic Health Development Plan
OOPs	Out-of-Pocket Payments
PHC	Primary Health Centre
PSF	Professional Service Firms
SHIS	State Health Insurance Scheme
SMoH	State Ministry of Health
TCAM	Traditional, Complementary and Alternative medicine
UNCTAD	United Nations Conference on Trade and Development
WHO	World Health Organisation

1.0 Introduction and Frame of Reference

From the sociology of professions, we understand that Professional Service Firms (PSF) evolved in the medieval period from their historical progenitors – guilds, monasteries and the earliest universities - and their distinguishing characteristics in terms of values and traditions are the historical outcome of these antecedent organisations.

UNCTAD[1] describes the professional services as occupations that require a large amount of training and expertise and are usually associated with accredited professions such as lawyers, doctors, accountants, architects and engineers as well as non-accredited and free-exercise professions such as consulting firms. It however distinguishes between professions (accredited from non-accredited) based on regulatory and ethical provisions that determine their ability to function. Thus for example, the accredited professions require authorization to practice and are expected to 'maintain a high professional conduct and standards and to uphold the welfare of clients and society over and above pursuing profit maximization'.[2] When these principles of professional conduct are not upheld, it challenges the very essence of such professions. Medical professionals for example, commit to the Hippocratic Oath as a necessary criterion for practice.

However, in addition to personal views that may or may not align with these principles of professional conduct, contextual dynamics tend to set the boundary conditions within which they are able to adhere to their professional commitment. Based on research into the experience of users, practitioners and other industry actors, this report explores these dynamics against the backdrop of four principles of healthcare ethics, to paint what we have described as an ethical portrait of the Nigerian health sector. We hope that the findings from this report are useful to guide policy recommendations and interventions to make the sector more efficient and thus truer to its calling.

2.0 Approach & Research

We may define Ethics as the application of moral values and rules to daily human activities. In the practice of health care in Nigeria, practitioners are required to uphold the ethical and legal requirements of their profession, in addition to deploying the skills and knowledge essential to carry out their profession effectively. The ethical guidelines provided by Nigeria's Medical and Dental, Nursing and Pharmaceutical Councils, as well as the four principles of healthcare ethics as developed by Tom Beauchamp and James Childress in the 1985 *Principles of Biomedical Ethics,* provided the framework for this research. In summary, these four principles include:[3]

2.1. Autonomy: This refers to a patient's right to retain control over their body – the right to choose what medical intervention to accept free of persuasion or coercion by the healthcare professional. In other words, the patient's decision in choice of care and right to accept and turn down treatment should be respected.

2.2. Beneficence or goodness: This means that goodness as an obligation should always be promoted by preventing or eliminating harm to a patient's health and acting in the patient's interest. This requires that healthcare professionals do all they can to benefit the patient in each situation.

2.3. Non-maleficence. This requires that healthcare professionals uphold the obligation not to inflict injury or harm on their patients because of inappropriate, inadequate or absent care.

2.4. Justice: This involves treating patients with similar health cases equally with respect to the benefits, costs and risks associated with treatment.

The study was designed to explore the level of ethical awareness and practice in the delivery and receipt of healthcare services across different regions in the country. Hence, respondents included health care users, practitioners and managers. We adopted a mixed-method approach, using quantitative and qualitative data collection methods, to facilitate both breadth and depth of the study. We began with surveys and the responses received from the surveys to some extent informed the guide used for the interviews. A total of 749 health care users and 203 practitioners (doctors and nurses) were surveyed using a closed ended survey instrument that asked the respondent to answer questions on a 5-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree). Further details on how the study was designed and how data was collected is provided in Annex 1 to this report.

3.0 Key Findings

Since the year 2000 when a World Health Organisation report ranked Nigeria's health system as number 187 out of 191 countries in the world, successive governments in Nigeria have strived to improve the state of the Nigerian health sector along several dimensions. One of those dimensions is universal access to primary health care services at all levels. Another aspect is the Human Resource for Health sufficiency and thirdly, governance. While some progress has been made along these lines, it has been slow and not very consistent. One of the most fundamental concerns remains the funding of the health system which underlies nearly all the other issues that affect the effectiveness and efficiency of the system. Nigeria's budgetary allocation to the health system continues to fall far below the 15% minimum agreed at the 2001 Abuja declaration.[4] In fact, the largest allocation to health since that year has been about 5.5% of the budget of 2013 and 2015.
We believe that this is at the core of many of the problems experienced in the sector, of course in addition to poor administration of the already strained resources.

With respect to the specific ethical dimensions that provided the framework for the field research, the study revealed that:

i. Overall, the experience of users with respect to each dimension was generally low, with the average responses to most of the questions /dimensions falling below 4 on the 5-point Likert scale and many respondents not having a strong view on some of the issues raised. In essence, the ethical standards by which Nigeria's healthcare professionals operate are not sufficient to deliver the quality of care Nigerians require.

ii. There is very little variation in the experience of our sample populations (users and healthcare professionals), whether they used / practiced in private hospitals or public hospitals and along regional lines.

iii. With respect to the Autonomy dimension, patients are sophisticated with respect to their expectation of how much control they should have over decisions regarding interventions in their health. However, some healthcare professionals tend to be unwilling to provide detailed information about the interventions they recommended, curtailing the extent of autonomy patients can express. There is therefore a considerable gap in how much control patients expect to have over decisions about interventions concerning their health and their experience with their healthcare professional.

iv. The desire for autonomy by users seemed to be balanced with confidence in their healthcare professionals' knowledge and expertise; while majority of our respondents believed they should have considerable autonomy over their healthcare choices, a significant number also felt the healthcare professional should have the final say in their healthcare interventions.

v. Regarding the Beneficence dimension, users were mostly affirmative about their belief that their healthcare professionals did their best to keep them healthy and the healthcare professionals group corroborated this thought.

vi. Paying for services that should ordinarily be free appears to be common practice with a significant proportion of our sample population experiencing it more or less than the others. It is therefore no surprise that out-of-pocket expenses for healthcare continue to rise despite efforts to minimize it.

vii. In terms of regions, our sample population (users) in the north-east seemed to have the poorest experience with ethical behavior among their healthcare providers, of all the regions along all the dimensions, while our respondents from the south-west and south-east had the best comparatively.

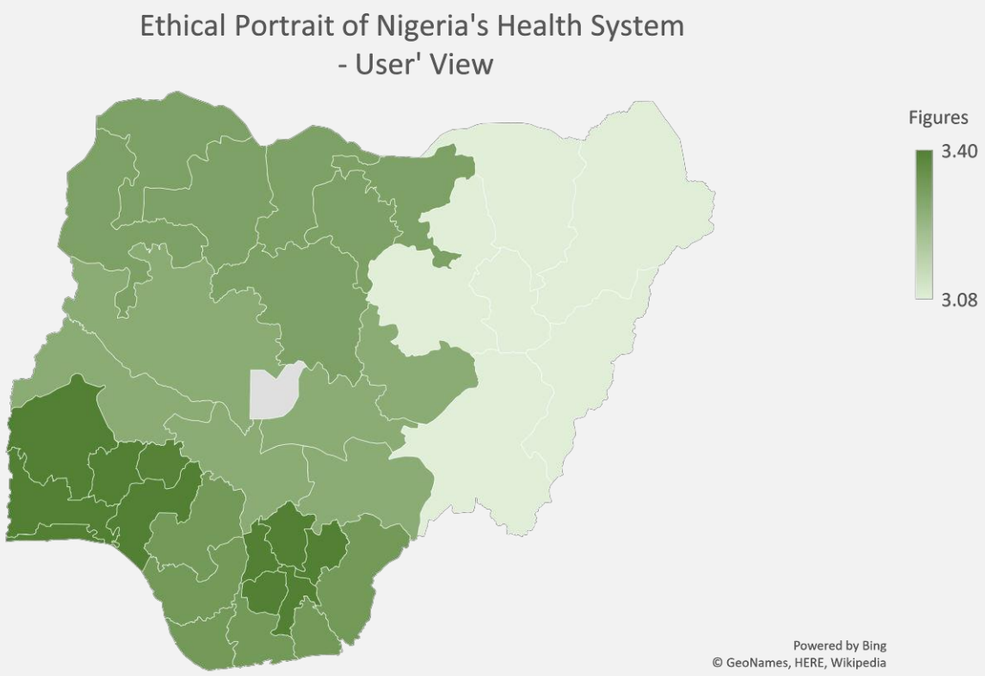
viii. Most of the healthcare professionals and users in our sample population believe that the current health insurance system is grossly inadequate. When asked what they would change about the healthcare system, several of our sample population of healthcare professionals mentioned health insurance. Particularly, they noted the need for health insurance to be more comprehensive and universal, for hospitals and Health Maintenance Organisations to operate seamlessly in order to minimize the time it takes to attend to patients.

ix. Some of the other issues our sample population of healthcare professionals were concerned about include sufficiency of healthcare practitioners in the light of the ongoing 'brain drain' in the health and other sectors of the economy, healthcare facilities and equipment, as well as the remuneration of healthcare professionals.

x. Finally, perhaps the most sobering finding from this study is that healthcare professionals mostly admit to the fact that it is not uncommon for fatalities to occur due to the patient's inability to pay their bills or for patients to be turned back and not given service due to their inability to pay. This goes to the core of the essence of the healthcare professions and is indicative of the extent to which the countries efforts at universal healthcare has not achieved its purpose. It should be important for the relevant bodies to carry out an investigation into how many Nigerians die for the failure of the system to provide what the government has declared a basic human right.

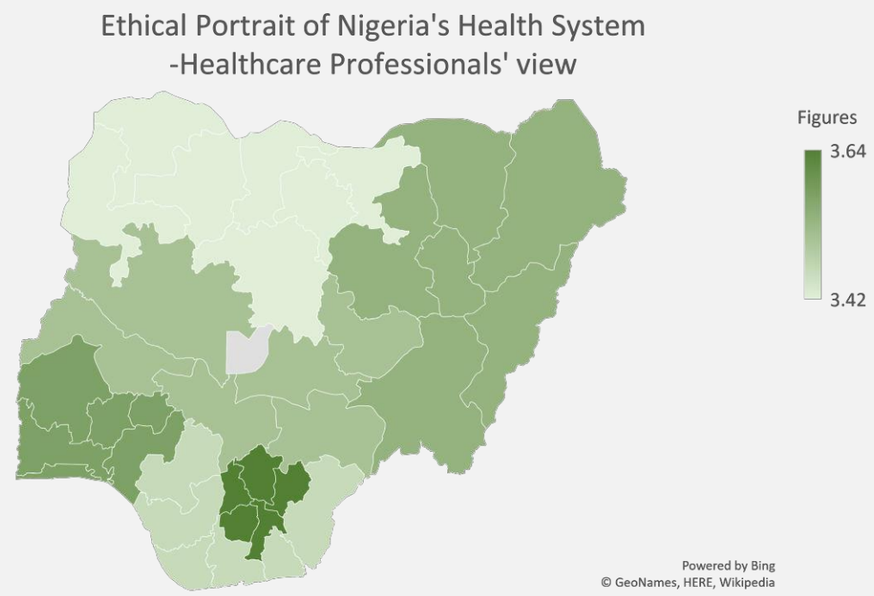
Below, are maps of the country showing the states / regions where data was collected for this study as well as how they ranked overall in terms of the experience of the four dimensions as expressed by about 740 users (Figure 1) and 207 professionals (Figure 2) in the healthcare system. The darker the colour, the higher or better the experience in general.
Overall, users ranked their experience of the healthcare system lower (highest average 3.40) than their healthcare providers (highest average value – 3.62). From the users' perspective, the map implies that overall, the experience of an ethical healthcare system is generally higher in the south-west and south-east and lowest in the north-east, even though the responses are generally below average across board as we explain further in parts B & C of this report.

Figure 1: Average responses to each principle along geopolitical zones (Users)



It is however interesting to note some differences in the views of our sample of healthcare professionals. While the south-east and south-west again retained the highest ranking overall respectively, the north-west and north-east seemed to trade places. Across all the ethical dimensions measured, the user group in the north-east rated their healthcare providers the lowest among all the regions; the healthcare professionals' group from that region however had a different view as they ranked themselves 3rd across regions, trailed by the north-central, south- south and north-west respectively.

Figure 2: Average responses to each principle along geopolitical zones (Professionals)



In Part B of this report, we present detailed results of the study from the users' / patients' perspective, and in Part C, from the perspective of our sample of healthcare professionals.

In the following section of the report (Part A), we provide some information about the country's healthcare system in terms of structure, policy and challenges, as well as set the contextual framework that guided this study. We begin with a brief background about Nigeria.

PART A –

ETHICAL PORTRAIT OF THE NIGERIAN HEALTH SECTOR:

An Overview

4.0 Country Backgroun d

Nigeria occupies an expanse of 923,678 square kilometres. It is situated on the west coast of Africa and within the tropics at a latitude of °1' and 13°9' N and longitudes 2°2' and 14°30' E, bordered to the north by Niger and Chad, to the west by Benin Republic, to the east by Cameroon and to the south by the Atlantic Ocean.

Nigeria is also blessed with abundant reserves of human and natural resources and is currently the largest economy in Africa by GDP and ranked 27th and 22nd largest economy in the world by nominal GDP and purchasing power parity respectively. It is the largest oil- producing nation in Africa and her growth has been fueled by the production and sale of crude since the late 1960s, with oil being the country's highest foreign exchange earner.
However, the non-oil sector currently contributes more than 90% to the nation's GDP and is getting increasingly diversified with growing investments in agriculture, technology & services.
The agricultural sector accounted for 22.58% of the total GDP during the first quarter of 2019.[5]
The growth in agriculture has been poor due to recurring clashes between herdsmen and farmers in addition to the flooding of key areas in the middle-belt regions and insurgency in the northeast region of the country.[6]

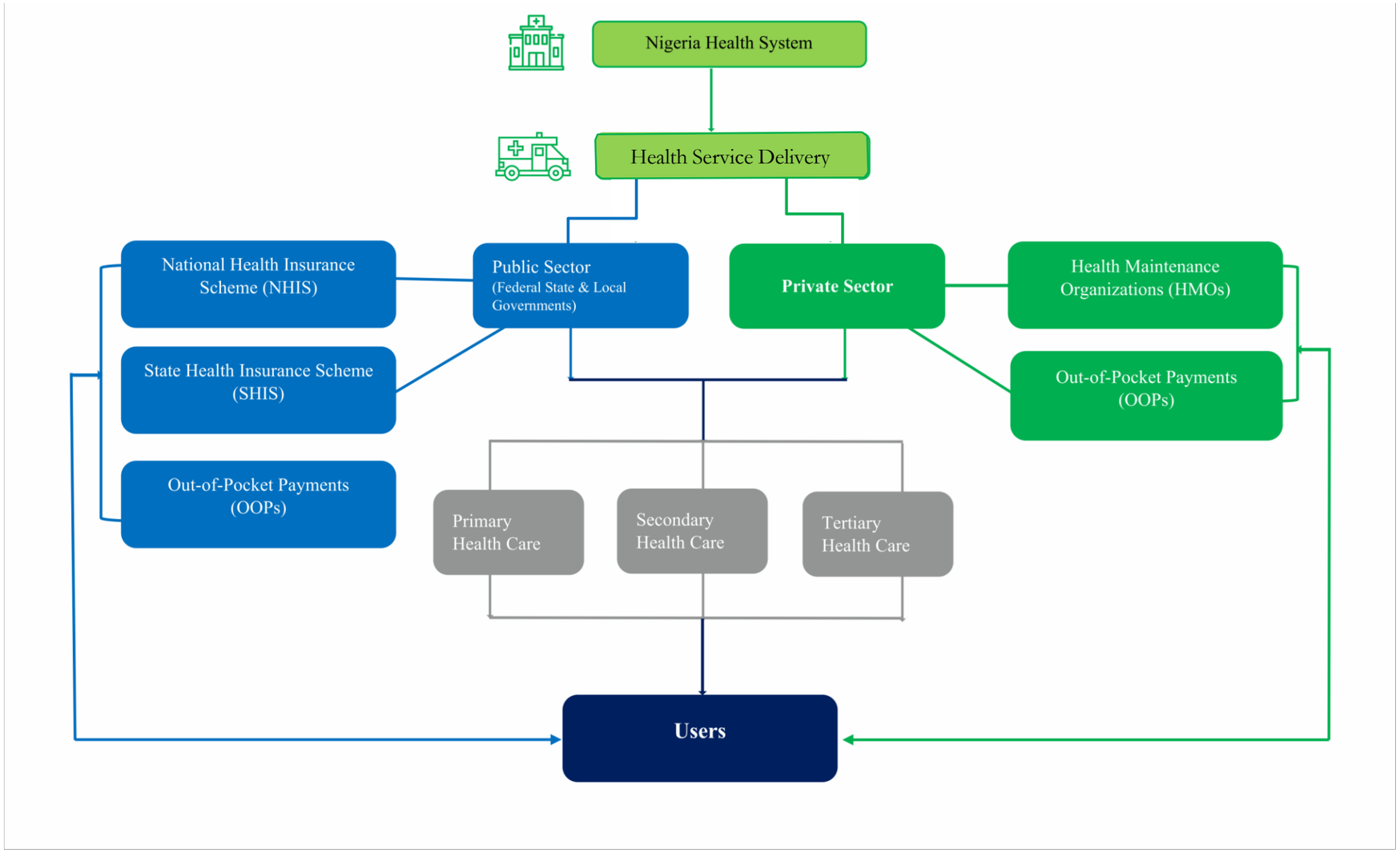
Nigeria is also the most populous country on the continent of Africa with a population of roughly 200 million people[7] and a population growth rate of 2.60%[8] , representing 47 per cent of the population of West Africa. The country also has one of the largest youth populations in the world[10,] with about 20 per cent under the age of 5 and 45 per cent under the age of 15 and a medic age of 17.9 years. Twenty two per cent of the population are women aged 15-45 years (childbearing age).[11]

Despite its abundant human and natural resources, Nigeria is still classified among the poorest nations on earth, with about 70% of her population said to be living in extreme poverty.[12] A significant number of her population (52.2%) inhabit rural communities where impoverishment is more prevalent, with inadequate nutrition and poor health care services.[13]

5.0 Overview of the Nigerian Health System

In 2000, the World Health Organisation (WHO) ranked Nigeria's health care system 187 out of 191 countries. Since then, the country has worked to design various policies and plans to address the poor state of the healthcare sector. While progress has been slow, the government through the federal ministry of health has continued in its efforts to improve the system.
As part of its efforts to strengthen the healthcare delivery system, the federal government of Nigeria in 2009 developed the National Strategic Health Development Plan (NSHDP I) to provide an all-embracing framework for sustaining health care development in the country. The NSHDP was an attempt to address what it described as the underlying weaknesses of the Health Sector Reform Programme of 2004-2007. Its goal was therefore to 'significantly improve the health status of Nigerians through the development of a strengthened and sustainable health care delivery system'[14]. Its aim was to achieve 'collective ownership, adequate resource allocation, inter-sectoral collaboration, decentralization, equity, harmonization, alignment and mutual accountability"[15] and it was to be executed over a period of six years (2009-2015).
The second National Strategic Health Development Plan (2010-2015) succeeded the first National Strategic Health Development Plan. The end-term evaluation of the NSHDP I showed impressive accomplishments such as the "domestication of the Primary Health Care", enactment of the National Health Act 2014 which established the Basic Health Care Provision Fund. Hence the purpose of the NSHDP II is to continue the successes of NSHDP I and surmount the challenges identified in end-term evaluation of NSHDP I. Some of the challenges of NSHDP I include: "gaps in political will and poor programme ownership at lower levels especially state and LGA levels; weak donor coordination and harmonization of development and technical assistance; low level of government financing of healthcare at the three levels of government; weak M&E systems to monitor implementation of the state Strategic Health Development Plans and weak Primary Health Care structures"[16] . The NSHDP II surpasses the NSHDP I because it incorporated a monitoring and evaluation plan to track the progress in attaining targets and promoting healthy living for all Nigerians[17].

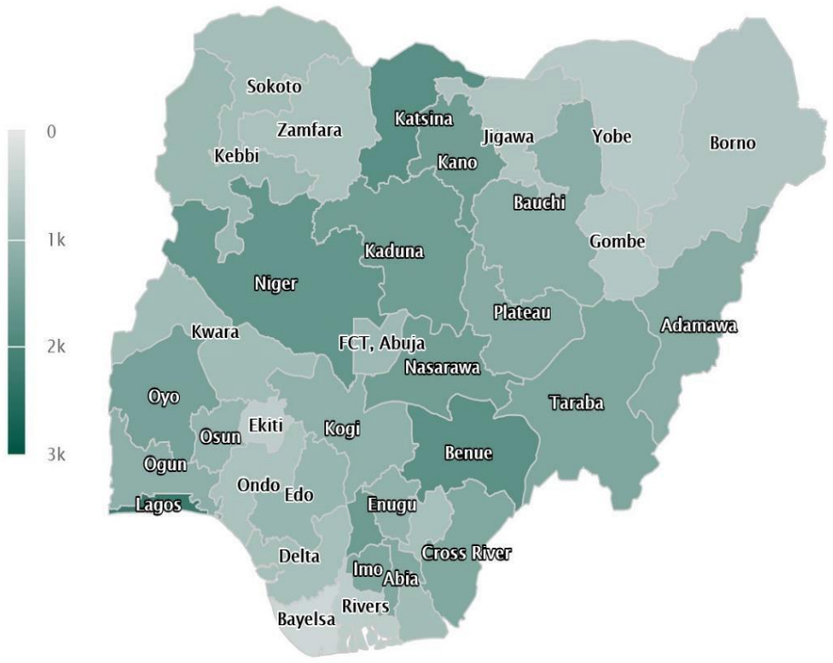
Nigeria's Healthcare Delivery System



5.1 Structure of the Healthcare System

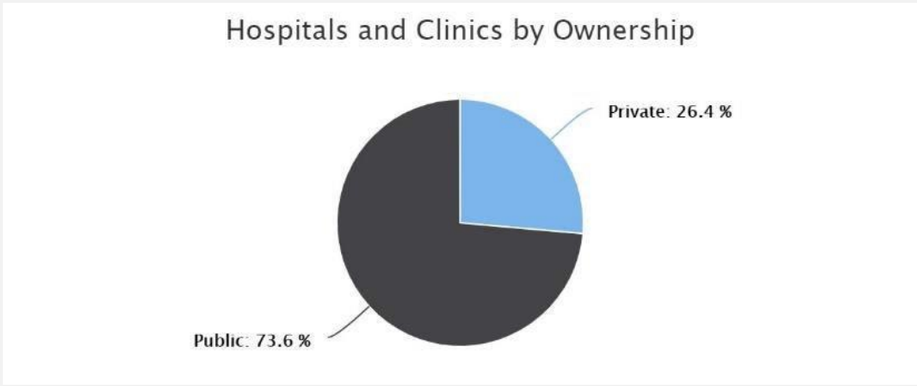
Nigeria's three-tier health system includes primary, secondary and tertiary healthcare facilities. According to the National Health Policy , the federal government through the Federal Ministry of Health is responsible for health care delivery at the tertiary level, State ministries of health are responsible for the secondary level and the Local Governments are responsible for primary healthcare. Health service delivery is however provided by both public and private organisations with most of the public institutions in the northern part of the country and the private ones in the south. Nigeria also embraces a pluralistic healthcare system with the adoption of traditional / alternative medical practice along with the orthodox health care provisioning. The Federal Ministry of Health has overall responsibility for driving the development of policies, plans and regulations for all players in the sector.

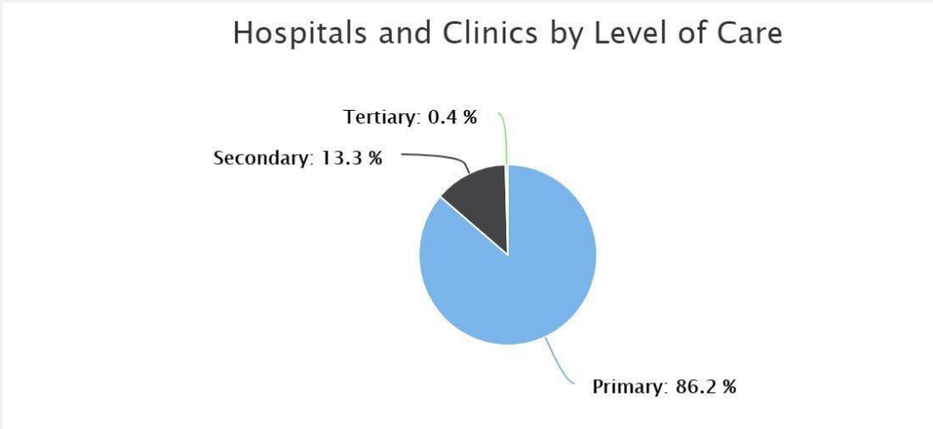
Figure 2: Map of Nigeria showing the distribution of hospitals and clinics



In total, the Nigerian Health Facility registry has on its record, 40,668 operational hospitals and clinics as at 2019. The Federal Ministry of Health (FMoH) estimate of the overall health facilities in the country puts primary health care centres to be about 87.9% of total available facilities, while the secondary and tertiary centres accounts for 11.6% and 0.5% respectively.

Of these, private facilities account for about 30% of the facilities but provide up to 60% of the healthcare needs of the population. The northern part of the country holds the largest percentage (58.87%) of the primary health care centres in the country while the southern part of the country holds (41.13%) of the public primary health care centres.



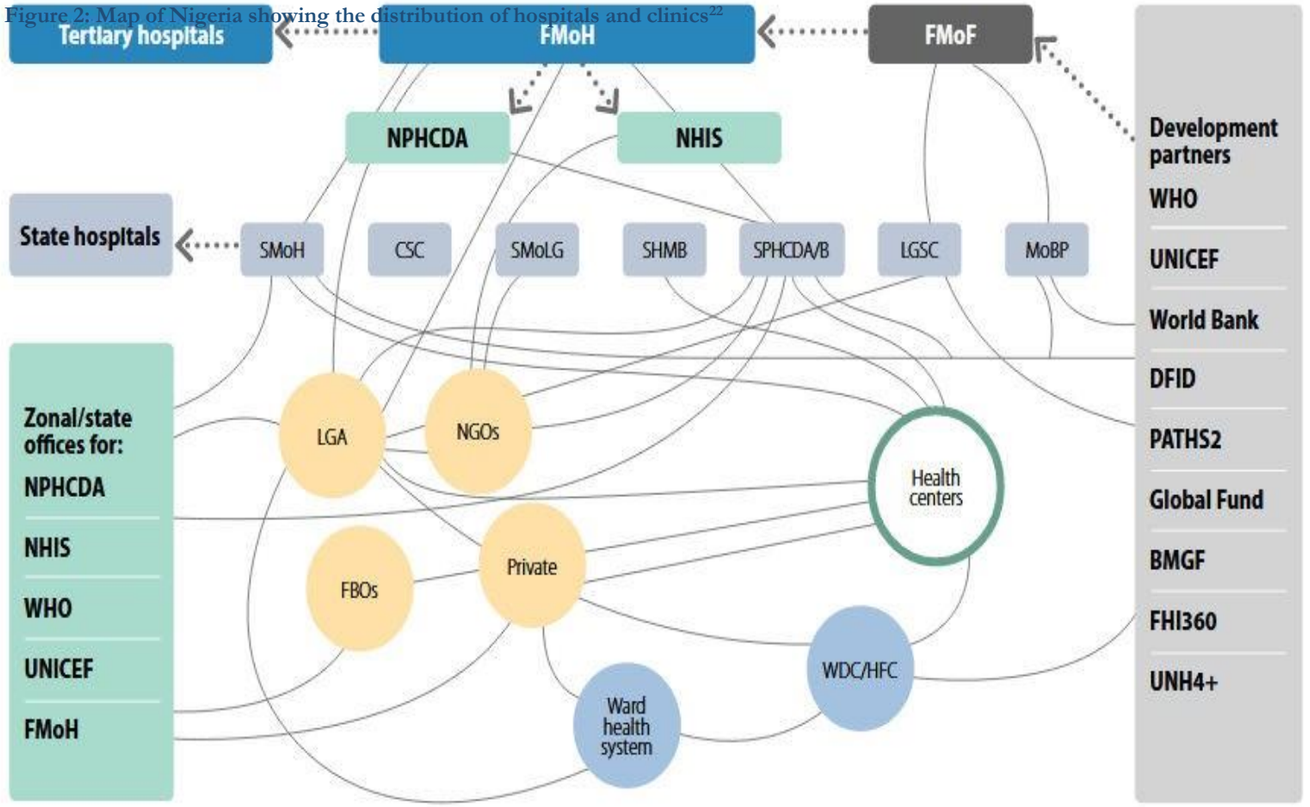


5.2 Primary Health Care (PHC) in Nigeria

The Alma Ata declaration of 1978[18] formulated primary health care (PHC) as a grassroots process towards a global and fair health care for humanity. The purpose of PHC is to combat the key health issues in local areas by ensuring the provision o f advance, precautionary, curative and rehabilitative health services. The World Health Organisation (WHO) defined PHC as a "whole-of-society approach to health that aims to ensure the highest possible level of health and well-being, and their equitable distribution, by focusing on people's needs and preferences (as individuals, families, and communities) as early as possible along the continuum from health promotion and disease prevention to treatment, rehabilitation and palliative care, and as close as feasible to people's everyday environment"[19]. The WHO firmly asserts that PHC is entrenched in a dedication to "social justice, equity and participation" and it is recognized as a fundamental right of every individual.

In Nigeria, the National Primary Health Care Development Agency (NPHCDA) supports the execution of the National Health Policy with respect to primary health care. The National Health Policy defined primary health care as "main focus for delivering effective, efficient, quality, accessible and affordable health services to a wider proportion of the population".[20] Hence, the primary health care centres act as the base of the healthcare system as they are the first point of contact for most Nigerians to seek solutions to temporary, simple health issues. The primary health care level is also the level at which efforts towards educating the citizenry about health issues and health promotion are tackled, and patients needing secondary health care are connected to the required specialized services. Primary health centres have been known by various nomenclatures including Comprehensive Health Centres (CHC); the Primary Health Centres (PHC) and the Basic Health Clinic (BHC)[21].

Figure 2: Map of Nigeria showing the distribution of hospitals and clinics[22]



Key: FMoH - Federal Ministry of Health; FMoF -Federal Ministry of Finance; NPHCDA -National Primary Health Care Development Agency; NHIS - National Health Insurance Scheme; SMoH - State Ministries of Health; CSC - Civil Service Commission; SMoLG - Ministries of Local Government Affairs; SHMB - State Hospitals Management Board; SPHCDA/B - State Primary Health Care Development Agency/Board; LGSC - Local Government Service Commission; MoBP - Ministry of Budget and Planning; WHO - World Health organisation; UNICEF - United Nations Children's Fund; LGA - local government area; NGOs - non-governmental organisations; FBO - faith-based organisations; WDC/HFC - Ward Development Committee/Health Facility Committee; DFID – Department for International Development; PATHS2 - Partnership for Transforming Health Systems phase II; BMGF - Bill & Melinda Gate Foundation; FHI360 - Family Health International 360; UNH4+ - United Nations Health 4+ [23]

The four critical approaches to PHC in the country are as follows: (i) Further community involvement in planning, management, monitoring, and evaluation; (ii) Enhance inter-sectoral alliance in primary health care delivery; (iii) Boost practical consolidation at all levels of the health system and (iv) Reinforce managerial procedures for the development of health at all levels.[24]

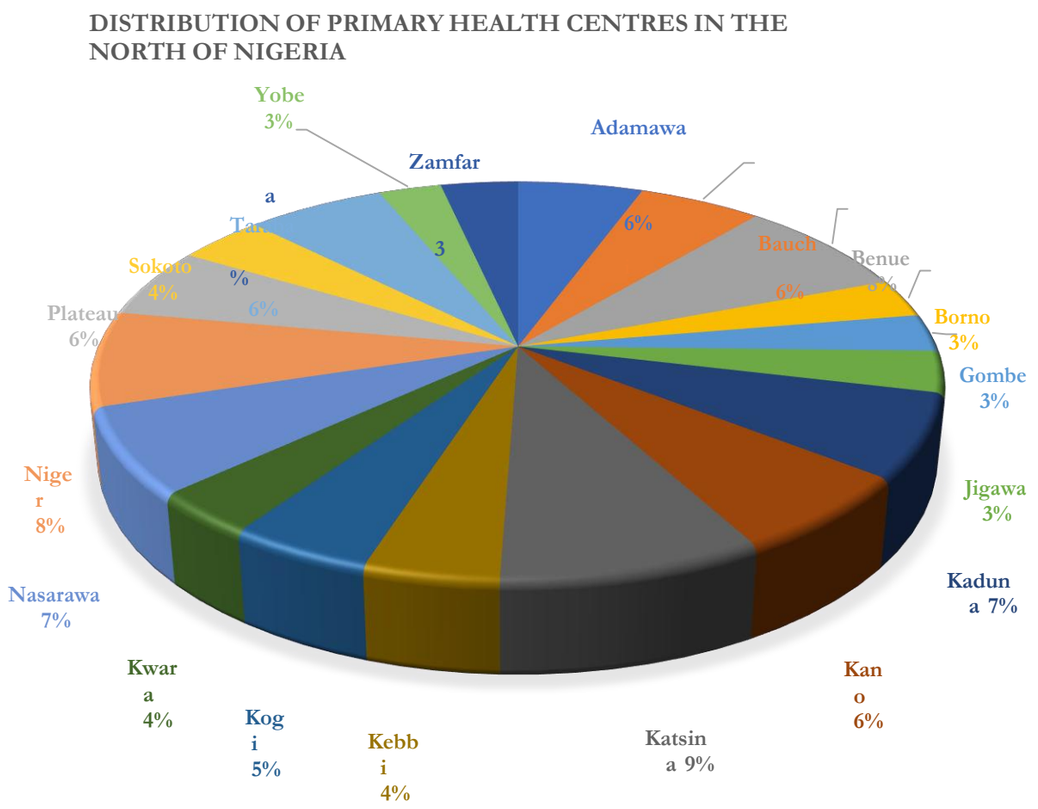


Figure 4: Primary Health Care Centres in Northern Nigeria

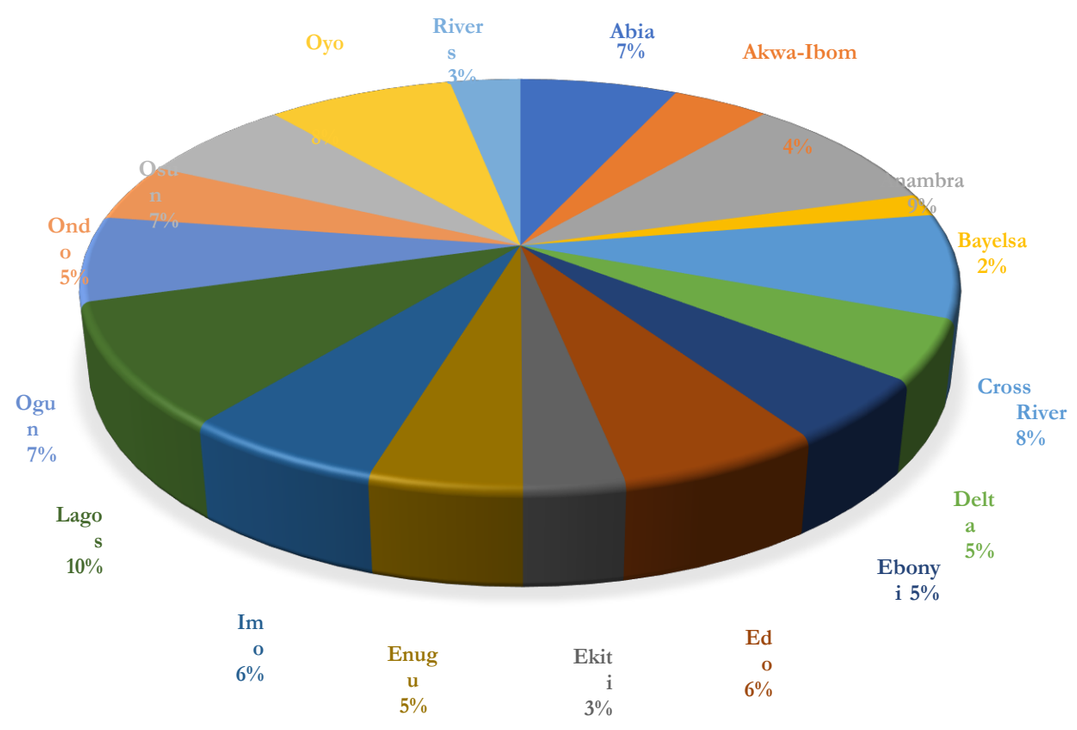


Figure 5: Primary Health Care Centres in Southern Nigeria

5.3 Secondary Health Care (SHC) in Nigeria

Secondary health care in Nigeria is the responsibility of the state governments. Secondary health care serves the needs of the people for advanced health care that the primary health care facilities are not equipped to provide whether in terms of personnel or equipment. Secondary healthcare facilities in Nigeria include the general and state hospitals. One of the challenges of the Nigerian health sector is the sub-optimal state of the secondary healthcare system. Strengthening the secondary healthcare system has remained a recurring area of focus in the two strategic development plans, particularly emphasizing the need for state governments to improve funding of the secondary healthcare facilities.

DISTRIBUTION OF SECONDARY HEALTH CENTRES IN THE NORTH OF NIGERIA

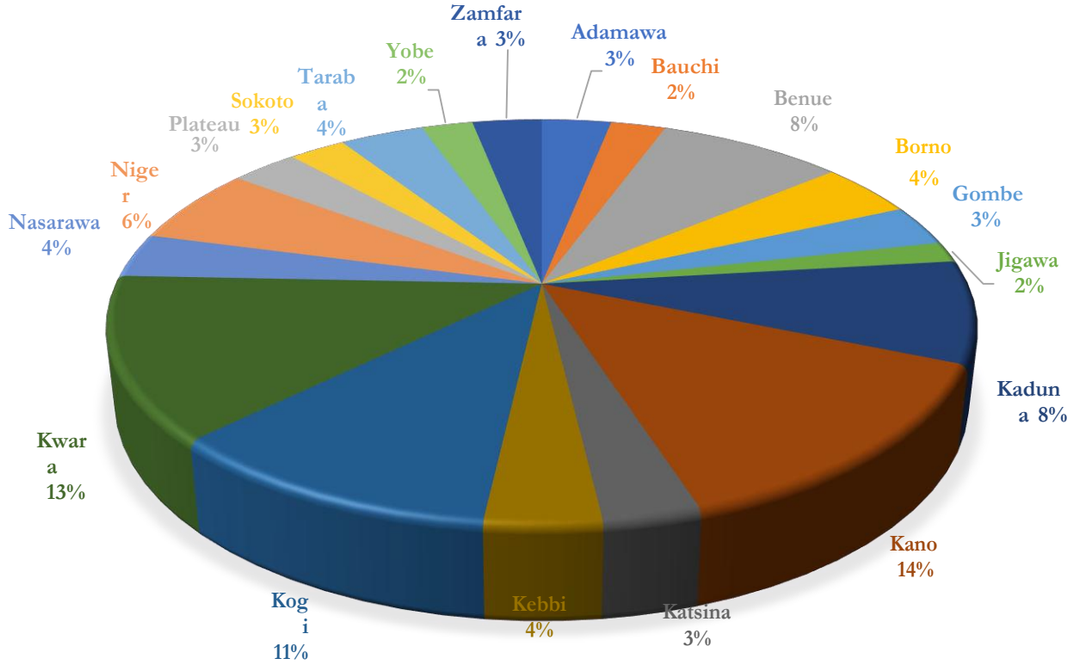


Figure 6: Secondary Health Care Centres in Northern Nigeria

DISTRIBUTION OF SECONDARY HEALTH CENTRES IN THE SOUTH OF NIGERIA

Figure 7: Secondary Health Care Centres in Southern Nigeria

5.4 Tertiary Health Care in Nigeria

The Federal Government, through the Federal Ministry of Health is responsible for the Tertiary health care systems which include the teaching hospitals and the federal medical centres. However, the services are provided both by the public and private health institutions. Tertiary healthcare services are highly specialized services requiring very technical equipment such as cardiology, intensive care unit and specialized imaging units and so on. Patients would typically be referred to the tertiary health centres from the primary and secondary centres when the level of care required is not available in the latter.

DISTRIBUTION OF TERTIARY HEALTH CENTRES IN THE SOUTH OF NIGERIA

Figure 8: Tertiary Health Care Centres in Southern Nigeria

DISTRIBUTION OF TERTIARY HEALTH CENTRES IN THE NORTH OF NIGERIA

Figure 9: Tertiary Health Care Centres in Northern Nigeria

5.5 Traditional, Complementary & Alternative Medicine

According to the WHO, Traditional, Complementary and Alternative medicine (TCAM), 'is the sum total of the knowledge, skill, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness.' The World Health Organisation (WHO) has supported traditional medicine in the continent of Africa, particularly for less developed countries of the world in order to buttress the 1978 Alma Mata declaration on primary health care.

The Nigerian Institute for Medical Research includes the Centre for Research in Traditional Complementary and Alternative Medicine which was established in 2017 to support the WHOs work to integrate this form of medicine into the mainstream of medical practice in Nigeria and across the world. Part of its mission is also to work with the Nigerian government at all levels to develop policies and plans for to make TCAM part of the strategy for keeping the population healthy.
While it is therefore formally recognized as one of the healthcare mechanisms in the country, it is still fairly undeveloped with respect to structure and is therefore not included in this study.

5.6 Health Insurance in Nigeria

At the presidential summit on Universal Health Coverage held in March 2014, the Nigerian government declared that health is a fundamental right of every human being, and it is the responsibility of government to assure that right is not violated. Hence, the National Health Act was promulgated in 2014 setting out a framework for the regulation, development and management of the Nigerian health system. In addition to this framework, the Act also establishes mechanisms to facilitate universal access to basic health services to vulnerable populations and the country in general. One of such mechanisms is the Basic Health Care Provision Fund of which 50% is to be allocated for the provision of basic minimum health care to the people through the National Health Insurance Scheme (NHIS). The rest of the fund is to fund the provision of drugs and vaccines, the procurement and maintenance of health facilities, equipment, and transportation, developing the human resources in primary health care facilities, and emergency health care treatment.

To make healthcare more accessible and affordable to Nigerians, The National Health Insurance Scheme (NHIS) was established under Act 35 of the 1999 Constitution. The NHIS was implemented in 2005, six years after its legal architecture was passed into law. The aim of NHIS was to provide comprehensive health services at modest cost to workers in the formal sector (employees in the federal civil service, ministries, parastatals and agencies and corporations) and self-employed Nigerians[25]. It also provides in-patient and outpatient care for the insured, spouse and four dependents under the age of 18[26]. The overall purpose of the NHIS is to provide social health insurance[27] through the pool of funds contributed by the participants of the NHIS scheme[28].

The operation of the NHIS is through a pre-payment plan and the payment of a fixed regular amount to allow Health Maintenance Organisations (HMOs) to attend to the needs of those seeking health care services. The government makes the provision of the guidelines of the scheme and ensures its compliance for the smooth running of the established scheme. The contributions of the formal sector to the social health insurance are earning related. In the public sector, the employer contributes 3.5% while the employee contributes 1.75% of the consolidated salary of the employee. In the private sector, the employer contributes 10% while the employee contributes 5% which represents 15% of the basic salary of the employee. It should also be noted that the entire contribution can be borne by the employer alone, and the employer may make provisions for additional contributions to the insurance package for extra cover.[29] NHIS also regulates HMOs in charge of private health insurance. There are a total of 60 HMOs in the country registered with the NHIS.[30]

6.0 Challenges in the Nigerian Health Sector

By 2017 estimates, life expectancy at birth in Nigeria was 53.8 years, compared with other African countries such as South Africa at 63.8, Kenya at 64.3 and Ghana at 67 years. Currently (2020 estimates) life expectancy at birth is 60.4 and is still one of the lowest in the world.[31] According to the World Health Organisation, four attributes define a well-functioning healthcare system - i. A steady financing mechanism, ii. Properly trained and adequately paid workforce, iii. Well- maintained facilities and iv. Access to reliable information for decision-making.
In 2000, the WHO ranked Nigeria 187th out of 191 member countries due to the deplorable state of her health care system.[32] The health care system has been identified as inefficient and weak because of poor coordination, dearth of crucial health resources (e.g. drug and medical supplies), poor health infrastructure and inefficient quality of health care. As at 2016, the World Health Organisation (WHO) presented statistics on the Nigerian health sector:

i. Population: 185,990,000
ii. Life expectancy at birth m/f 55/56
iii. Probability of dying under five (per 1 000 live births, 2017) 100 irths, 2016) 372/333
v. Total expenditure on health per capita (Int $ 2014) 217
vi. Total expenditure on health as % of GDP (2014) 3.7

While deliberate efforts to improve the sector are ongoing, the nation continues to struggle under the burden of providing adequate healthcare services as a result of underfunding, poor administration and coordination. In addition, Nigeria's burgeoning population continues to put huge pressure on the already struggling healthcare system with obsolete equipment, decaying physical facilities and shortage of skilled Human Resources for Health (HRH). Fifty-five percent of the Nigerian population dwell in rural communities and lack access to adequate healthcare services. The private sector provides a large chunk of the country's healthcare needs with a large majority unable to afford the huge cost of good private Medicare. At the local government level, health care remains poorly funded and poorly managed and this has created a fragile foundation for the nation's health care system.[33]
We explore some of the issues in more detail below.

6.1 Human Resources for Health

According case studies prepared by the Global Health Workforce Alliance "The Nigerian health sector is facing a major human resource for health crisis, with mal-distribution of the available workforce and the increasing 'brain drain' resulting in shortage of critically needed health professionals"[34] Nigeria faces a major challenge of ensuring the continued supply of skilled health personnel for the nation. The World Health Organisation in its policy document titled "Global Strategy on Human Resources for Health: Workforce 2030" noted that the global investment in the health workforce is far below what is desirable and has reduced workforce and health processes sustainability.[35] According to the WHO, shortages in the Human Resources for Health (HRH) has contributed to the mobility in global labour and recruitment of health workers from countries with low resources. WHO further estimated that by 2030, there would be a shortfall of 18 million HRH, mostly from low and lower-middle-income nations. The challenges countries face varies from education, jobs, retaining, deploying, and ensuring the performance of the health workforce. In the Countdown to 2015 Decade Report, the WHO puts the physician-to-patient ratio in Nigeria as four doctors per 10,000. Whereas in the UK, the physician-to-patient ratio is 28 doctors per 10,000 people, in the USA, 26 doctors per 10,000 people[36]. In Mauritius, the physician-to-patient ratio is 2 doctors per 1,000 people[37].
For many years, Nigeria has not only faced a dearth of adequately skilled health care professionals, it has also faced an inequitable spread of the health workers that are available. The World Health Organisation (WHO) identified the southern part of the country as having the largest concentration of health care service provisioning, particularly Lagos. The inequity in the spread of health workers have been attributed to:

i. The favouritism for indigenous hires.
ii. Poor coordination among private and public sector
iii. Poor quality of workers as a result of commercial pressures in the private sector.
iv. Low motivation on the job, sub-optimal productivity and high attrition rate in the health sector environment with emphasis on rural areas.
v. Overproduction of some categories of health personnel and a lack of other key health personnel.

6.2 The huge burden of disease

Nigeria faces a huge burden of disease characterized by a high incidence of both communicable and non-communicable diseases[38]. According to the Federal Ministry of Health, the leading cause of morbidity in Nigeria are communicable diseases constituting as much as 55.4%, while one of the leading causes of mortality is Malaria, constituting about 17.1% of the proportion of total deaths. Statistics from the World Health Organisation – Non-Communicable Diseases (NCD) showed that NCDs accounted for 29% of all deaths in the country. The statistics are as follows: 11% cardiovascular diseases, 4% cancers, 2% chronic respiratory diseases, 1% diabetes, injuries 8% and 12% other NCDs. WHO statistics showed that communicable, maternal, perinatal and nutritional conditions accounted for 63% of diseases[39]. The table below presents a comparison with Ghana, South Africa and Kenya.

Nigeria	%	Ghana	%	Kenya	%	South Africa	%
NCDs	29%	NCDs	43%	NCDs	27%	NCDs	51%
Cancers	4%	Cancers	5%	Cancers	10%	Cancers	10%
Chronic respiratory diseases	2%	Chronic respiratory diseases	2%	Chronic respiratory diseases	1%	Chronic respiratory diseases	4%
Diabetes	1%	Diabetes	3%	Diabetes	1%	Diabetes	7%
Other NCDs	12%	Other NCDs	13%	Other NCDs	8%	Other NCDs	11%
Injuries	8%	Injuries	10%	Injuries	10%	Injuries	9%

Source: World Health Organisation - Non-Communicable Diseases (NCD) Country Profiles, 2018

6.3 Adequacy of facilities and service delivery

The Nigerian Health Facility Registry (HFR) reports that Nigeria has a total of 40,463[40] operational hospitals and clinics by levels of ownership (public and private). Across the 36 states and FCT, Public ownership of hospitals and clinics make up 29,861 of these facilities, and private ownership of health facilities make up 10,602. The total number of hospitals and clinics by level of care is 40,463. Across the 36 states and FCT, primary health care has a total of 34832 facilities, secondary health care has a total of 5464 health facilities, and the tertiary health care has a total number of 167 health care facilities[41]. The private sector provides as much as 60% of the healthcare needs of the country 'through 30% of the conventional healthcare facilities'[42].

6.4 Healthcare financing & spending in Nigeria

Despite various interventions at the federal and state levels, Nigerians continue to face rising health expenditure. The expenditure on health (out-of-pocket expenses) stood at 70%[43]. The World Health Organisation (WHO) defined out-of-pocket payments (OOPs) as "direct payments made by individuals to health care providers at the time of service use". Health insurance provides a financial safeguard against the costs of accessing health care services. While the national health insurance scheme has been in operation in Nigeria since 2005, its uptake has been very low with just about 3% of the health care expenditure in the country going through health insurance service providers.

On a broader note, for many years, the allocation to the health sector has been paltry. The government has consistently failed to meet the specified budgetary allocation for the health sector in spite of the 2001 Abuja Declaration, which specified that a minimum of 15 percent of yearly budgets of the endorsing countries be allotted to health care on the continent of Africa[44]. The table below shows the budgetary allocations to the health sector from 2013-2020. Much of these funds have been concentrated on recurring expenditure at the expense of much-needed capital investments in the sector[45].

Table 2: Budgetary allocations to the health sector[46]

Year	Allocations to the Health Sector	Percentage of Allocations %
2013	₦270 billion naira	5.5%
2014	₦216.40 billion naira	4.4%
2015	N237 billion naira	5.5%
2016	₦282.1 billion naira	5%
2017	N304 billion naira	4.6%
2018	N340.45 billion naira	3.9%
2019	₦424.03 billion naira	3.4%
2020	₦427.30 billion naira	4.14%

Other challenges related to leadership and governance include: inadequate political will and commitment to health, as evidenced by low budgetary allocation to health; constant change in leadership of the FMoH and the SMoHs; high level of corruption and fraud; inadequate level of accountability and transparency; ineffective coordination among the three levels of government, as well as between the private and public sectors; lack of effective mechanisms for engaging consumers in policy and plan development and implementation; weak donor coordination and harmonization of donor aid.

7.0 The ethics of care

The practice of medicine is rooted in a covenant of trust among patients, physicians and society. The ethic of medicine must seek to balance the physician's responsibility to each patient and the professional, collective obligation to all who need medical care.

- The Council of Medical Specialty Societies, 2000

The above quote sums up the principles of healthcare ethics across various disciplines in the healthcare field. The term "ethics" originated from the Greek word ethos meaning behaviour. Ethics is concerned with conduct classified as right or wrong, good or bad. The application of moral rules and values to the activities of human beings is referred to as ethics[47]. A form of applied ethics is healthcare ethics which is concerned with the judgments and moral values applied to the field of medicine. This began in the evolution of medicine during the ancient civilization with the introduction of the Hippocratic Oath which is very important today as it is the "constitution" upheld by medical doctors inducted into the medical field in many countries across the world. In the opinion of Kirsti Dyer, 'ethics can be viewed as a prerequisite for the success of medical practice, much the same way that safety is a prerequisite for the success of airline travel'[48].

The focus of healthcare ethics is very broad because it encompasses ethical issues experienced by health researchers, health policy makers, health professionals, communities, patients and families in aspects related to health such as clinical services, epidemiology, public health, information technology, and the use of animals in health research[49]. Healthcare ethics is the aggregation of ethical dimensions of health previously ascribed to medical field such as biopharmaceutical and so on and the ethics of business related to stakeholders engaged in the provision and rendering health services to the people.

While there are several ethical frameworks that could drive a discussion on healthcare ethics, the principle of Principlism has stood out among them over the last three decades. Its proponents argue that it takes a universal and practical approach to ethical behaviour in a way that makes it widely adaptable regardless of customary, cultural or local beliefs[50].

7.1 Principlism

Principlism is a commonly used ethical framework in healthcare and biomedical ethics, and it is defined by four principles including – (i) autonomy (ii) beneficence or goodness (iii) nonmaleficence (iv) justice[51]. We explain these briefly below:

7.2 Autonomy

The word auto in Greek means "self" and nomos means "rule". In the context of moral philosophy, autonomy refers to "personal self-governance" – free from controlling influences, interferences or limitations that prevent freedom of choice[52]. Respecting the autonomy of the people in healthcare includes a moral obligation for healthcare professionals to keep their patients records and information confidential. The obligation to keep patient's information confidential helps in promoting trust. Autonomy as an ethical norm also advocates the freedom of choice for the individual and freedom from control. It rests on two key pillars which are: liberty (ability to withstand domination) and agency (putting the physical and mental capacity of a person to action)[53]. In expressing liberty, the patient must be granted full access to information about his/her health care and the health care provider is under obligation to respect the autonomy of the patient. In exercising agency, the patient must understand the full details of the disclosure in order to make an enlightened decision about their ongoing treatment.

7.3 Beneficence

The second ethical principle – beneficence means that goodness as an obligation should always be promoted. The healthcare professional does this by acting in the patient's best interest at all times. The word bene originates from a Latin word meaning "good". It means that individuals are obliged to take impactful steps to assists others. The terms that showcase this principle are love, humanity, kindness, charity and altruism[54]. Beneficence is an important principle in healthcare ethics and while the society in general may not be considered negligent by not demonstrating beneficence, the same cannot be said of the healthcare professional.

7.4 Nonmaleficence

The third ethical principle – nonmaleficence means that healthcare professionals must uphold the obligation not to inflict injury or harm on their patients as a result of inappropriate, inadequate or absent care. It also refers to the avoidance of the source of harm. It stands on the proclamation of primum non nocere, meaning 'first, do no harm'. There is no debate in healthcare ethics over the requirement to avoid causing harm.
The definition of "harm" in this context is worsening the situation of a patient in the process of healthcare provisioning. The failure to monitor a patient or equipment properly can lead to jeopardy for the patient and the institution.
Moreover, the disposal of hazardous materials without taking into consideration the health of the community is another dimension of harm. Harm can also be referred to as negligence in several ways that it occurs.

7.5 Justice

A civilized society is governed by the cultural, moral and legal principles of justice. Justice refers to the moral commitment of fairness, that is, a standard that requires the "equal distribution of benefits, risks, and costs among all involved groups"[55]. The term justice relates to the respect of the rights of the people and in the practice of health care, everybody has equal rights. Justice in health care has been divided into three categories: distributive justice, legal justice and rights- based justice[56].

7.5.1 Distributive Justice

This focuses on the distribution of scarce resources such as medical expertise, privacy and communicatory content in the context of error situation. Distributive justice requires that scarce resources in healthcare should be distributed equally among patients. This also implies that health care providers are obligated to ensure that competent health professional are available to patients on a need basis.

7.5.2 Legal Justice

It is always expected that patients and health care providers respect the law of the land. There are situations where ethical and legal standards clash and this may be related to a lack of cohesion between the two areas. The two areas (ethics and law) are inclined towards disclosure, but disclosure in terms of ethics is not adequately protected and covered by the law of the land. The medical and dental practitioners affirm that a medical or dental practitioner should be proactive in promoting the well-being of the patient and accord him or her full respect to his or her dignity[57]. Legal justice also seeks to compensate patients when the error of the health practitioner harms them. It also means that patients should be aware of their rights and the financial reparations that accrue as a result of the failure of the medical practitioner[58].

7.5.3 Rights-based justice

Patients are desirous of getting comfort and support from their health care provider. The rights and obligations of health care providers and patients are necessary to ethical decisions and avoiding dilemmas. Rights-based justice emphasizes the respect for people's rights rather than recourse to the law. The general belief in the healthcare industry is that all persons have equal rights in the process of seeking healthcare and to participate in the health care procedure[59]. Health workers are obligated to inform the patient of the truth of their health status and also protect their health information. There is the possibility of contradictions occurring in the case of an adverse event related to insurance coverage and disclosure. Due to the tensions that may arise, an ethical procedure is needed to eliminate these dilemmas.

8.0 The Ethics of Care in the Nigerian Health Sector

In the words of a WHO video, 'taking ethics into consideration puts people at the heart of the problem.' It is reasonable to conclude therefore, that countries with very high rankings on the health systems indexes have put people at the heart of the problem, and that a valuable way to evaluate the state of the health care sector in any environment is to feel the pulse of key participants regarding their experience of the ethical state of that health sector. Therefore in Part B of this work, we present our research on the experience of ethics in the Nigerian health sector guided primarily by the four principles discussed above which succinctly capture the essence of the code of ethics of the medical & dental associations as well as the nursing association. We discuss our findings along the lines of these principles and provide some insights about how users / patients experience ethics in the Nigerian health sector.

We begin with our findings from healthcare users, defined simply as anyone that uses or has used any of the Nigerian healthcare facilities at any time. We follow this up in part C with the findings from the healthcare professionals infused with comparisons with the results from users.

PART B –

USERS' PERSPECTIVE

9.0 Findings

In this section, we present the views of the healthcare users along the lines of the four principles of Autonomy, Beneficence, Non-Maleficence and Justice, along various dimensions such as age, geographical region and level of education, as relevant. We also present our findings with respect to the perception of our study population of the usefulness or otherwise of health insurance, which is one of the critical aspects of the Nigerian Health Policy – the need to provide access to good quality healthcare to all Nigerians regardless of financial capability. In the following section, we begin with a general overview of the characteristics of our survey population, to set the context for the results obtained.

9.1 General Information

Majority of our respondents were based in the south-west. This is not surprising since we visited two states representing the region – Lagos and Ondo states. The north-central represented by Abuja, was however a close second, while the fewest number of respondents were from the north-east (Bauchi), north-west (Kano) and south-east (Abia), largely due to a combination of security concerns, language barriers and time constraints. In terms of numbers, we were only able to reach about 49, 76 and 51 respondents in those regions respectively, within the time frame of this study

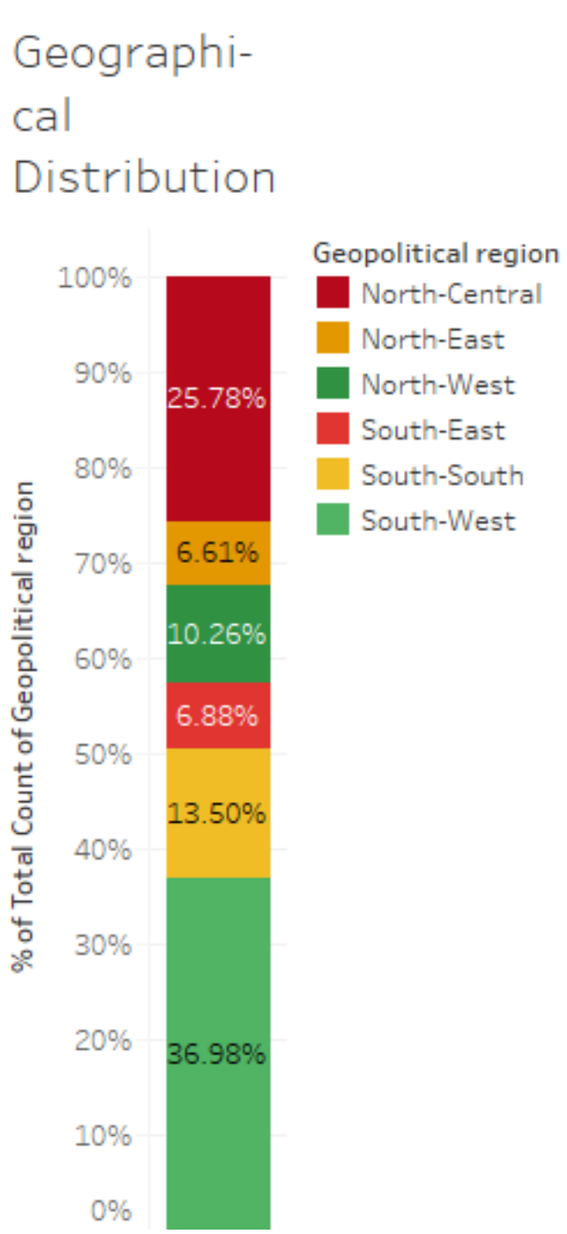


Figure 10: Geographical distribution

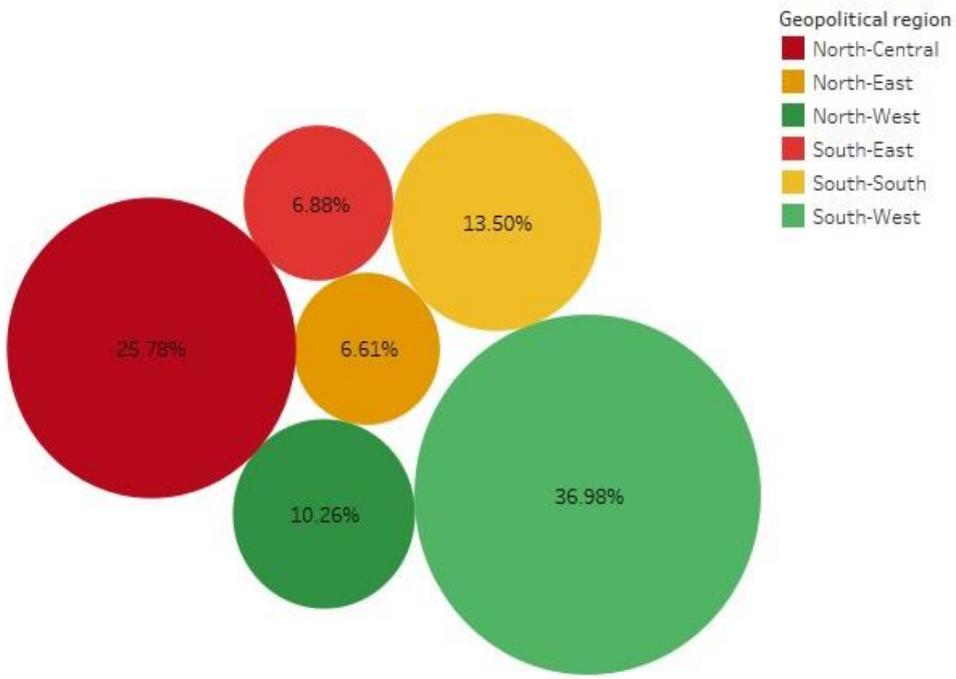
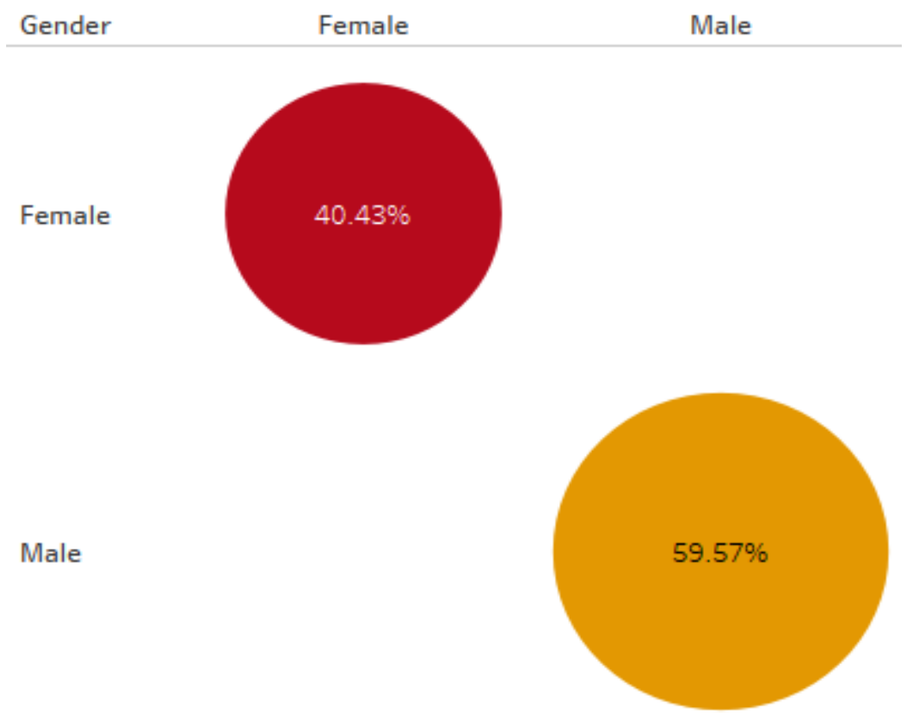


Figure 11: Respondents by region

Our sample included 302 females, representing a little over 40% of the study population. Of these, the south-south had the largest percentage of female respondents, followed by the north-central and north-east.



There were more male respondents across all the regions than female, with the north-central, south-west, south-east and north-west standing out more than the other regions in terms of this disparity. With the exception of the south-south with an almost equal spread, this result was consistent across all regions.

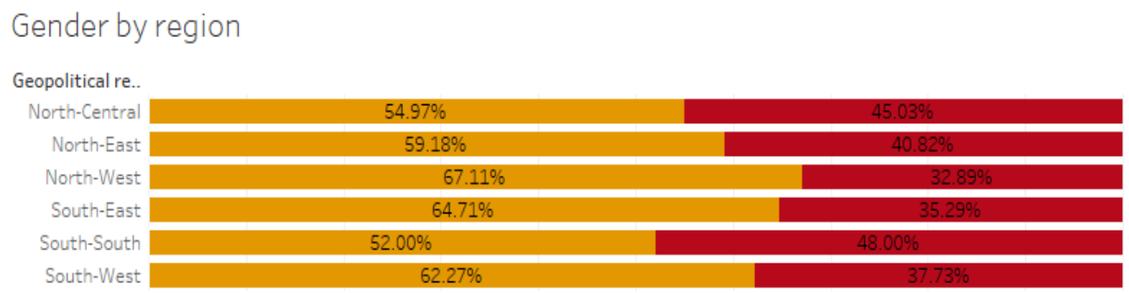


Figure 13: Gender by region

The largest cohort in terms of age, were the age range 26-35 and 18-25. Together, they constituted just over 70% of the study population. This age range seemed to be the most willing to participate in the research.

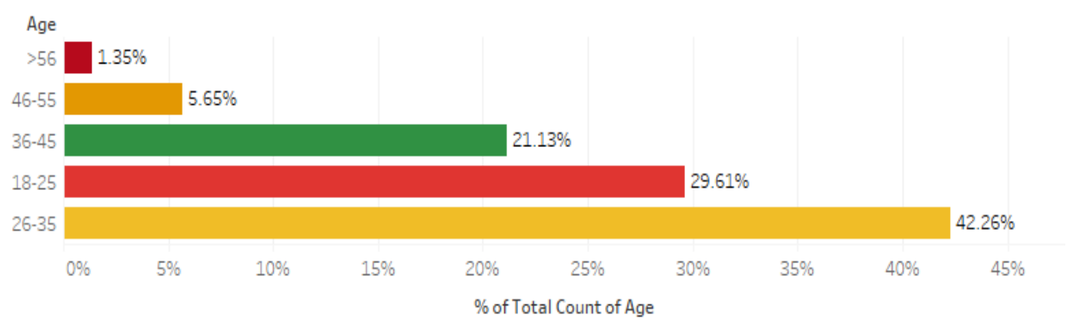


Figure 14: Age

About 67% of our respondents had completed post-secondary education at the time of the study, the largest cohort being first degree holders at 44%. About 23% held a secondary school certificate as their highest educational qualification . Since this was designed as a self-administered survey, it was important that the respondents were able to read and write.

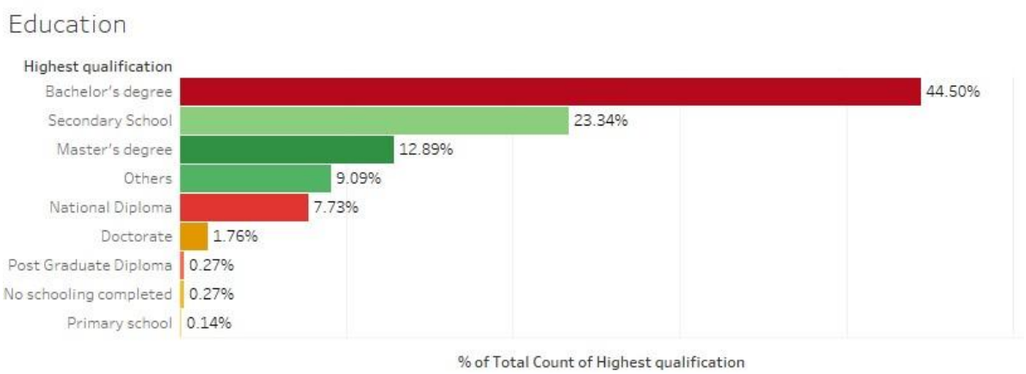


Figure 16: Primary health provider

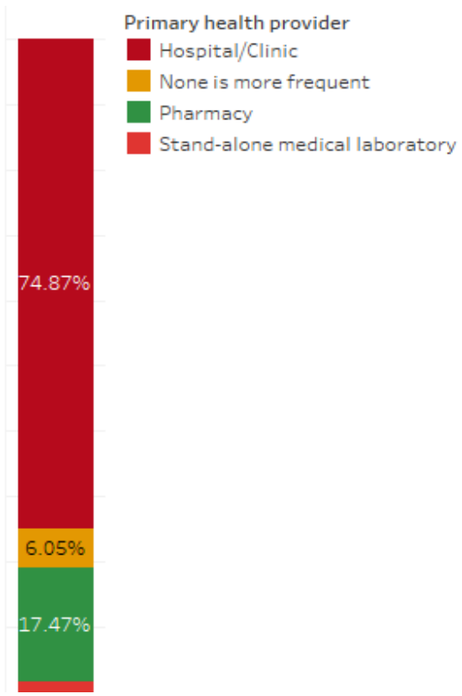


Figure 15: Education

About 75% of the study population reported that their primary healthcare provider was a hospital / clinic. The trend is the same across all age ranges and geographical location.

Primary health provider

Age	Hospital..	None is more fre..	Pharmacy	Stand-alone me..
18-25	62.84%	7.34%	27.52%	2.29%
26-35	77.39%	5.41%	16.56%	0.64%
36-45	84.52%	5.16%	8.39%	1.94%
46-55	88.10%	2.38%	4.76%	4.76%
>56	70.00%	30.00%		

Among our north-central respondents, 82% use hospitals as their primary healthcare provider, while nearly 30% of the respondents in the south-east use pharmacies primarily.

Geopolitical region	Hospital/..	None is more freq..	Pharmacy	Stand-alone me..
North-Central	82.01%	3.17%	14.29%	0.53%
North-East	59.18%	14.29%	24.49%	2.04%
North-West	66.67%	9.33%	22.67%	1.33%
South-East	60.78%	7.84%	29.41%	1.96%
South-South	77.32%	7.22%	12.37%	3.09%
South-West	77.94%	5.15%	15.44%	1.47%

Figure 17: Geopolitical region

With respect to hospital type, our respondents mostly preferred private hospitals to public hospitals. The south-south had the largest proportion of respondents that indicated that they preferred the private hospitals to the public ones, with about 58% responding disagree or strongly disagree to the statement 'I am generally more comfortable using public hospitals than private hospitals in Nigeria'. The north-central, northwest, north-east and south-west followed closely with about 47%-48% .The south-south stood out with the lowest percentage at about only 32% expressing a preference for private hospitals.

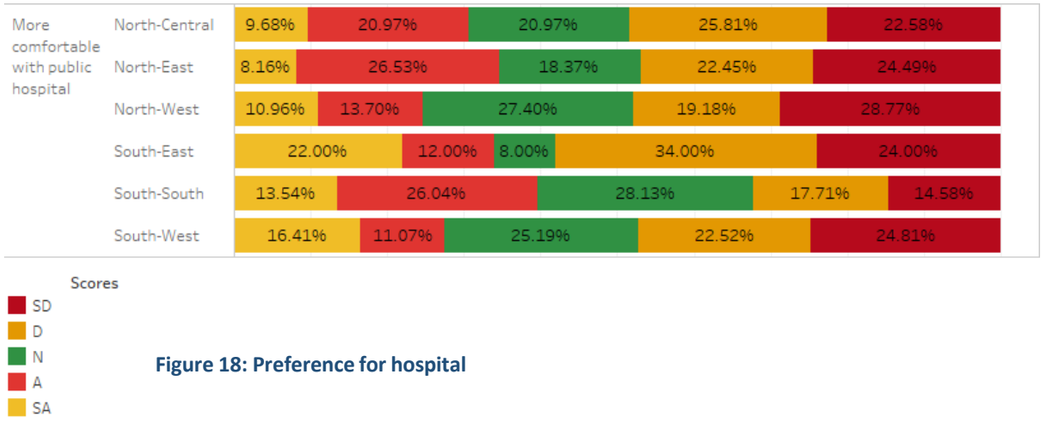


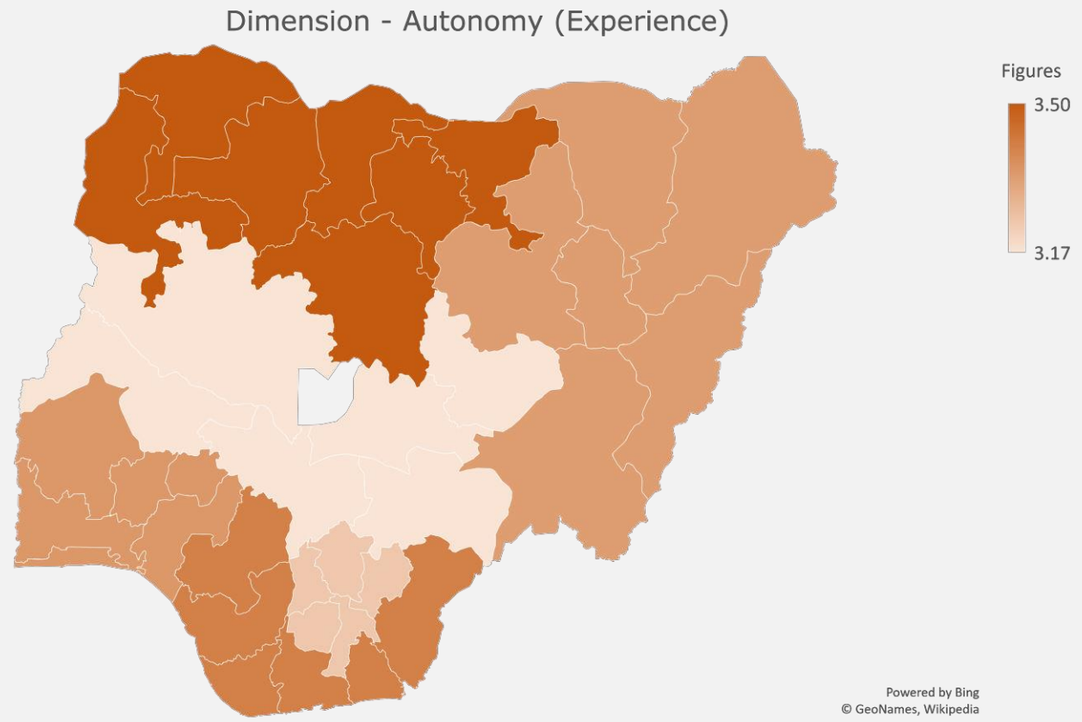
Figure 18: Preference for hospital

As a follow on to the previous data, about 60% of our study population used private hospitals as their primary healthcare provider, while just about 6% used both to an equal extent.

In summary, from the foregoing, we see that our study population is constituted from a diverse demographic and geographic base, so that the views expressed in the next few pages are considerably broad-based. While we recognize that the generalizability of the findings to the general population of Nigeria may be limited, as we will see in the following sections, there are fairly consistent patterns in the views expressed along some dimensions regardless of age, education or geography.

10.1 Principle: Autonomy

Representative statement: – I have considerable control over decisions regarding my health and my healthcare professionals generally give me simple and adequate information to make an informed judgment regarding my health.



For autonomy, we sought to know how respondents felt about the level of control they should have over decisions concerning interventions about their health and the level of control they feel they do have in relation to their healthcare professional. Of the four principles, this was the only one where this distinction was made in the light of debates in Western medicine over how much autonomy patients should have over their health choices vis-à-vis the medical professional, and informed consent. While the level of sophistication in Nigeria about these matters may be relatively low, we believe it was important to understand how Nigerians thought about it on a general level. Hence a distinction was made between patient's expectation regarding autonomy over their healthcare interventions and their experience.

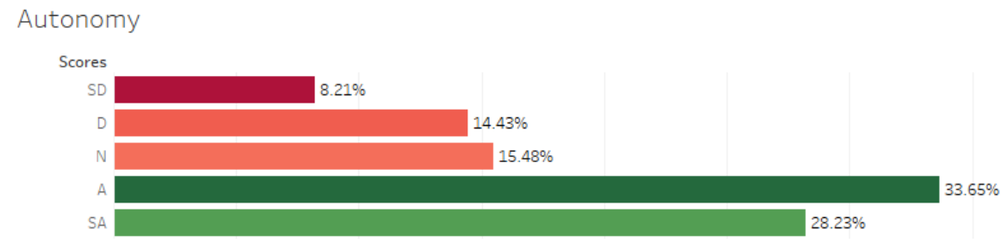


Figure 19: Autonomy

On the balance, about 62% felt it was important for patients to have a measure of control over decisions about their healthcare interventions, having been provided all the relevant information, in a simple and concise manner, by their healthcare professional. However, when a distinction was made between the expectations and experience of the respondents, there was a marked difference in their experience versus their expectation. From the chart below, we see that while about 75% of our study population believed they were entitled to a significant level of autonomy over their healthcare choices, only about 25% believed they were getting the level of autonomy over decisions concerning their healthcare as they required.

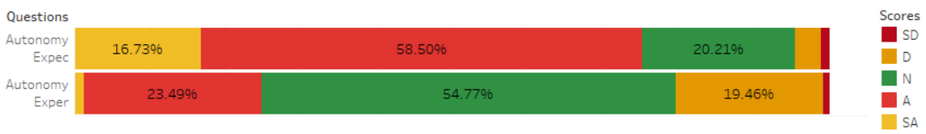


Figure 20: Expectations and Experiences of Autonomy

Using education as a proxy for enlightenment, it is interesting to note that the expectation of autonomy over healthcare choices did not differ significantly by level of education as seen in the chart below. Our respondents were categorized by their level of education into post-secondary and secondary education and below. In both cases, about 75%-80% expected a significant level of autonomy over their healthcare choices while only about 25% believe that they enjoyed some measure of autonomy from their healthcare professionals. It is also interesting to note that in comparison with the other principles, our study population seemed to feel strongly about their expectation of autonomy, so that the proportion of respondents that expressed a neutral view on the matter was relatively small.

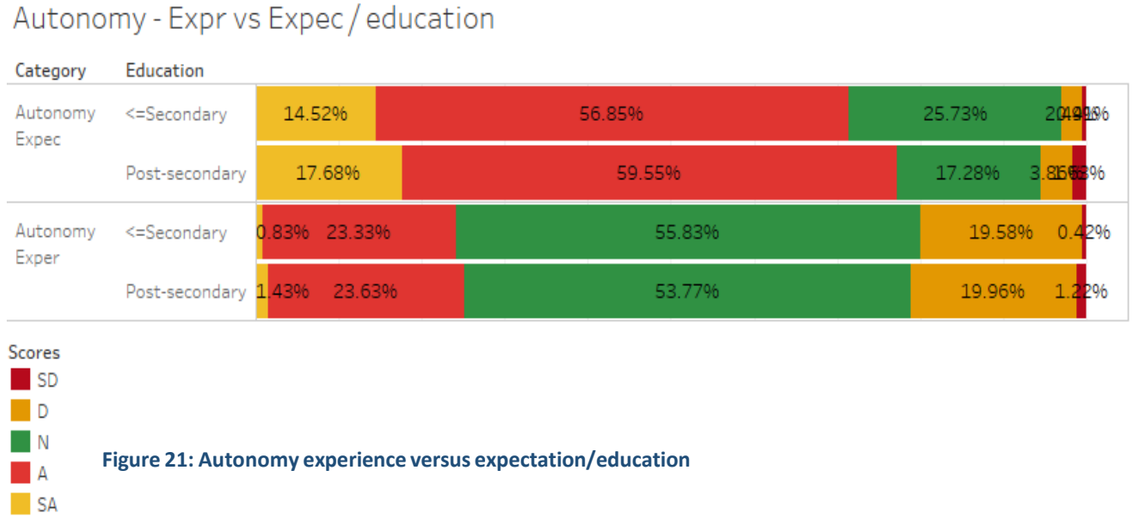
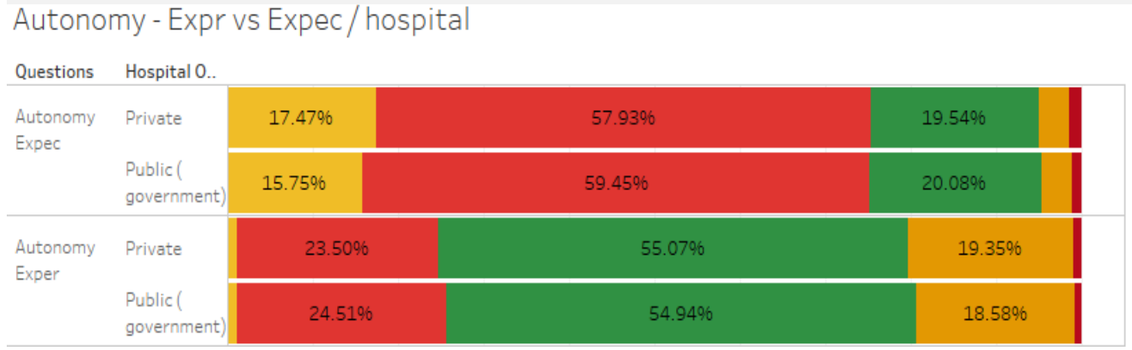


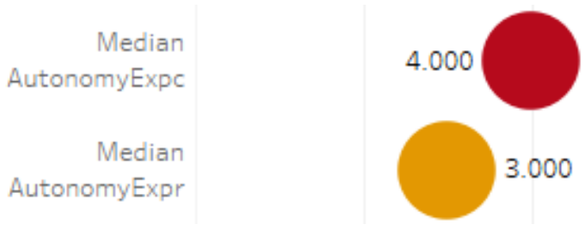
Figure 21: Autonomy experience versus expectation/education

The response was not much different whether our respondents used privately owned hospitals or government hospitals. In both cases, only about 25% indicated that they experienced some level of autonomy in decisions regarding their healthcare interventions.

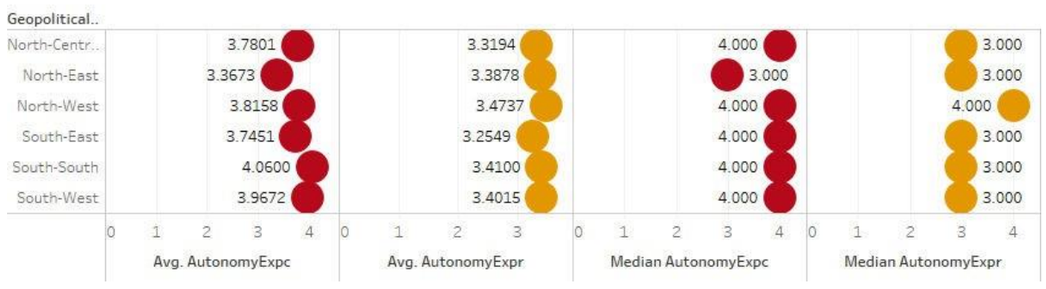


On average, while the general expectation of the level of autonomy patients should have over their health care interventions exceeded their experience as seen below, we could argue that the general expectation of the level of autonomy they should have is low in the light of the Likert scale that defines 4 or 5 as the indicator of agreement with the representative statements.

In the chart below, we see that the median value for expectation is 4, while for experience is 3, suggesting that at least half of the study population had high expectations for autonomy, compared with at least half of the population that felt their experiences did not match up to their expectation.



The pattern was also consistent across geographical regions, except for the north- east where expectation and experience were nearly at par. The south-south region had the widest gap between their expectation and experience of autonomy.



Some specific questions that constitute the Autonomy principle are worth highlighting. While over 75% of our respondents believed they were entitled to a certain level of autonomy over decisions concerning their health, it is interesting to note that about 55% still felt their healthcare professional should have the final say in such decisions.

Asked whether they thought their healthcare professional felt uncomfortable when they asked questions regarding recommended interventions, about half of our survey population responded affirmatively. Conversely, over 80% of respondents believed they had a right to receive simple, adequate and truthful information about their health from their healthcare professional, indicating a considerable gap between their expectation and their experience and suggesting also that patients may not be receiving sufficient information on which to base their healthcare choices.

About 60% of the study population indicated that there has been at least one time when the healthcare professional did not obtain their consent before they were treated, compared with about 75% that felt they should do so.

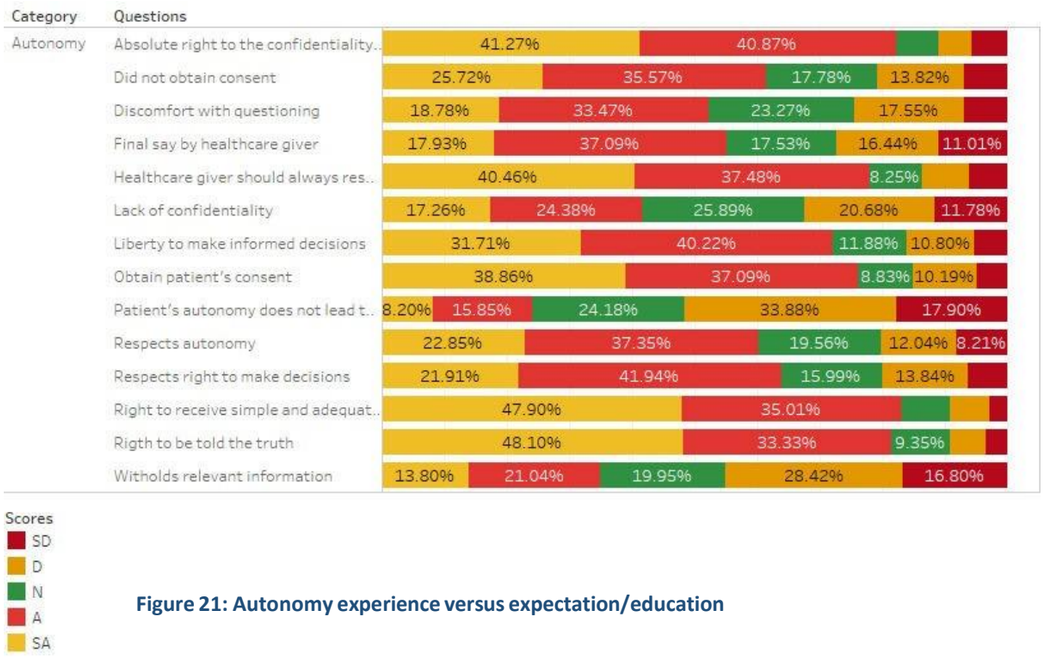


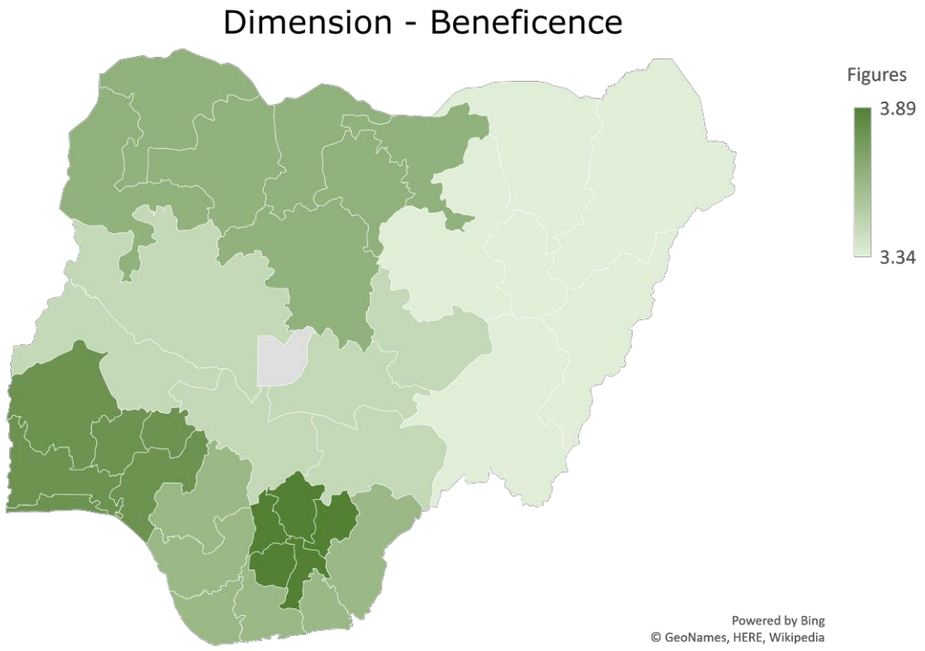
Figure 21: Autonomy experience versus expectation/education

10.1 Key Insights

- Patients are sophisticated with respect to their expectation of how much control they should have over decisions regarding interventions in their health.
- In the experience of our respondents, healthcare professionals tend to be generally unwilling to provide detailed information about the interventions they recommended.
- There is a considerable gap in how much control patients expect to have over decisions on interventions concerning their health and what they get from their healthcare professional and there does not appear to be much of a difference whether it is in a private hospital or government run hospital.
- On the contrary, our study population appear willing to let the healthcare professional make the final decision regarding their health interventions.
- The difference in expectation and experience of autonomy is neither defined by level of education nor region in the country. This may suggest the universality of the inherent need to have a measure of control over one's body and therefore healthcare interventions.

11.0 Principle: Beneficence

Representative statement: 'My healthcare professionals do their best to facilitate my health and well-being'.



The principle of beneficence prescribes that healthcare givers should carry out their duties with the intention to do the most good to the patient. To measure participants' experience of beneficence, we asked questions around the healthcare giver's demonstration of knowledge and competence in their dealings with the respondent, the willingness of the healthcare professional to do their best concerning their health, and their experience of empathy with the healthcare professional.

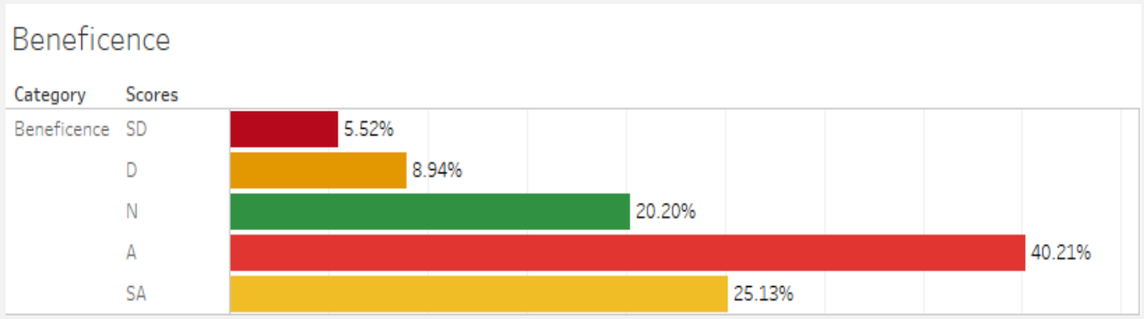


Figure 25: Beneficence

Our study population generally believed that their healthcare professionals were beneficent towards them in several ways. From the chart above, we see that about 65% either agreed or strongly agreed that they experienced a certain measure of beneficence from their healthcare professionals. Effectively, their healthcare professionals did their best to keep our study population healthy. From the chart below, we see that there was very little difference in the views expressed by the respondents whether they used public hospitals or private hospitals.

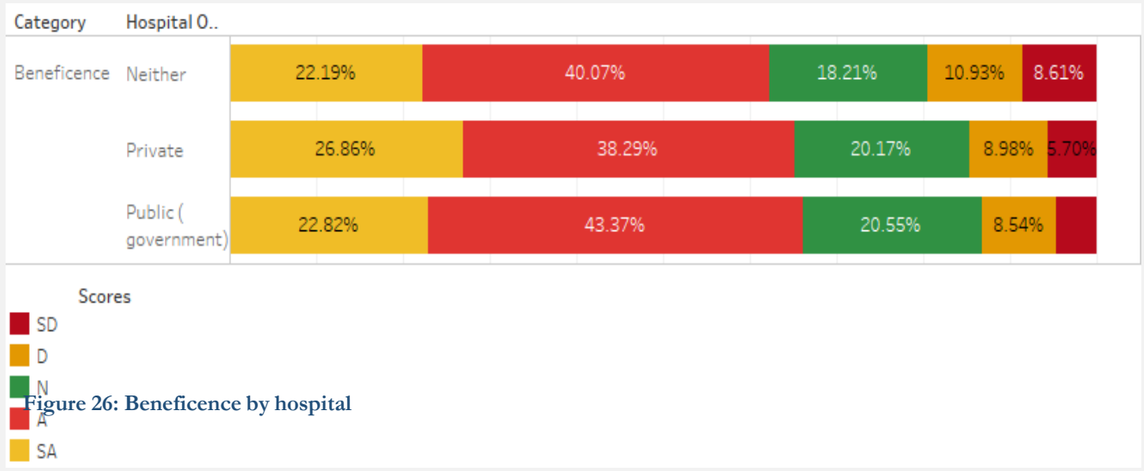


Figure 26: Beneficence by hospital

However, with an average of 4.4, the south-east stood out as the region where the experience of beneficence was the highest as reported by the respondents. This is corroborated further with a median score of 5, indicating that at least half of the study population strongly agreed that their healthcare professional was beneficent toward them. It is also interesting to note that this score was based on respondents' experience of government provided healthcare services. The lowest average however came in from users of private hospital services in the North-East, with a score of 3.23 and a median score of 3, while most of the other regions had a median score of 4. These suggests that the duty of care that is fundamental to the healthcare professions is lacking in the experience of our study participants in the regions where more than half of them could not respond affirmatively to the questions.

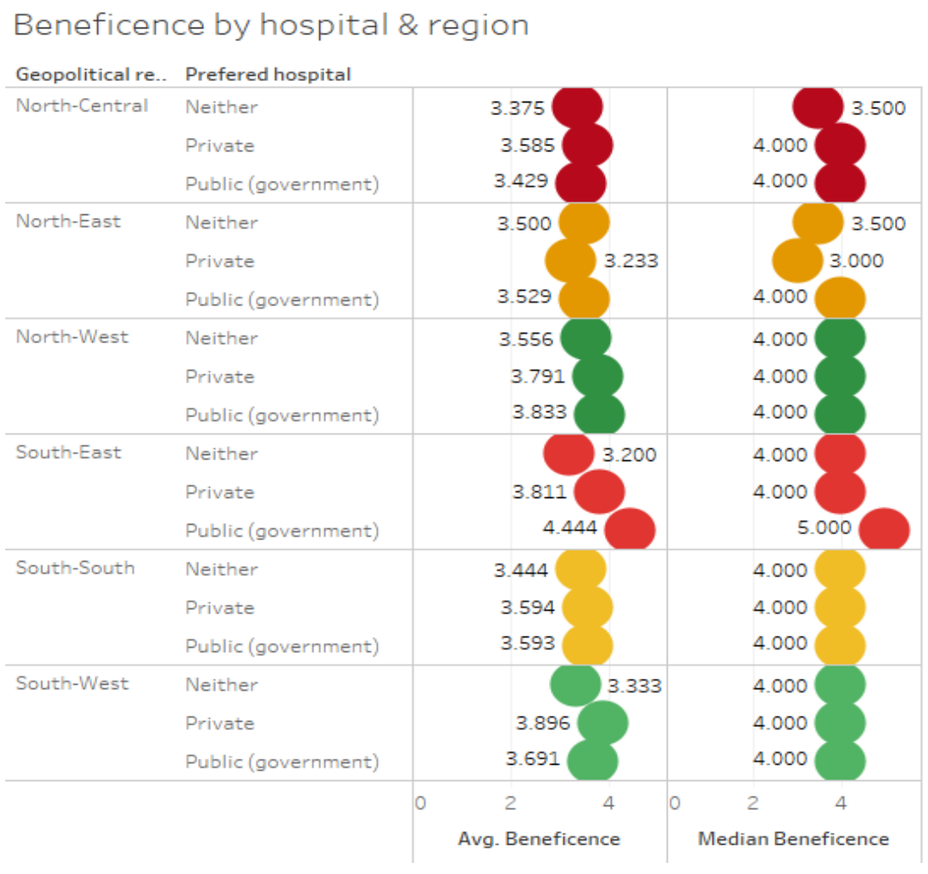


Figure 27: Beneficence by hospital and region

Given the importance of special care for the elderly, we checked to see if there was any difference in the experience of our sample population aged 56 years and above. While that age range reported the highest average, the difference was very little, compared with the other age ranges.

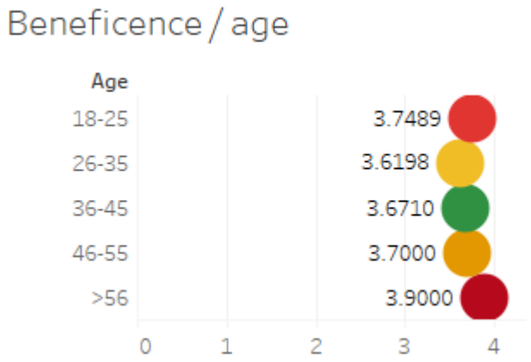


Figure 28: Beneficence/age

The chart below shows the different questions that made up the Beneficence principle and how our study population responded to them. Nearly 80% of our respondents believed that their healthcare professional did their best to improve or maintain their health status. This perhaps explains the Autonomy results that indicated that patients at once believed they should have more control over decisions concerning their health and thought the healthcare professional should have the final say in such decisions. If patients believed their healthcare professional had their best interest at heart, then they would trust them to make the right decisions about their health.

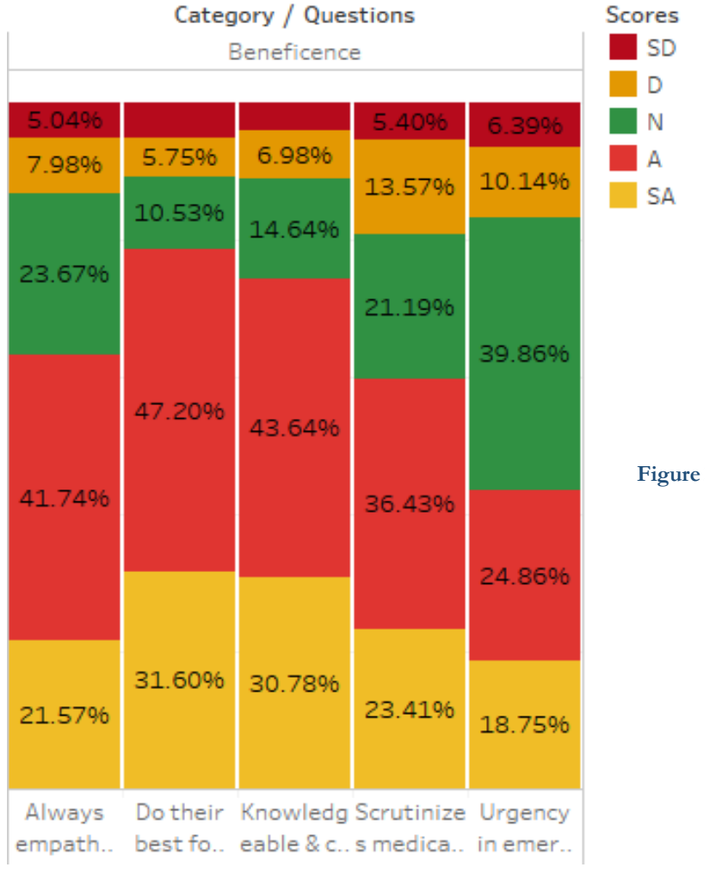
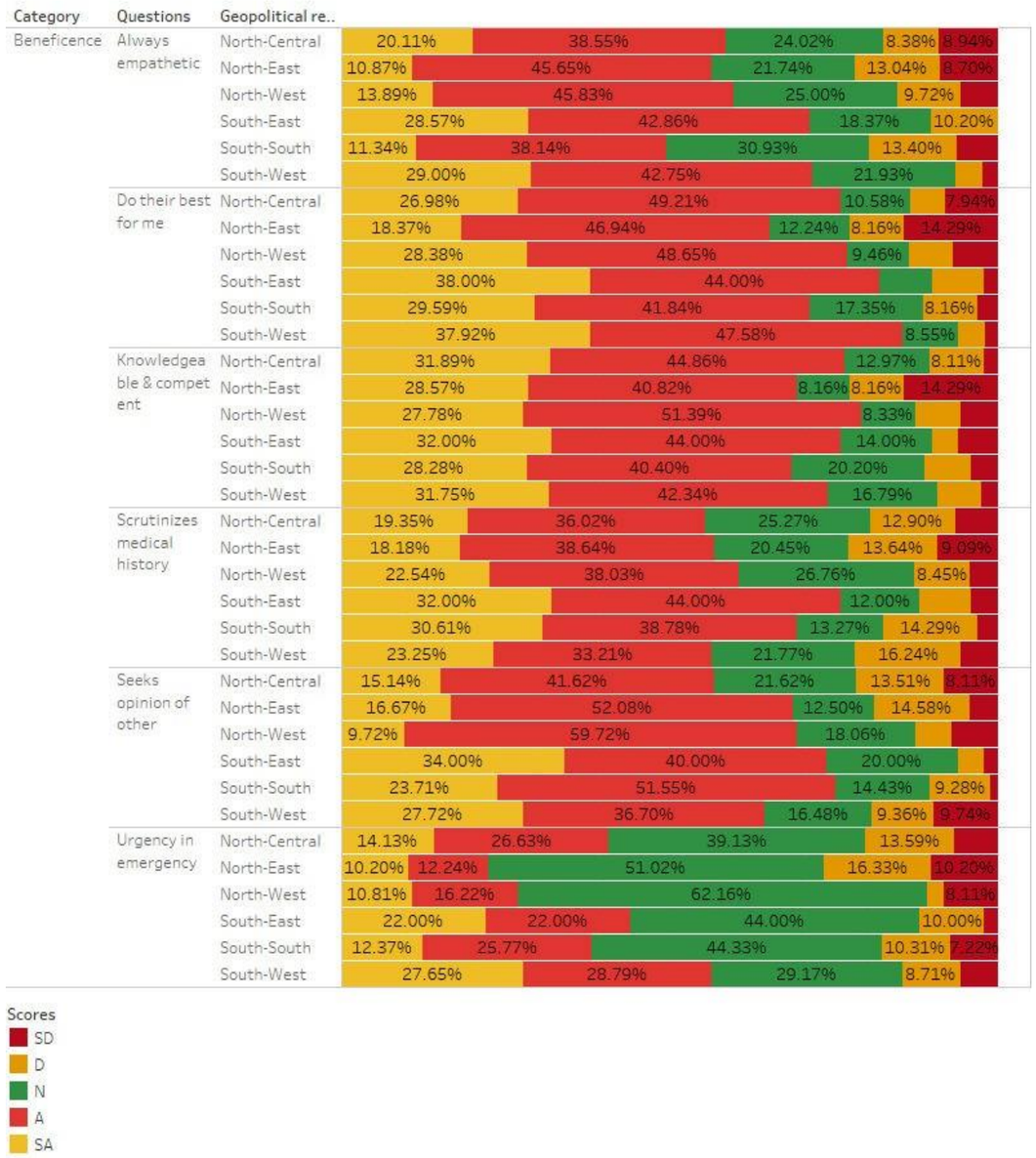


Figure 29: Beneficence questions

In four of the six questions that made up the Beneficence principle, the south- west and south-east respondents seemed to have had the best experience with their healthcare professionals. In the final question asking the participants how they were treated during an emergence, the Neutral category is high because participants were asked to select that option if they had never had an emergency. The south-west and south-east still had the largest percentage of respondents that felt their cases were treated with the urgency they deserved during emergency situations.

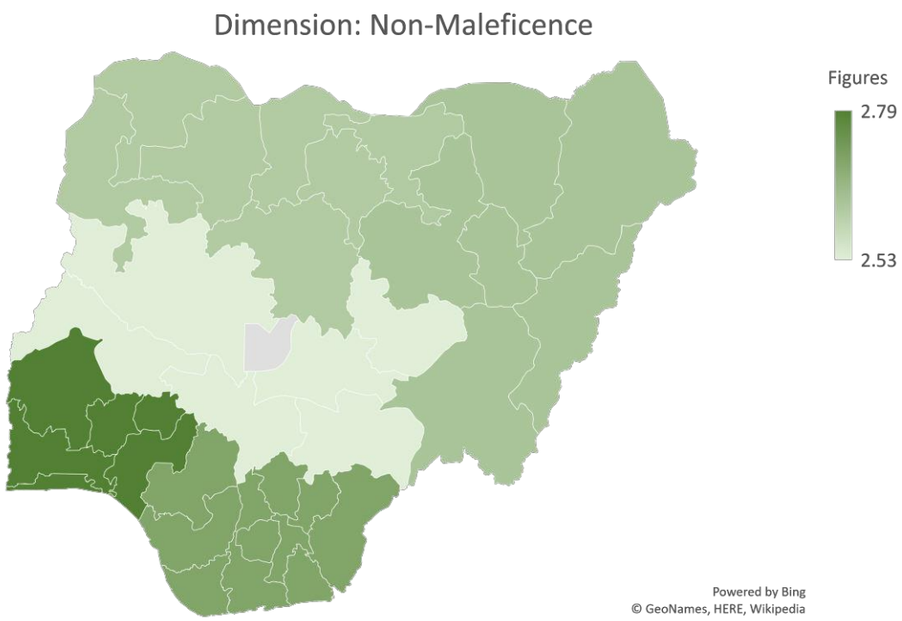


11.1 Key Insights:

- From the report of our study population, Nigerian healthcare practitioners seem to do their best to facilitate the health and well-being of their patients.
- Respondents in the south-west and south-east probably experienced the beneficence of their healthcare professionals much more than the other regions.
- There seems to be good camaraderie among the healthcare professionals as majority of our survey population report that their healthcare professionals seek the opinion of more knowledgeable colleagues when they are not clear about a case.
- Our survey population also believe their healthcare professionals are knowledgeable and competent.

12.0 Dimension: Non-Maleficence

Representative statement: My healthcare professionals do not engage in behavior with the potential to harm me in the course of my interactions with them.



The principle of non-maleficence in healthcare ethics refers to the obligation of the healthcare professional to refrain from behaviour that can harm the patient and society. Specifically, we asked respondents questions around the state of their healthcare professionals when they had attended to them in the past, whether they felt the healthcare professional had taken advantage of them one way or another and whether they had had to pay for services that should have been free.

The survey questions were framed in a non-negative fashion (for example, 'my health condition has been misdiagnosed before'), such that an affirmative response would suggest maleficence. Thus, in interpreting the results, it is important to recognize that a low average or low percentage in the aggregated results for example indicates a low level of or absence of maleficence in our respondents' experience with their healthcare professionals, which is the desirable situation. In the same fashion, a score of 5 (strongly agree on the Likert scale) on any questions indicates that the respondent has experienced that form or level of maleficence.

In general, the following chart suggests that just about 32% of our respondents have experienced some form of maleficence in their dealings with their health care provider, while about 19% are agnostic about their experience, and about 49% indicate that they have not been victims of maleficent behaviour from their healthcare professional.

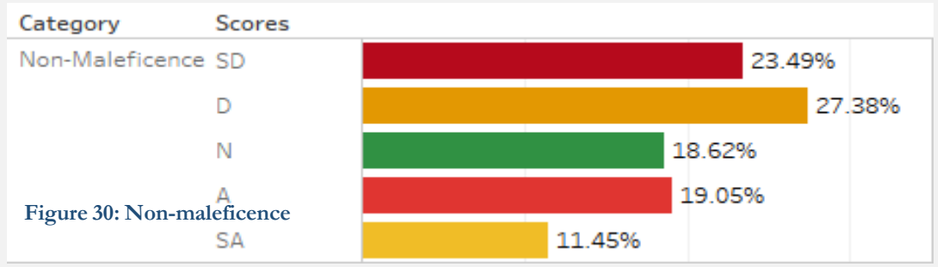


Figure 30: Non-maleficence

As with the previous two principles, from the chart below, we see that there was not much of a difference in the experience of those whose primary healthcare providers were private hospitals or public hospitals as well as with those that did not use one more frequently than the other. However, it corroborates the conclusion of the overall chart above.

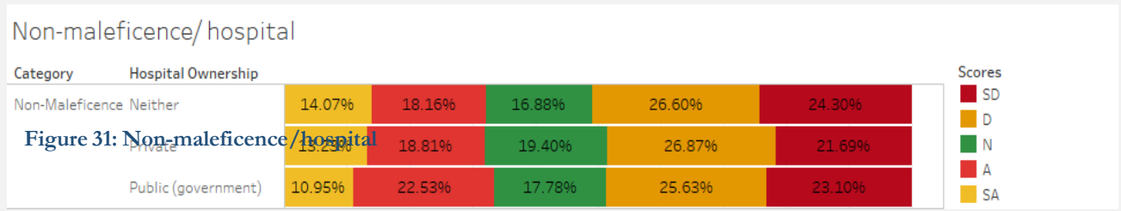
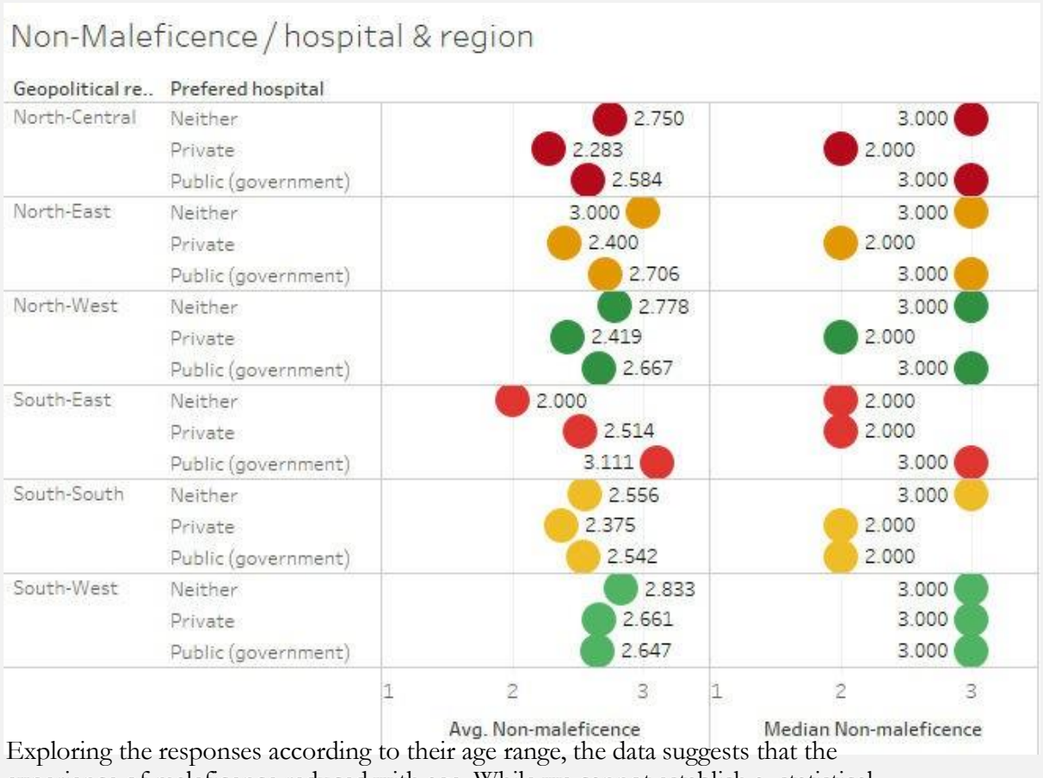


Figure 31: Non-maleficence/hospital

Unlike the first two principles above, there is no readily observable direction to which our respondents learned regarding their experience of maleficence. Across all regions, many respondents indicated that they had not experienced certain acts of maleficence in either private or public hospitals. However, the proportion of our respondents that had experienced some level of maleficence is quite significant, especially in some specific dimensions. In general, users of government hospitals in the south-east recorded the highest percentage of respondents that had experienced some level of maleficence and private hospitals in the north-central recorded the lowest.

Figure 32: Non-maleficence/hospital & region

However, the mean and median responses probably provide a clearer picture. As we see in the chart below, the median values for all the regions regardless of hospital ownership are 2 and 3. A median value of 2 indicates that at least 50% of the study population disagree or strongly disagree with the questions that were asked. In other words, in their experience, the level of maleficence was considerably low. The south-east stands out once again with the highest average on non-maleficence, indicating that their experience of maleficence in government hospitals is higher than the rest of the population, even though it is still low. However, the south-west also stands out as the region where respondents experienced the highest level of maleficence overall. In other words, they are subjected to harm more or more often than their counterparts in other regions.



Exploring the responses according to their age range, the data suggests that the experience of maleficence reduced with age. While we cannot establish a statistical correlation between the age of the recipients and their experience of maleficence, we can propose that there was probably more effort by healthcare professionals to refrain from behaviour that may be harmful to more elderly patients.

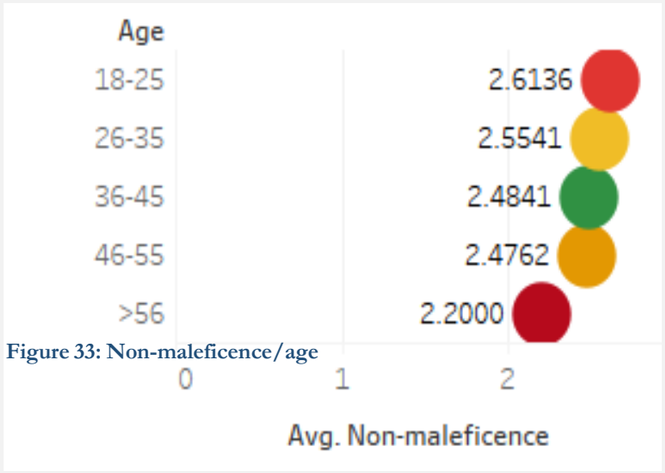


Figure 33: Non-maleficence/age

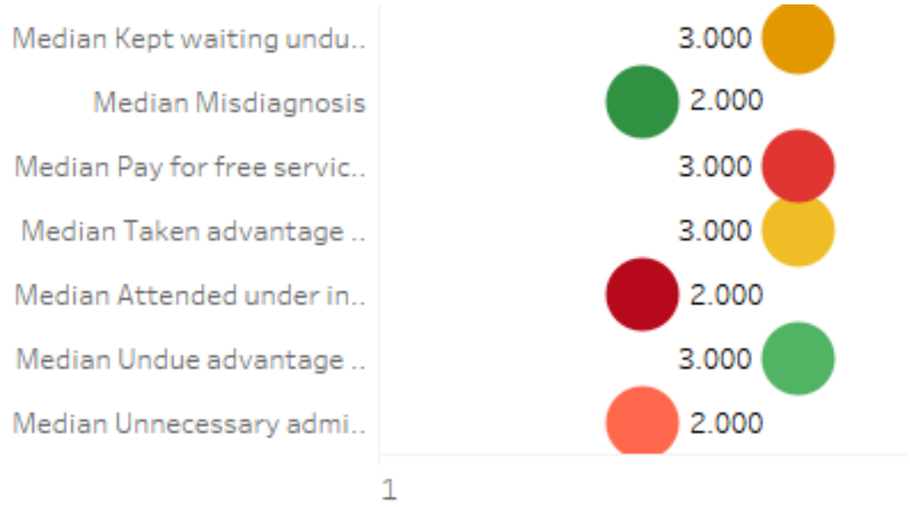
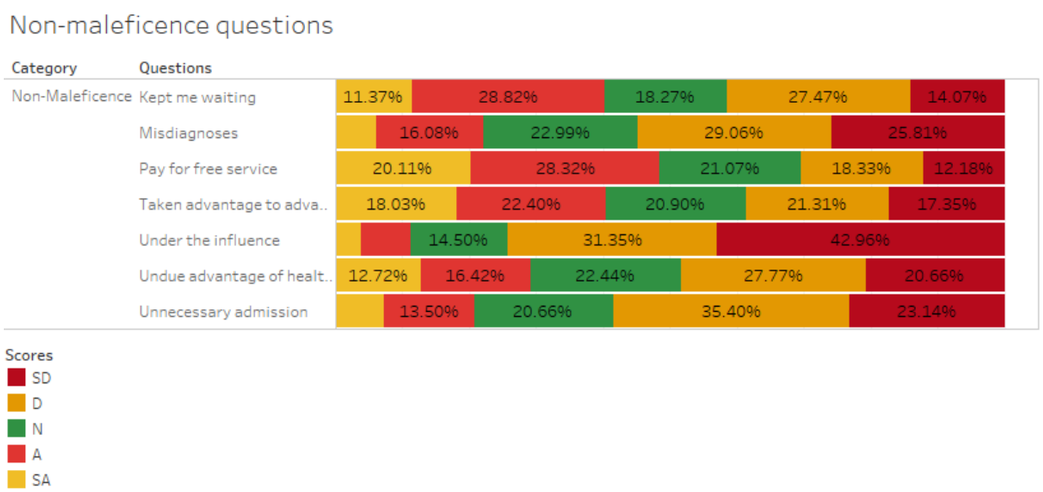


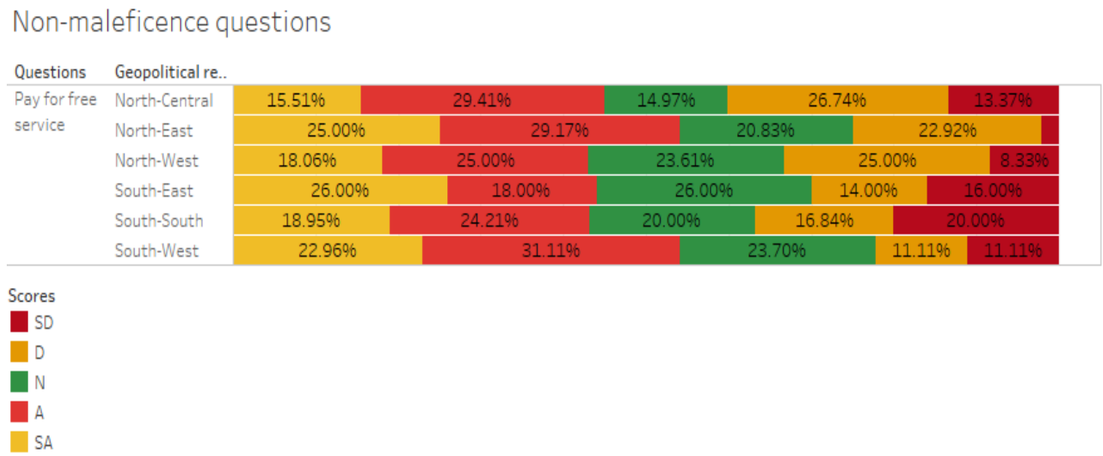
Figure 34: Non-maleficence questions

Next, we explore the specific questions that constitute the non-maleficence principle. Three areas stand out as the areas where our sample population have experienced maleficence the least – medical practitioners attending to patients under the influence of drugs and alcohol, cases being misdiagnosed, and being placed on admission unnecessarily. In the first case, about 74% of our respondents disagreed with the notion that their healthcare professional had treated them under the influence of alcohol or drugs, while at least about 11% affirm that they have been so treated. This is concerning, as there should be no condition under which a healthcare professional would attend to patients under the influence of drugs or alcohol or any other substance.

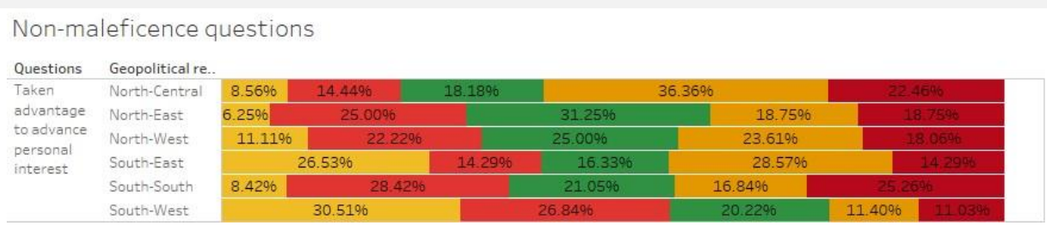


With respect to the other dimensions, about half or more of the population of those that responded other than 'neutral', indicated that their healthcare professional has taken advantage of their health situation in one way or the other to advance their own interests. It is noteworthy that the percentage of those that indicated that they have been placed on admission unnecessarily is comparatively low. A possible explanation might be the fact that healthcare facilities are not able to cater to the population.

While the general picture suggests that the level of maleficence is low, the results of specific questions by region paint a clearer picture. One of the most outstanding statistics is 59% of respondents in the north-west that indicate that they have had to pay for services that should ordinarily have been free, followed by respondents in the south-west with 54% and so on.



Similarly, we see a high proportion of our respondents indicating that their healthcare professionals have taken advantage of them before, to advance personal interests such as marketing a product or recommending their personal practice. This is particularly so in the experience of the south-west respondents with nearly 60% of them affirming that this is the case.



Worth highlighting also is the proportion of our survey population that affirm that their condition has been misdiagnosed before, with as many as 36% of our south-south respondents.

Non-maleficence questions

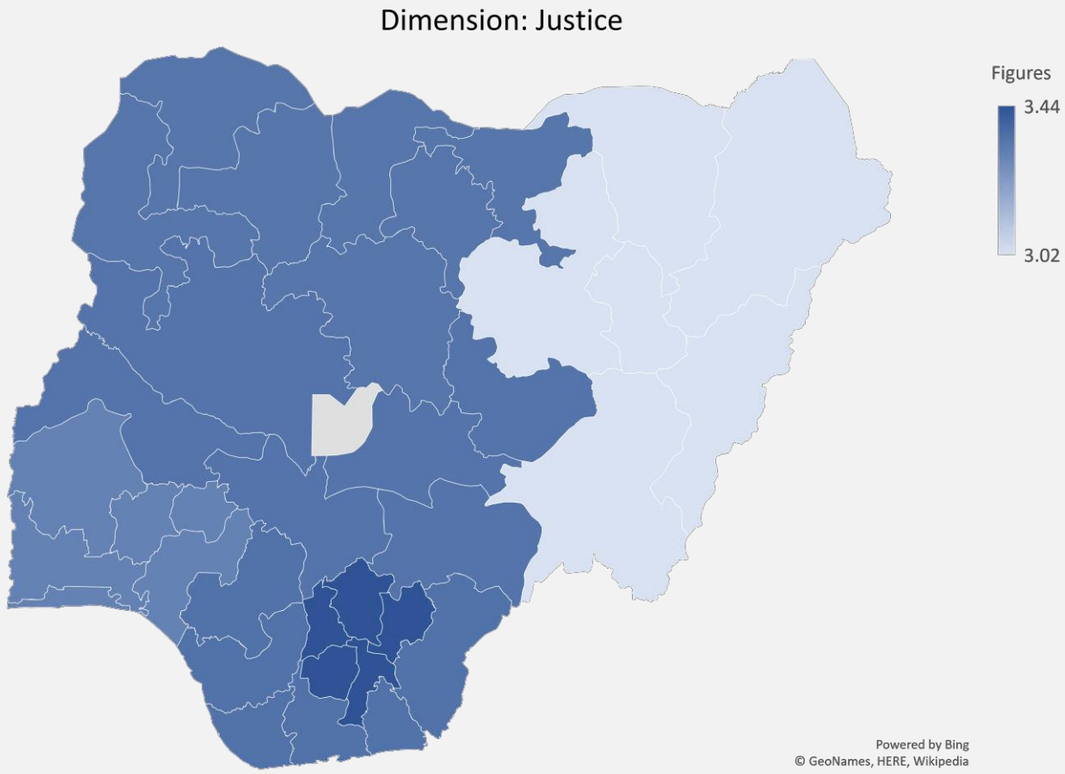
Questions	Geopolitical re..					
Misdiagnoses	North-Central		13.48%	19.10%	32.58%	28.65%
	North-East	6.67%	11.11%	20.00%	44.44%	17.78%
	North-West	8.57%	14.29%	20.00%	20.00%	37.14%
	South-East	10.00%	28.00%	16.00%	26.00%	20.00%
	South-South	6.52%	30.43%	17.39%	21.74%	23.91%
	South-West		12.08%	29.06%	30.19%	24.53%

12.1 Key Insights:

- The level of maleficence in Nigerian hospitals may appear low on the face of it, as at least half of our sample population report that they have not experienced maleficence in the way defined by the questions. But to the extent that the value of life or well-being cannot be measured purely by numbers, the percentage of respondents that have experienced maleficence, especially with respects to healthcare givers not being in the right state of mind when discharging their duties is cause for concern.
- Given the rising rate of Out-of-Pocket expenditure on health and the government's policy efforts to reduce such expenditure in the midst of a strained economy, it is also cause for concern that nearly 50% of our respondents claim to have had to pay for services that should ordinarily have been free.
- Generally, our respondents also indicate that their healthcare professionals have taken advantage of their health situation one way or another. These issues are cause for concern with respect to the commitment of our healthcare professionals to adhere to the principle of 'primum non nocere' – 'first, do no harm'.

13.1 Dimension: Justice

Representative statement: My healthcare professionals give me the time and attention I require without prejudice to who or what I am.



Justice as a principle of healthcare ethics prescribes that healthcare professionals / providers treat all patients equally without regard to social background or status or other such considerations. In effect, there should be no discrimination in terms of who attends to a patient, how, when and with what resources, to the extent that they have a common ailment or condition. In effect, the Justice principle is about participant's experience of fair treatment by their healthcare providers / professionals. To explore this dimension, we asked questions about our respondents' experience of how healthcare professionals treat them, prioritize emergency cases and the affordability of quality healthcare.

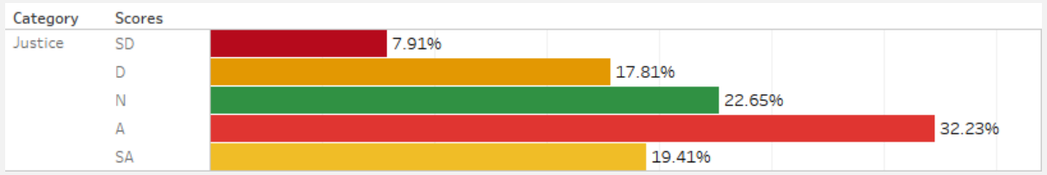


Figure 35: Justice

In general, just about 41% of our respondents agree or strongly agree that they have been treated fairly by their healthcare professionals and the difference in the responses of our sample population do not appear to be very different whether they use private or public hospitals as their primary healthcare provider.

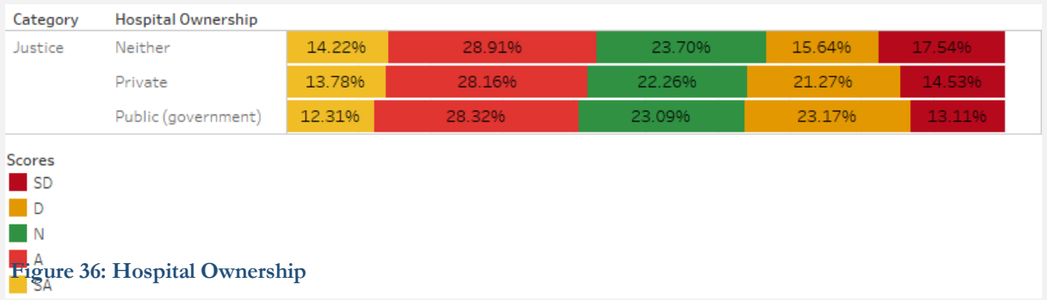


Figure 36: Hospital Ownership

With respect to our respondents' experiences along geopolitical regions however, the south-west results from the respondents whose primary hospitals are government-run suggest that that sample population has experienced the most unfairness or 'injustice' from their healthcare professionals / providers, with only about 30% affirming that they have not been victims of unjust behaviour, compared to 50% in the south-east. With respect to private hospitals, the respondents from the south-south region have reported the best experience of justice when compared with the rest of the population.

While the differences from region to region may be generally small, they are all much lower than they should be. Except for the public hospital respondents from the south-east, less than half of the sample population in all the other regions agree that they have been treated with fairness by their healthcare professionals. The median and average values also confirm that.

Figure 37: Justice/hospital and region

In the light of the fact that the discharge of justice may be influenced by other factors as implied by the definition of the principle, we explore the possibility that patients' income level and education (as proxy for social status and or awareness of rights) may influence their experience but making them more likely to be treated differently by health care providers. It is interesting to note that the highest and lowest income categories - above 2million naira and below 100,000 naira - were the least pleased with their experience of justice with their healthcare professionals, while the middle category, 501k – 1m, were most pleased with their experience. The median value of 4 indicates that at least half of the people that made up those income categories agreed or strongly agreed that they have been treated fairly by their healthcare professionals.

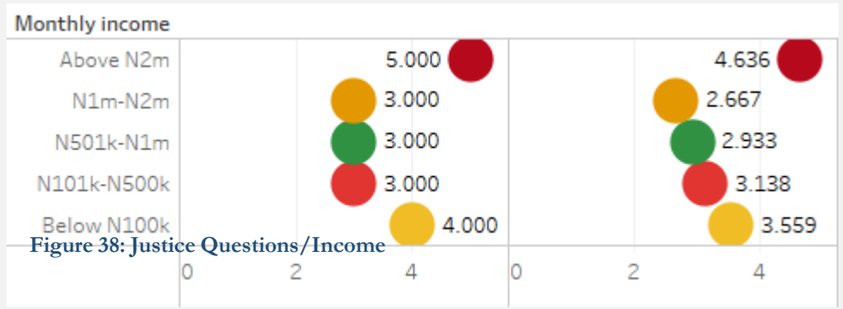


Figure 38: Justice Questions/Income

With respect to level of education, respondents with post-secondary qualifications probably feel more strongly about the issue of fairness in their interactions with their healthcare professionals than those without. While more of this category report a higher experience of fairness (about 44%) than those without post-secondary education (38%), a few more of them also report experiences of unjust behaviour on the part of their healthcare professional than those without post-secondary.

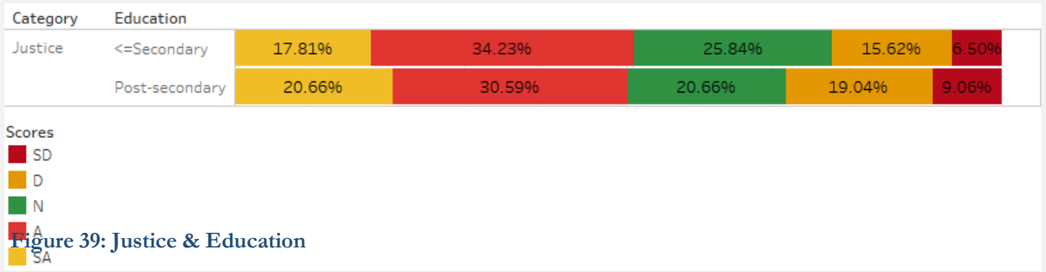


Figure 39: Justice & Education

Exploring responses to the specific questions that make up the Justice principle, about 70% of our survey population indicated that their healthcare professionals always treated them with respect. On the other hand, about 47% and 37% felt that their healthcare professional acted like they were doing them a favour and were generally rude to patients respectively. More than half of our survey population, about 55%, felt that quality healthcare was out of their reach financially.

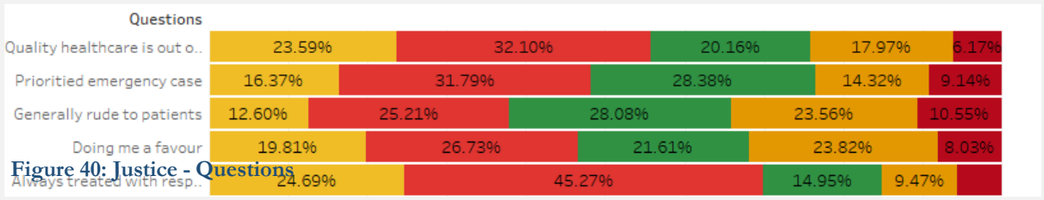


Figure 40: Justice - Questions

The median of the responses to each question corroborates the chart above – at least half of the sample population agree or strongly agree that their healthcare professional treats them with respect. About as many people also believed that quality healthcare was out of their reach.

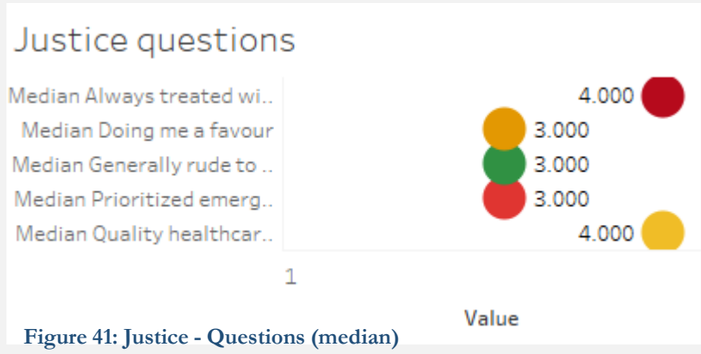


Figure 41: Justice - Questions (median)

14.0 Justice - B

In this section, we address other issues that relate to the participant's experience of professional misconduct from their healthcare professional. Our survey addresses participants awareness of and willingness to escalate professional misconduct to the appropriate authorities. Among other questions, we asked our respondents how they felt about reporting a healthcare breach to regulatory authorities, if they were willing to take legal action against a healthcare professional if the need arose and how confident they were that such a report will be treated appropriately.

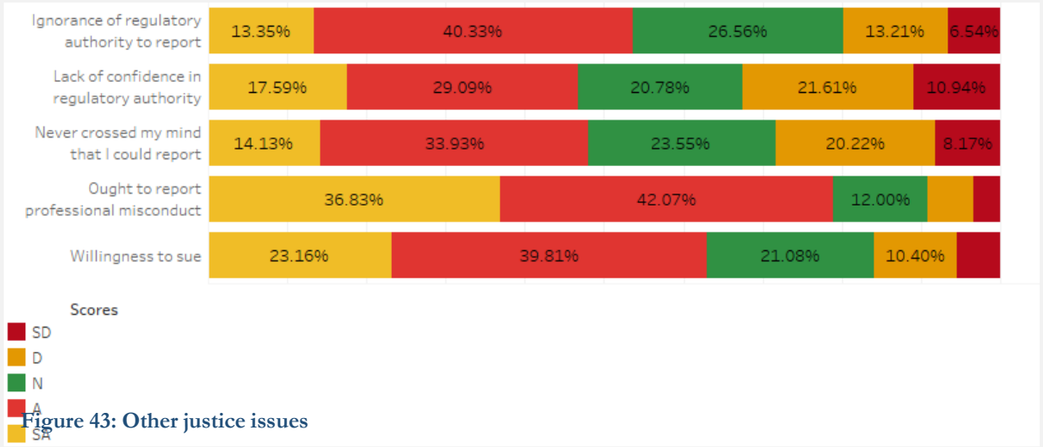


Figure 43: Other justice issues

While nearly 80% of our survey population believed that healthcare breaches should be reported to the appropriate authorities, about 53% said they did not know who to report a matter to and another 48% said it had never crossed their minds to do so. Even more importantly, about 47% did not trust that anything would come out of it even if they made such a report. It is however interesting to note that about 63% of our respondents indicated that they were willing to sue a healthcare professional for any breach of their responsibility towards them.

14.1 Key Insights:

The wide gap between those respondents that believed ethical breaches by a healthcare provider should be reported to the appropriate authorities and those that actually believed there is value in that action and that the report will be acted upon, indicates the level of confidence or lack of it that patients have in the health system. More broadly, it probably also suggests that without any additional checks and balances, misconduct could happen with impunity.

15.0 Health Insurance

When the Nigerian government passed the National Health Insurance Scheme (NHIS) Act in 1999, the intention was to improve access to healthcare and reduce the financial burden of out-of-pocket payment for healthcare services. Following up on the not so successful effort of the first National Strategic Heath Development Plan to achieve this objective sufficiently, NSHDP II (2018-2022) listed the expansion of NHIS coverage and the reduction of out-of-pocket expenses on health as one of its key priorities. Halfway through its implementation and 15 years after the NHIS scheme was launched, several reports suggest health insurance remains accessible to less than 10% of Nigerians. Just about 25% of our survey population claim to have one form of health insurance or the other.

Of those, about 61% believed it was better to relate directly with the hospitals rather than go through the HMOs. However, in response to the statement that HMOs should be scrapped, only about 20% of the survey population agreed or strongly agreed.

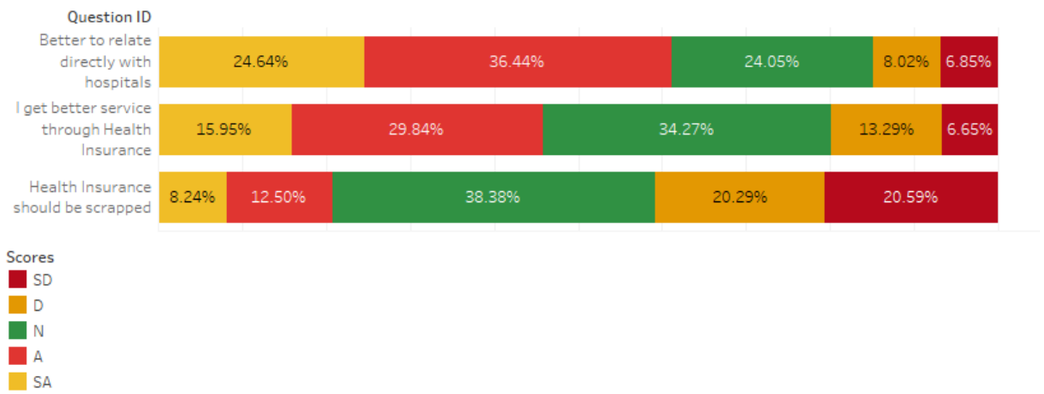


Figure 44: Health Insurance

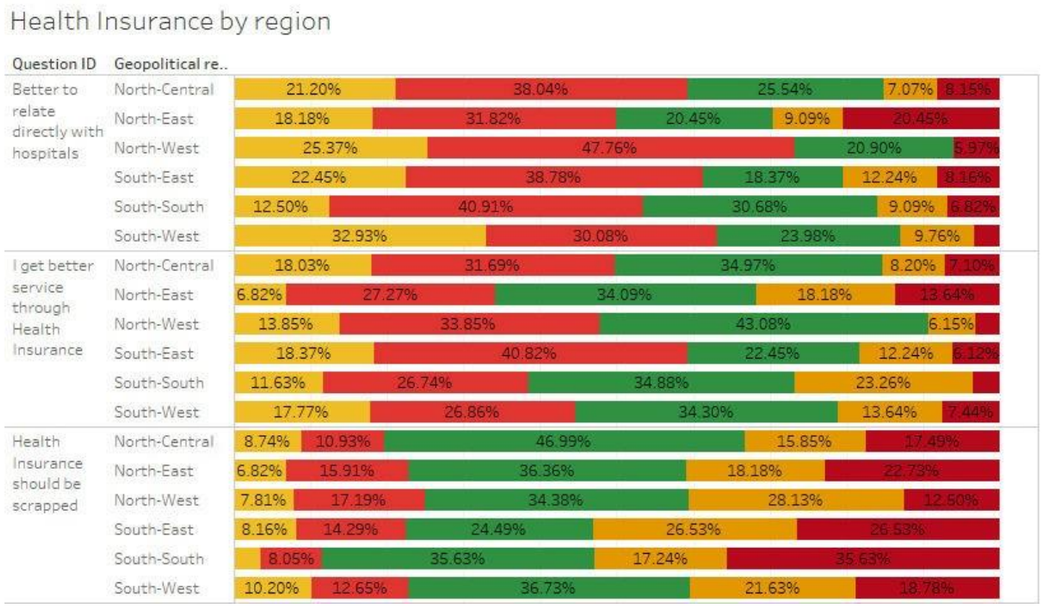


Figure 45: Health Insurance by region

While across the regions, most respondents agree that it is better to deal directly with hospitals, at 82%, the north-west respondents were overwhelmingly in support of dealing with hospitals directly. However, about 40% of them also felt health insurance should not be scrapped. In fact, across all regions, less than 25% of our respondents felt health insurance should be scrapped.

15.1 Key Insights:

There are many problems with the health insurance service, but it probably still provided some value to users in its current state. One of the key requirements to make the health insurance scheme function optimally is strong coordination.

PART C –

HEALTHCARE PROFESSIONALS' PERSPECTIVE

16.0 Findings

In this section, we present the views of the healthcare professionals also along the lines of the four principles of Autonomy, Beneficence, Non-Maleficence and Justice, along various dimensions such as age, geographical region and level of education, as relevant. We also present our findings with respect to the perception of our sample population of healthcare professional of the usefulness or otherwise of health insurance, which is one of the critical aspects of the Nigerian Health Policy – the need to provide access to good quality healthcare to all Nigerians regardless of financial capability.

In the following section, we begin with a general overview of the characteristics of our survey population, to set the context for the results obtained.

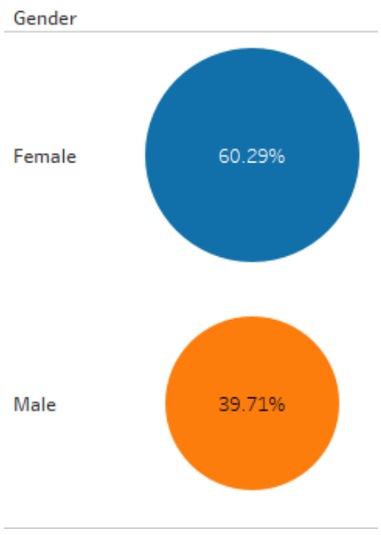


Figure 46: Gender

Nearly 60% of our sample population were women including doctors, nurses and dentists. The 26-35 years age range was the largest age group represented making up nearly 55% of the sample population, followed by the 36-45 age group, much like in the case of our user group. Together, they make up about 75% of our sample population.

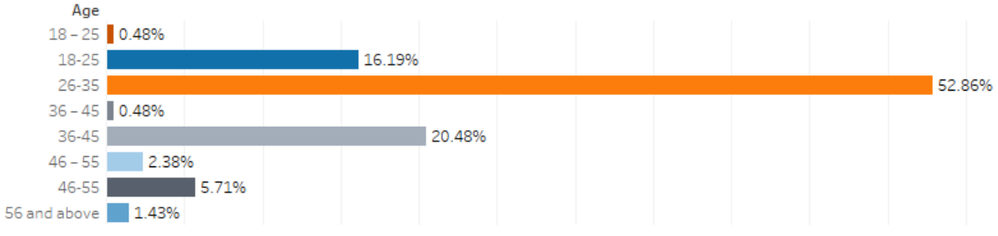


Figure 47: Age range

About 32% of the respondents were based in the south-east and constituted the largest respondent group by region, followed by the south-south and south-west regions.

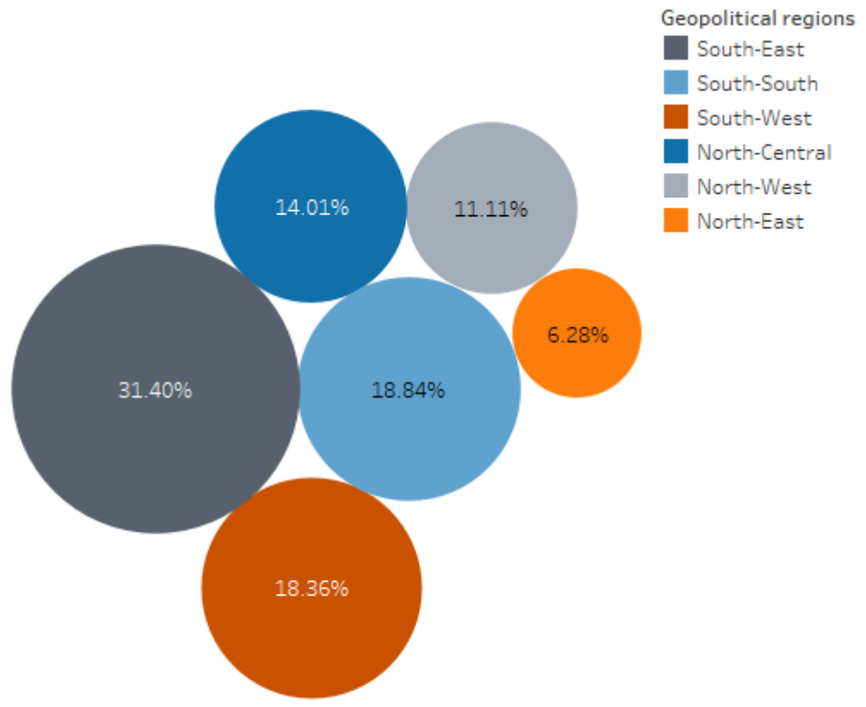


Figure 48: Geopolitical region

Our survey population was almost evenly split between those who discharged their services primarily in private hospitals and primarily in public / government-run hospitals, with private hospitals being the largest group. About 13% of our survey population provided their services in both the public and private hospitals to equal extents.

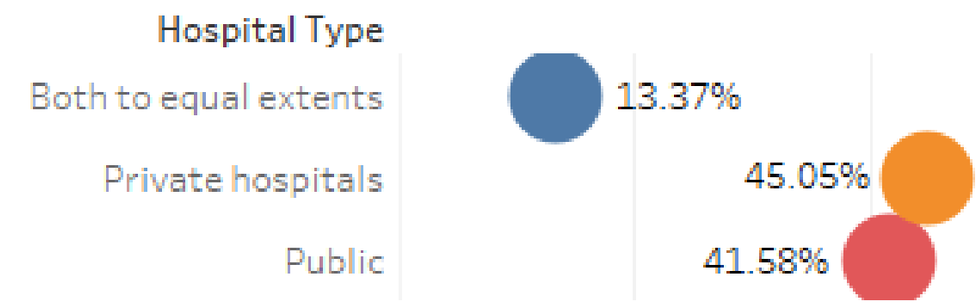


Figure 49: Respondents by hospital

Across the regions except for the south-south, healthcare workers that provided their services largely in the public hospitals made up less than 50% of our sample population.

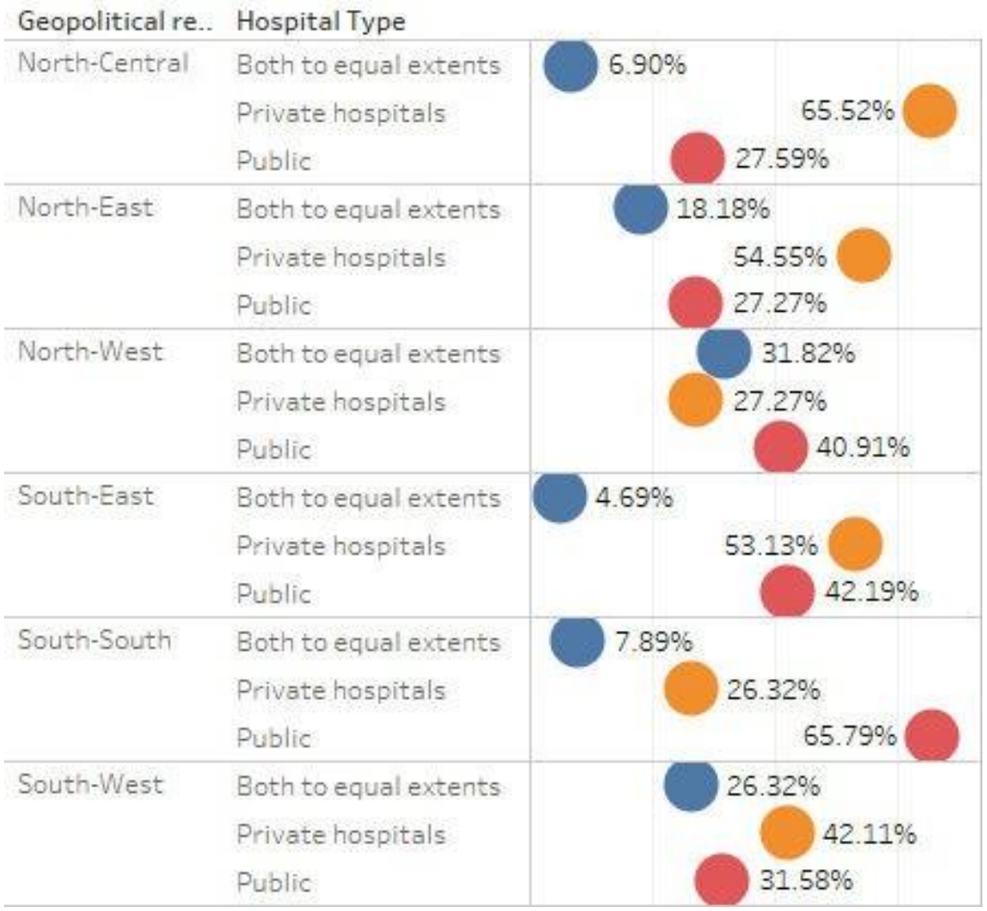


Figure 49: Respondents by region and hospital type

We had a very rich diversity of job categories represented in this study as indicated below. People in the nursing profession, from staff nurse to chief nursing officer, constituted about 40% of our sample population, while the rest of them were medical doctors on various cadre. The largest income band was 51,000 naira to 200,000 naira monthly.

Job cadre	
Chief Nursing Officer(CNO)	2.07%
Assistant Director of Nursing Services ..	3.63%
Assistant Chief Nursing Officer (ACNO)	1.55%
Principal Nursing Officer (PNO)	2.07%
Registered Nurse/Midwife	13.47%
Staff nurse	16.06%
Consultant	10.36%
Senior registrar	11.40%
Junior registrar	4.15%
Medical officer	6.22%
D.0 (Dental)	1.04%
House Officer	12.44%
Other	4.66%
Junior Registrar	10.88%

Figure 50: Job categories

Above N1m	Both to equal extents	0.55%
	Private hospitals	0.55%
N501k-N1m	Both to equal extents	0.55%
	Private hospitals	1.09%
	Public	3.83%
N201k-N500k	Both to equal extents	1.64%
	Private hospitals	4.37%
	Public	17.49%
N51k-N200k	Both to equal extents	5.46%
	Private hospitals	23.50%
	Public	19.13%
Below N50k	Both to equal extents	4.92%
	Private hospitals	13.11%
	Public	3.83%

Figure 51: Income distribution

In our final list of respondents, we excluded the medical student (1), student nurse (1) and intern categories (1), since they were not really our target population, bringing our sample population of healthcare workers to a total of 206.

17.0 Principle: Autonomy

Representative statement: Patients should have the right to make decisions concerning their health and healthcare professionals should equip them with simple, accurate and adequate information to do so.

As we did with the healthcare users' group, we sought the opinion of our healthcare professionals regarding the ideal versus the experience that patients have with respect to their rights to autonomy over decisions concerning their health. An overwhelming 75% of our sample population believed that patients should have considerable autonomy over decisions regarding their healthcare. However, about 57% believe that patients actually get to exercise that right.

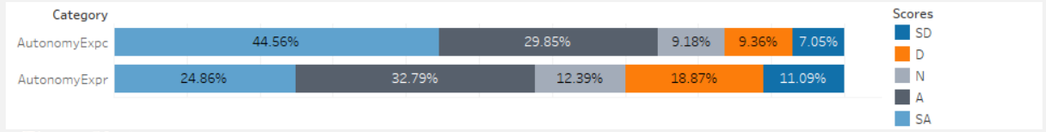


Figure 52: Autonomy

This is corroborated by the chart below. With a median value of 4, we can conclude that at least 50% of our sample population believe in patients autonomy over their healthcare decisions, compared with a median value of 3.33 which shows that majority of the population believe they do not receive that measure of autonomy over their healthcare decisions.

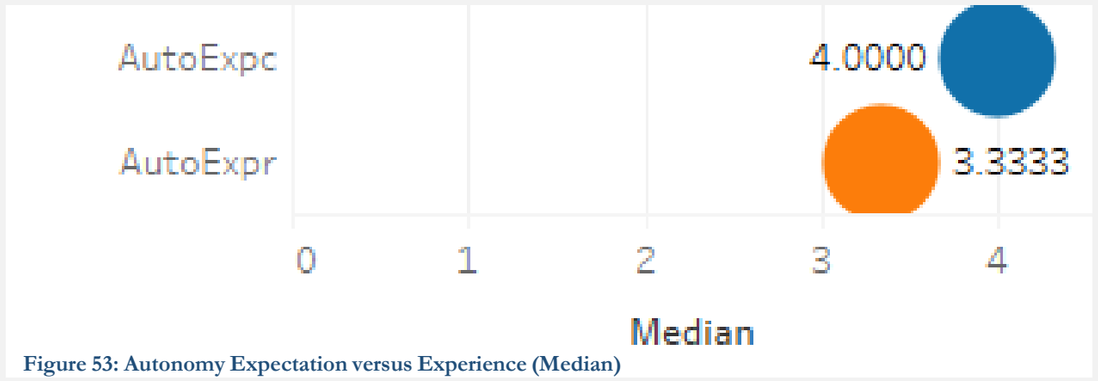


Figure 53: Autonomy Expectation versus Experience (Median)

The dynamics are the same when the data is interrogated along the lines of the type of hospital the respondents provide their services in primarily. In other words, the difference between what patients should expect and what they get in terms of autonomy over their healthcare decisions is just as different. However, we see in figure 54 below that in public hospitals, patients appear to enjoy even less autonomy than in the private hospitals, with just about 52% of our respondent indicating that their patients experience the desired level of autonomy, compared with 62% in the private hospitals.

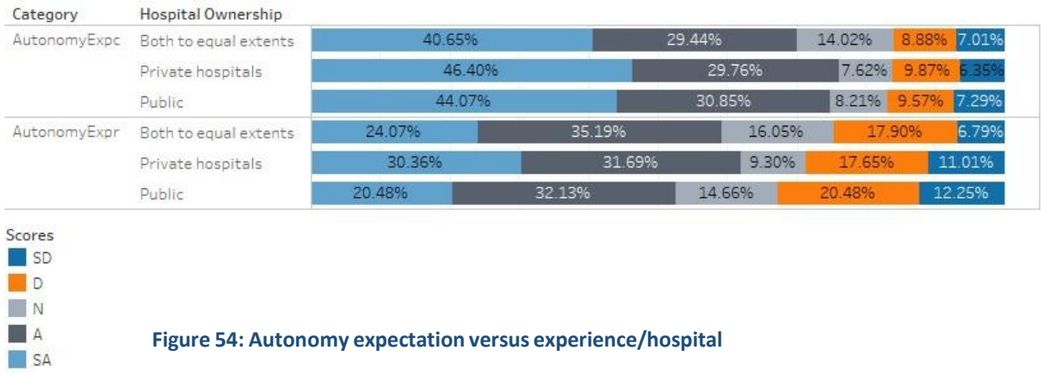


Figure 54: Autonomy expectation versus experience/hospital

When we explore the data further in terms of the specific questions that make up the Autonomy principle, a few interesting findings stand out. While an overwhelming 94% of the sample population believed that patients had the right to receive simple and adequate information from their healthcare professional in order to make informed decisions, 57% believe patients do not understand the sophisticated language their healthcare professionals use when talking to them. This fundamentally compromises the right to autonomy if patients do not have enough information to make informed decisions regarding their health. In addition, 27% of our respondents agree or strongly agree that their colleagues feel uncomfortable when patients ask questions and about 30% and just 63% believe certain kinds of information should be kept away from patients and patients should have unhindered access to their medical records, further convoluting the issue of patients having simple and adequate information to make informed decisions. This notwithstanding, there was nearly 100% consensus among our sample population that healthcare professionals should always respect patients' autonomy.

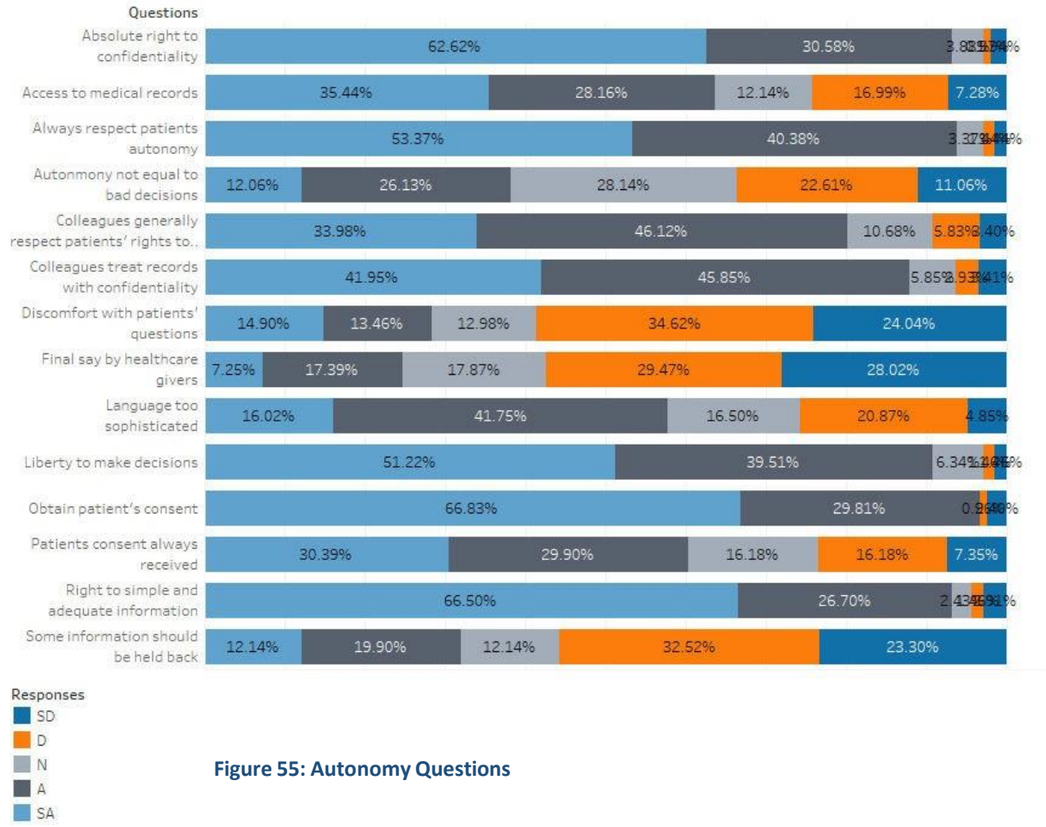
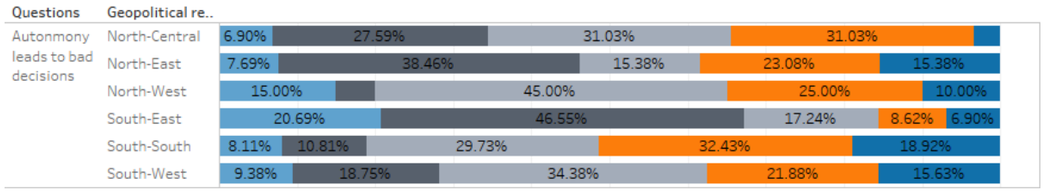


Figure 55: Autonomy Questions

From a regional perspective, the most contentious question was whether patients' autonomy led to poor decisions about their healthcare. While 67% of respondents from the south-east believed it did, only about 19% and 28% from the south-south and south- west believed it did. All other questions followed the same pattern more or less.



17.1 Key Insights

There is a considerable gap between what healthcare professionals consider to be a patient's right to autonomy regarding decisions on their healthcare and what patients experience. That gap appears to be a result of healthcare professionals' unwillingness to generally provide all the information that patients need to make informed judgements regarding their healthcare. This is evident in the reluctance of healthcare professionals to give patients access to their medical records, withhold other relevant information as well as provide information in a way that is difficult for the patients to understand.

18.1 Principle: Beneficence

Representative statement: I have a professional obligation to do the best I can for the patient, not only in my interactions with them, but also in ensuring I am adequately skilled to deploy the knowledge I claim to have.

To measure beneficence, we asked our sample population to express their opinions on some statements bordering on how patients are treated – empathy, due diligence and care, in relation to their colleagues. Below, we see that our sample population believed that they acted largely in the interest of patients, with about 86% indicating that they agree or strongly agree to most of the statements that make up the Beneficence dimension.

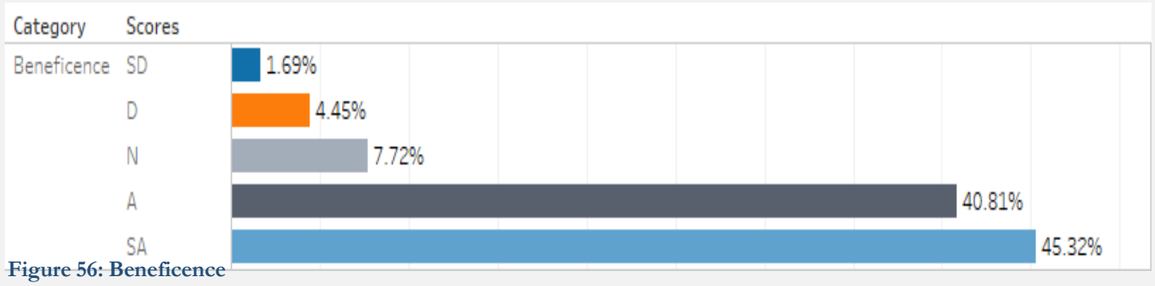


Figure 56: Beneficence

There was very little difference in the results whether the respondents worked with public or private hospitals.

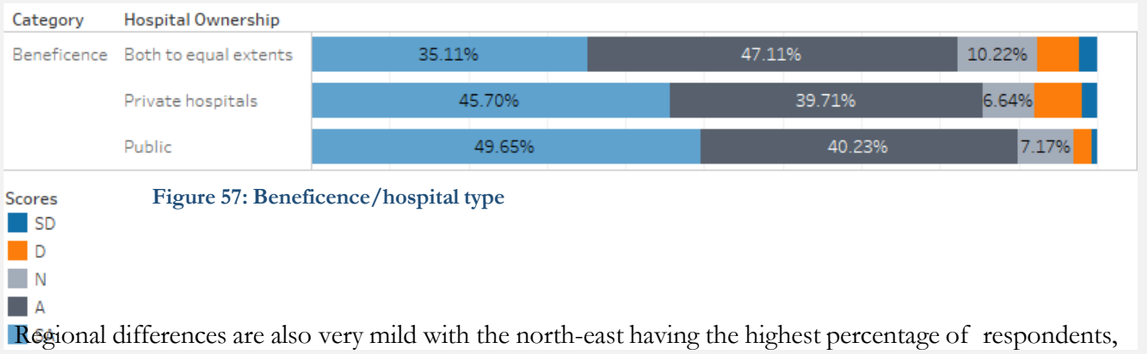


Figure 57: Beneficence/hospital type

Regional differences are also very mild with the north-east having the highest percentage of respondents, 89%, that agreed or strongly agreed that their colleagues do their best for the health of their patients.

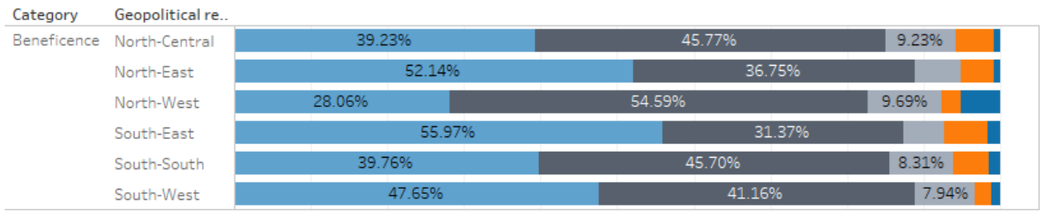


Figure 58: Beneficence/region

Mean and median figures also corroborate the foregoing as more than half of the respondents believed their colleagues acted towards patients with their best interest in mind more so in the south-west and north-east than the other regions, with mean and median values of 4.15 and 4.33 and 4.41 and 4.44 respectively.

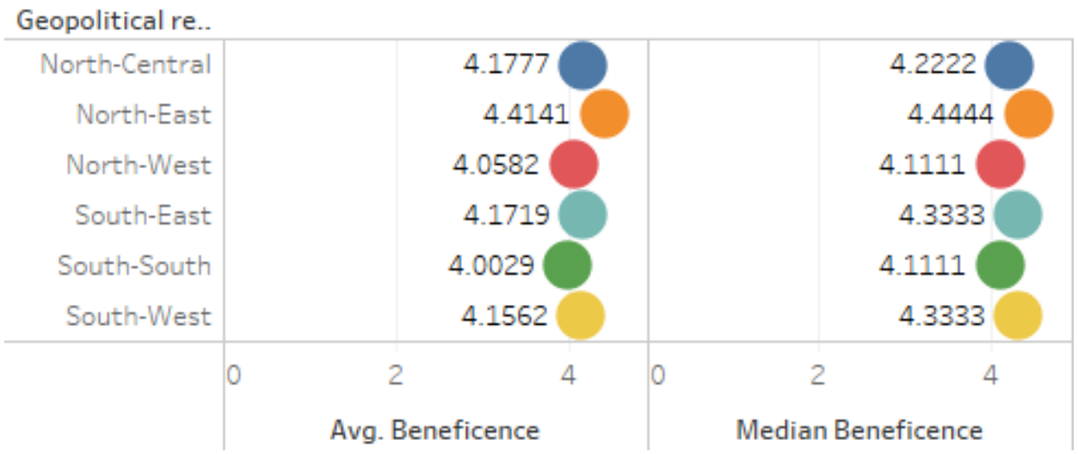


Figure 58: Beneficence/region (mean, median)

When we explore the data further along the questions that constitute the beneficence dimension, it appears that our sample population believes strongly that they do their best for patients even when patients are unfit to make decisions for themselves. Only about 19% believed their colleagues did not care enough about their patients and about 33% believed they kept patients waiting unnecessarily due to their preoccupation with unnecessary activities.

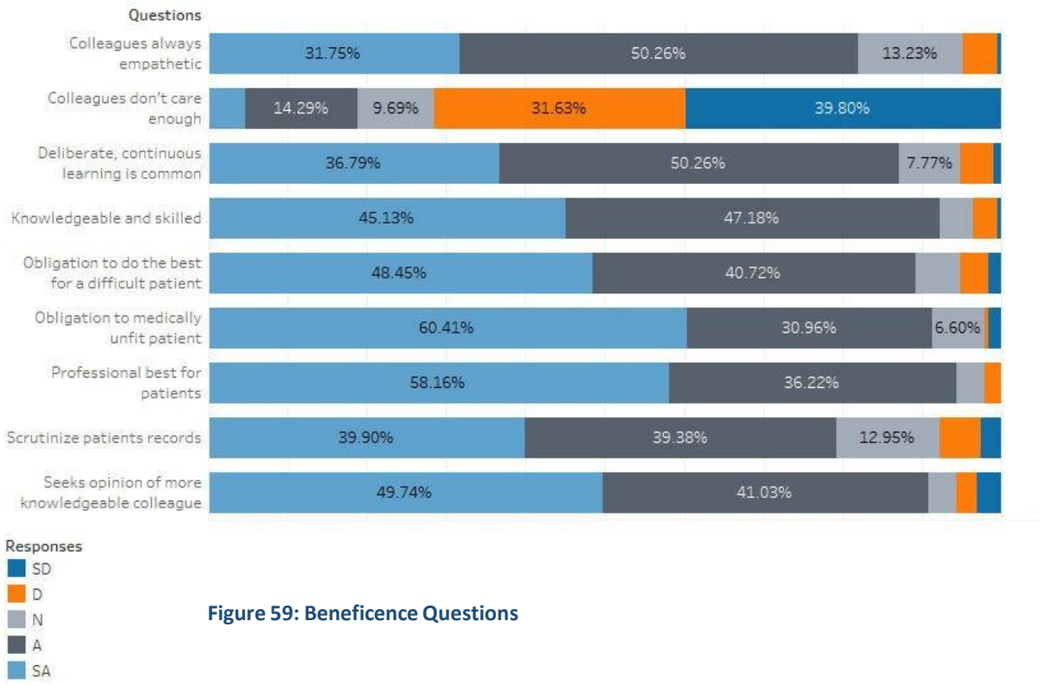


Figure 59: Beneficence Questions

The responses to each question are presented below along regional lines. The north-east respondents standing out on how empathetic their colleagues are and how they do their best for the patient even when they are unable to help themselves, seek one another's opinion on issues and prioritize emergency cases.

18.1 Key Insights

- Nigerian healthcare professionals across all regions are generally clear about their obligation to act in the patients' best interest even when they are not being cooperative or when they are unfit to make decisions on their own.
- Knowledge sharing is also quite common among them, perhaps demonstrating the value they place on their responsibility towards their patients.

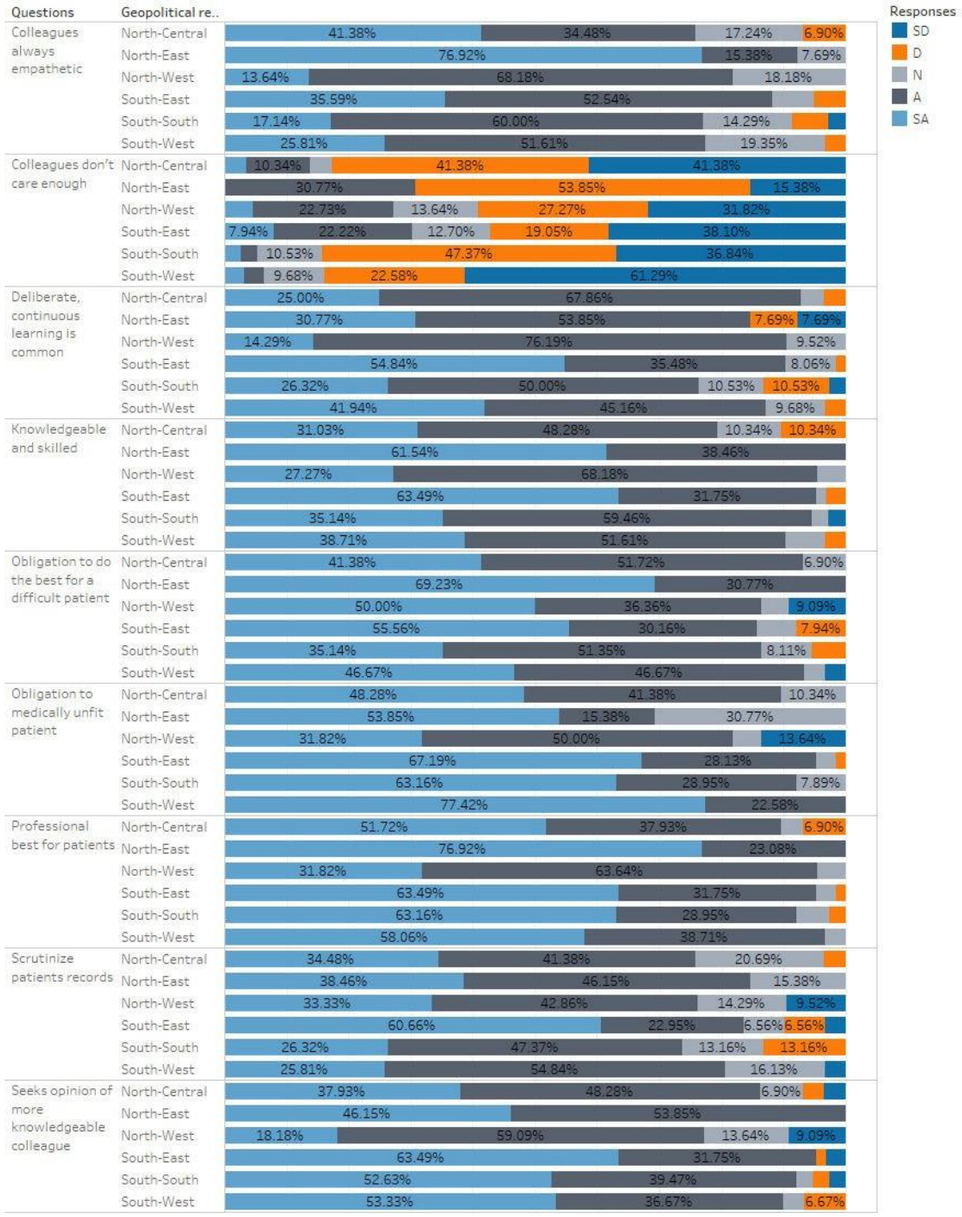


Figure 60: Beneficence Questions by region

19.1 Principle: Non-maleficence

Representative statement: I refrain from engaging in behavior that could harm the patient, potentially causing them more suffering than they would ordinarily have to bear with in their condition.

We ask respondents to give their opinion on how their colleagues fare in various aspects that border in refraining from behaviour that has the potential to cause harm to the patient. Most of the questions were framed to reflect maleficence, so that a high score on any item suggests a high level of maleficence. However, the responses were reverse coded in order to be able to interprete the aggregate results to reflect non-maleficence.

In general, therefore, the chart below suggests that about 39% of our sample population believe their colleagues demonstrated some level of maleficent behaviour or the other toward patients, about 21% are agnostic about their views on their colleagues' behaviours and 40% indicate categorically that they there is really no maleficent behaviour among their peers. The pattern is similar to the results from the user group, with 32% saying they had experienced maleficent behaviour from their healthcare professional, 48% indicating otherwise and a much smaller agnostic group of 18%.

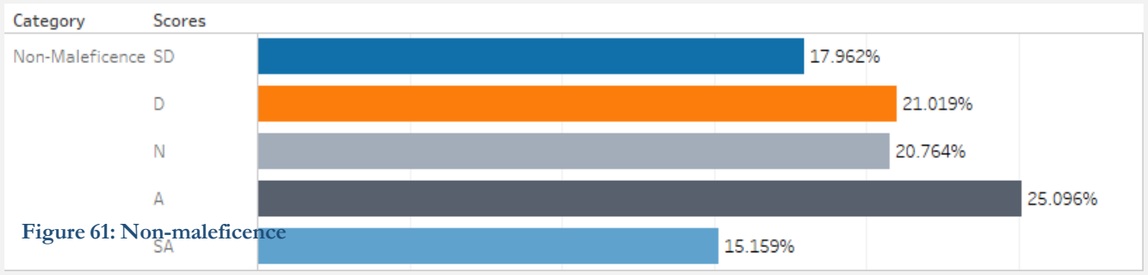


Figure 61: Non-maleficence

At the regional level, under 50% of the sample population indicate that they expect or have experienced some level of maleficence on aggregate, from their peers with the south-east being the highest and the north-east being the lowest.

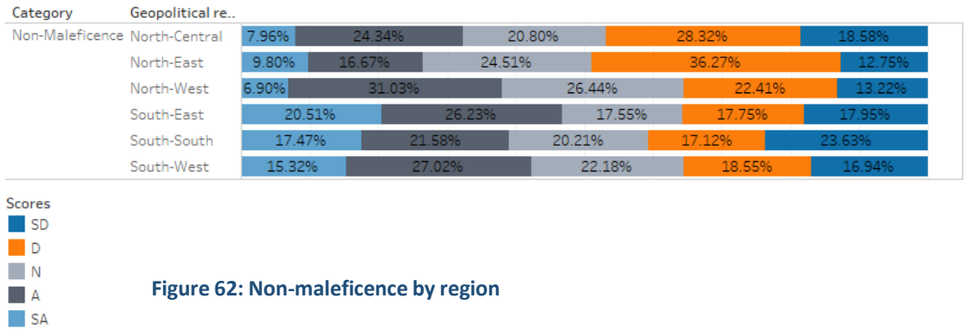


Figure 62: Non-maleficence by region

In general, the survey responses suggest that the highest levels of maleficence are experienced among healthcare professionals in the south-east and south-west.

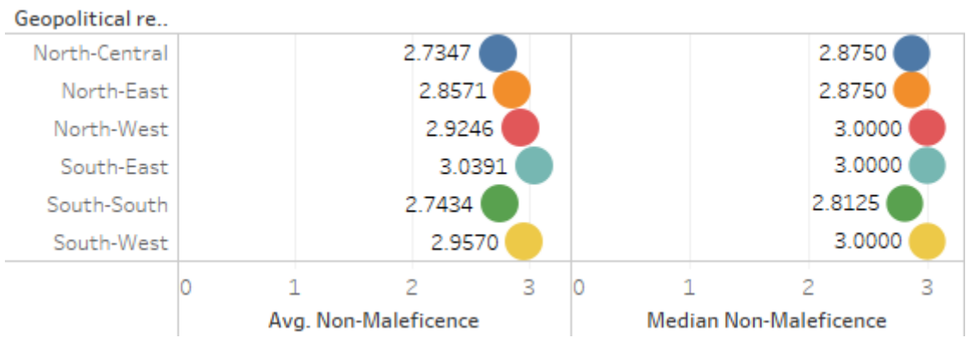


Figure 63: Non-maleficence region (Mean & median)

With respect to the hospital where they practiced, more of the private hospital healthcare professionals believed their colleagues demonstrated maleficent behaviour overall, by about 5%, than their public hospital counterparts.

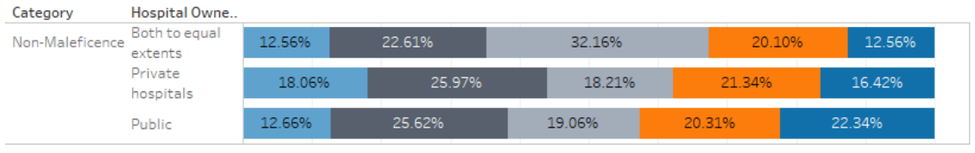


Figure 63: Non-maleficence by hospital type

When we interrogate the specific questions, we find the following. In response to the statement, 'I don't expect my colleagues to misdiagnose a patient's condition', just about 17% believed their colleagues could misdiagnose a patient's condition, while about 19% stayed neutral, in comparison to about 23% of user group that indicated that their condition had been misdiagnosed before.

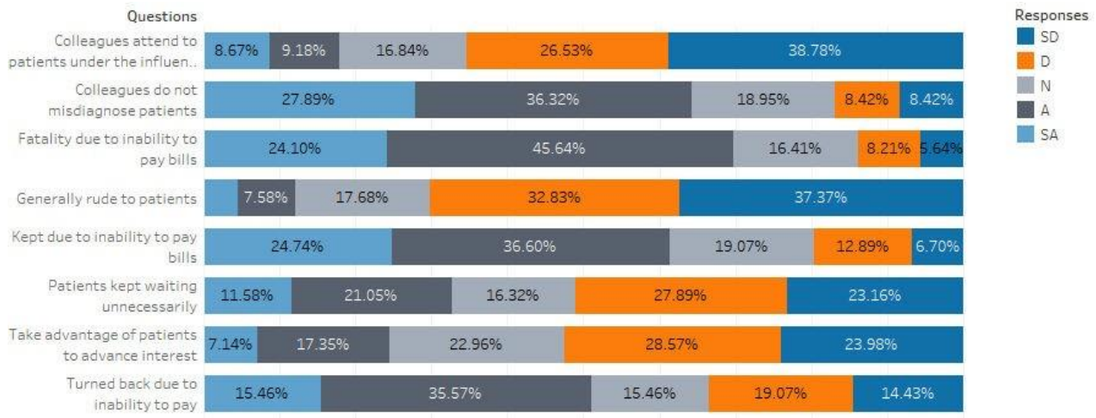


Figure 64: Non-maleficence Questions

Perhaps of more concern is the fact that about 51% of our healthcare professionals indicate that it is not uncommon for patients to be turned back from the hospital due to the inability to pay the hospital bills and about 70% indicated that it is not uncommon for some patients to die in the hospitals due to their inability to pay for hospital services. In other words, they are deprived of medical attention because they cannot pay for the required medical. As seen in the table below, at 75% and nearly 71%, there is barely any difference in the experience of our sample population whether they worked in private hospitals or public hospitals respectively.

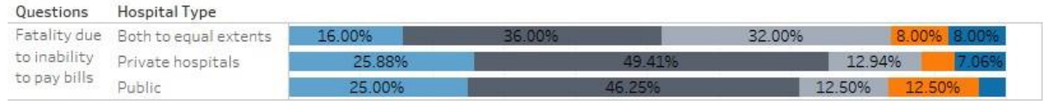


Figure 64a: Fatality rate due to inability to pay

Keeping patients in the hospital because of their inability to pay their bills appears to be a more common phenomenon in the public hospital than it is in the private hospitals, among our sample population.

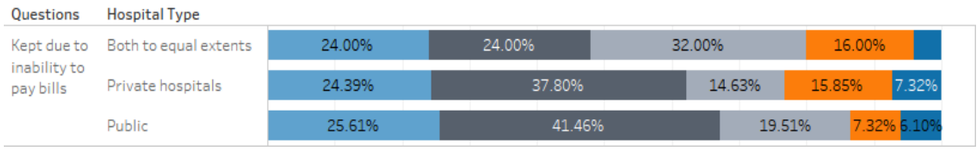
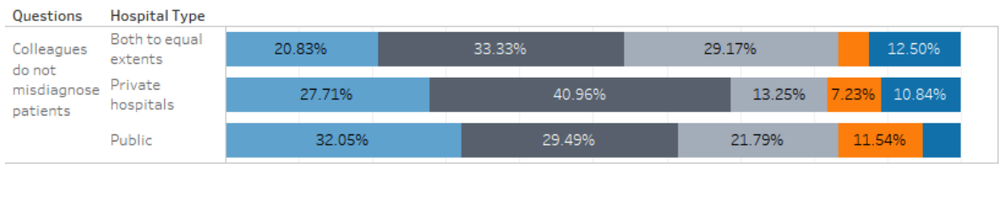
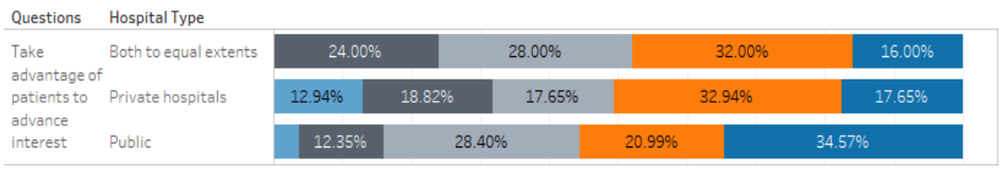


Figure 64b: Hospital stay due to inability to pay

About 68% of our sample population in the private hospitals say they do not expect their colleagues to misdiagnose a patient's case, compared with 61% in the public hospitals. About 23% of the respondents that worked for private hospitals however thought otherwise, in comparison to 13% of those that worked for the public hospitals.



Majority of our respondents however do not agree with the statement that their colleagues take advantage of the patients to advance their personal interests.
However, about 13% more of our private hospital respondents believed their colleagues would take advantage of patients to advance their personal interest, than their public hospital counterparts.



From a regional perspective, the north-east (72%), south-east (78%) and south-west (87%) have the highest percentage of respondents that indicated that in their experience, patients have died in the hospitals due to their inability to pay for services. More than half of the respondents from the other regions agree.

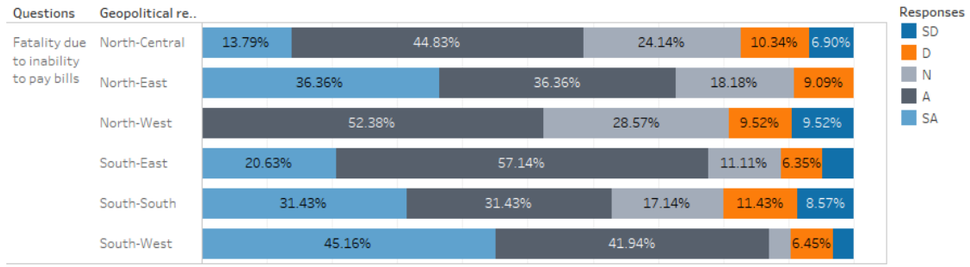


Figure 68: Non-maleficence question by region 1

Also, while the percentages are numerically small, it is worthy of note that some of our respondents indicate that they would not be surprised to know that some of their colleagues attend to patients under the influence of drugs or alcohol. In the, south-east and south-south, that percentage is about 21% each, and the others are under 20%.

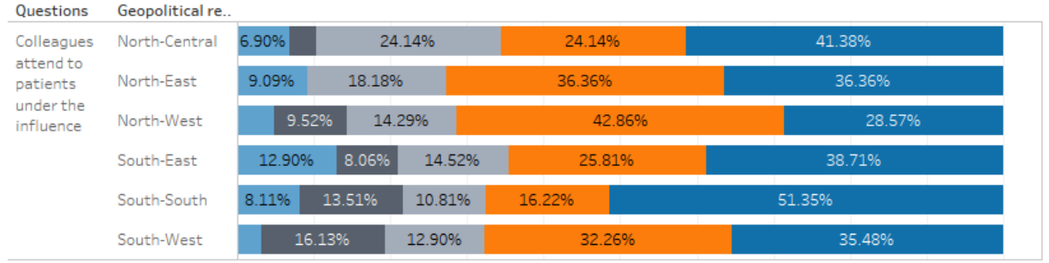


Figure 67: Non-maleficence question by region 1

The complete result showing all questions by region is produced below. Across all the regions, fatality and prolonged hospital stay seem to be the maleficent behaviour most commonly seen and experienced by our sample population.

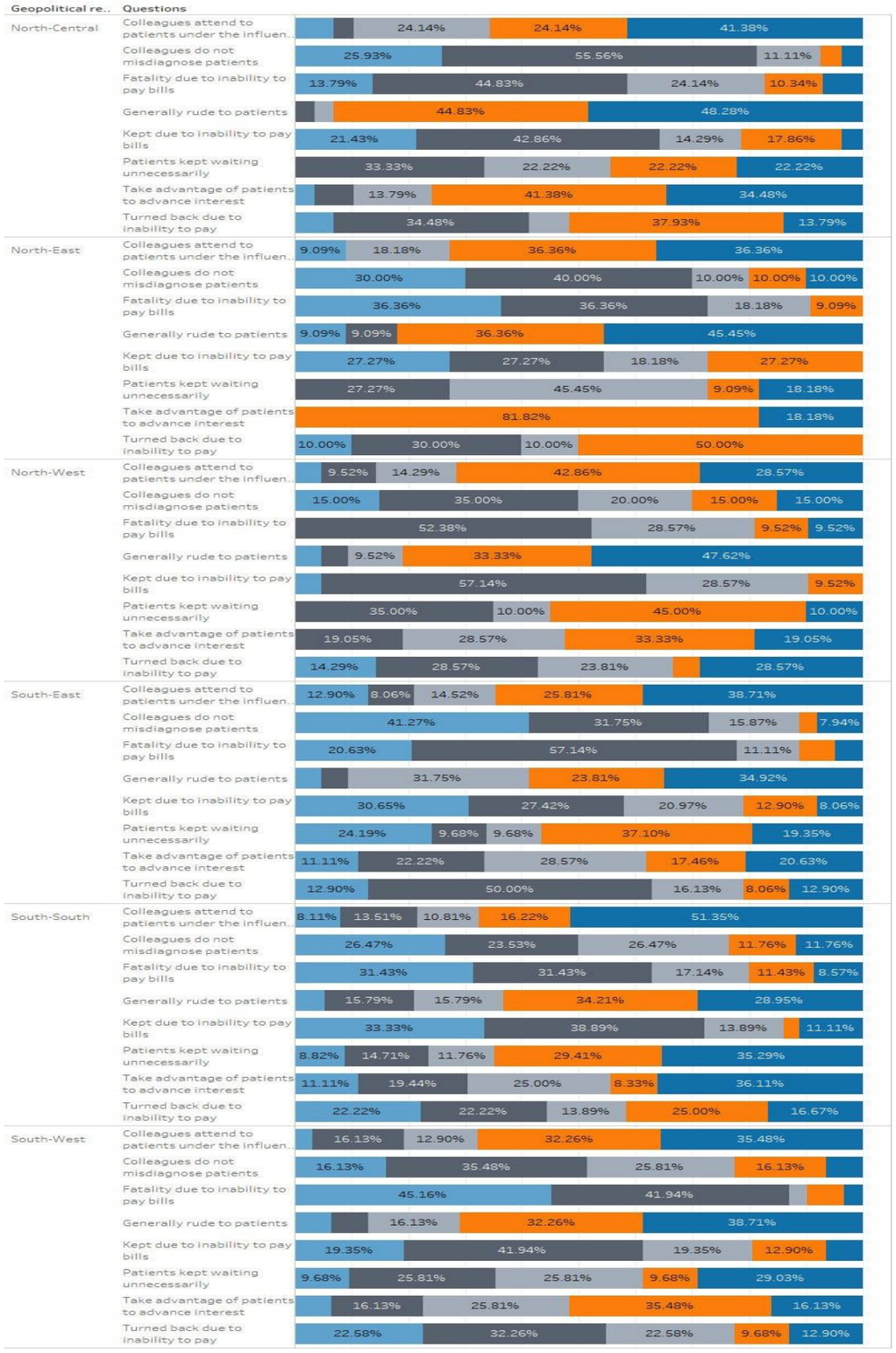


Figure 67: Non-maleficence questions – all regions

19.1 Key Insights

- The duty of care that is at the core of the medical and ancillary professions seems to lie at the mercy of the availability of the patients' pecuniary resources.
- While many deaths occur in Nigeria ostensibly as a result of the nature of the diseases themselves and sometimes improper care and wrong diagnoses, more people probably die for lack of the required medical attention, borne out of their inability to pay for hospital services. One may have expected that this would be more so in the private hospitals since they are self-funded, but the data suggests that there is no significant difference in the experience of the healthcare professionals that work in the public and the private hospitals.

20.1 Principle: Justice

Representative statement: I treat all patients with respect and I am fair in the distribution of resources within my control among patients irrespective of who they and where they come from. My judgement is based on the balance between the need and the resources at hand.

At the core of the justice principle is the equitable distribution of the resources in the care of the healthcare professional in terms of their time, skills and expertise and other resources, to patients that need them the most, irrespective of status or other menial considerations. It also requires that all patients be accorded respect and their rights to quality healthcare be not hampered.

In general, a little over half (about 58%) of our sample population believe that their colleagues treat patients fairly with respect to the distribution of the healthcare professional's skills, expertise and resources.

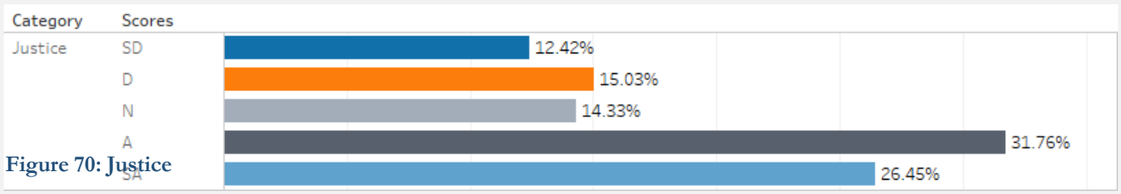


Figure 70: Justice

The pattern is similar across all the regions, with the north-central (69%) and north-east (69%) respondents claiming the highest level of justice in their experience.

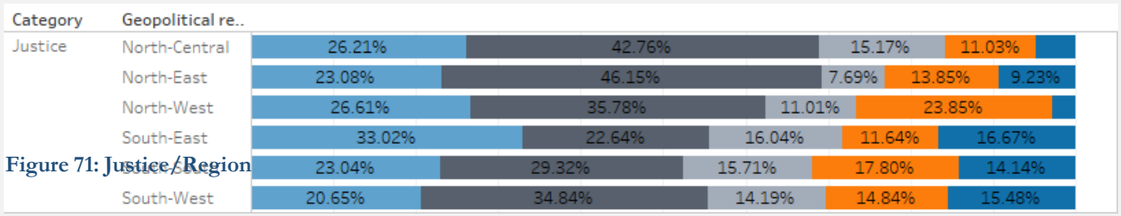


Figure 71: Justice/Region

The experience was similar regardless of primary place of practice.

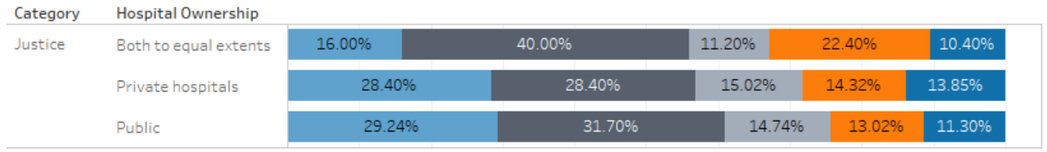


Figure 72: Justice/hospital type

In response to the statement that 'my colleagues act like they are doing the patient a favour', just about 32% of our respondents believe this is the case. On the other hand, 75% believe they treat patients with respect.

About 75% of our respondents agree or strongly agree that quality healthcare is out of the reach of most Nigerians financially. This corroborates the earlier finding that fatalities have occurred, in their experience, as a result of patients' inability to pay hospital bills and patients being turned back as a result of their inability to afford hospital services.

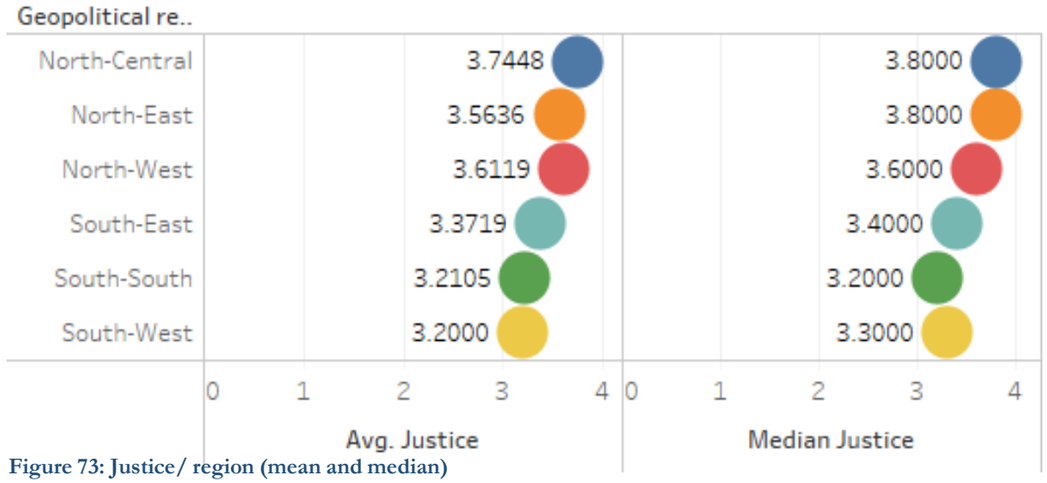
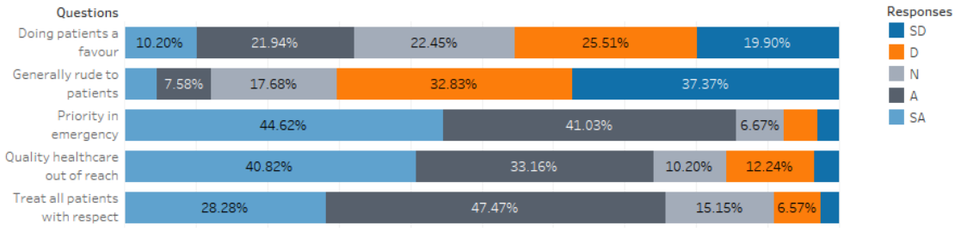


Figure 73: Justice/ region (mean and median)

The aggregate averages on the Justice dimension are generally low, with the highest average and median values being 3.74 (north-central) and 3.8 (north-east and north- central) respectively. The south-west and south-south had the lowest average and median values at 3.2 and 3.3 respectively

The Justice dimension is made up of two categories of questions: one category, was concerned with distributive justice and was made up of five questions aimed at understanding how fair our sample population perceived the healthcare system was to patients generally. As such it included questions around ability to pay and how providers treated patients. The second category of questions was concerned with legal justice – whether and how our sample population was willing and able to report situations that were a breach of the ethical conduct.

In the first case, about 45% of our respondents disagreed with the statement that their colleagues acted like they were doing the patient a favour, even more (about 70%) disagreed with the statement that their colleagues are generally rude to patients. Conversely, about 75% and 85% believed their colleagues treated all patients with respect and prioritized emergency cases. However, over 80% thought that quality healthcare was out of the reach of Nigerians.



While our sample population of healthcare professionals mostly disagreed with the statement that they treated patients as though they were doing them a favour, nearly 50% of our respondents representing the south-south region agreed or strongly agreed with the assertion.

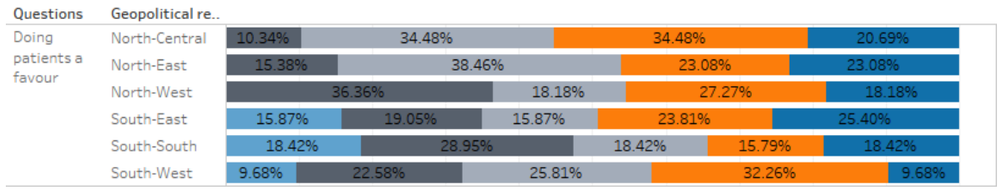


Figure 74: Justice Questions by region

In response to the statement 'healthcare professionals always treat patients with respect', while nearly all our respondents in the northern region agreed, healthcare professionals in the south-west had the lowest percentage (58%) of respondents that felt their colleagues treated patients with respect regardless of their social status; 69% in the south-south and 75% in the south-east.

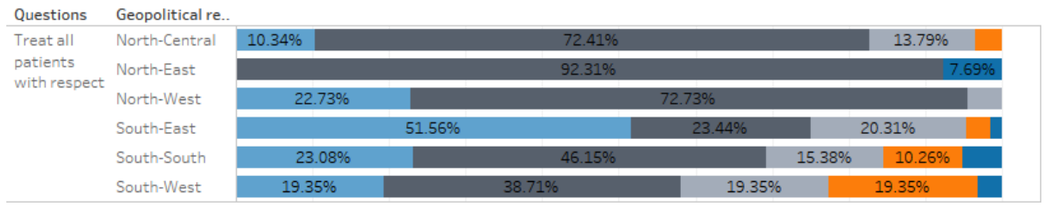
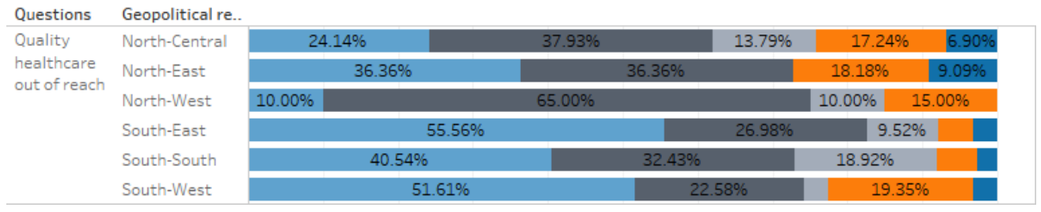


Figure 75: Justice Question by region 2

While a large percentage of our sample population believe that quality healthcare is out of reach of Nigerians financially, it seems to be more so in the southern region than in the northern region as the former felt more strongly about it.



There are other questions that border on equitable access to quality healthcare that border on the healthcare professionals' willingness to report healthcare breaches in their organisations or by their colleagues and how confident they are that those issues will be addressed adequately. In this regard, over 75% of our respondents indicate that they were willing to report any ethical infraction on the part of their colleagues or the hospitals they work for. However, while about 26% said they had reported such an infraction before, about 22% said it had never crossed their minds to do so and about 22% said they have no confidence that the regulatory authorities will act on such reports adequately. About 73% however acknowledge that they have an obligation to report such infractions, while about 17% feel agnostic about that obligation.

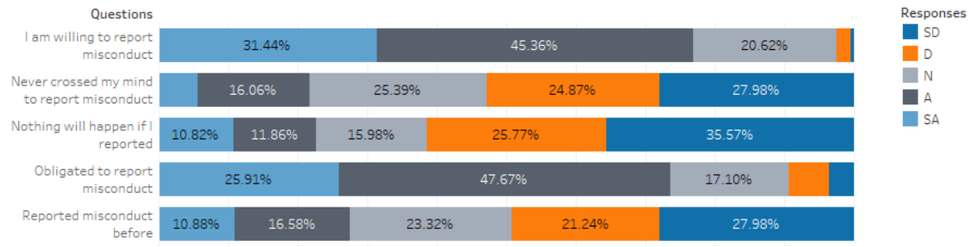


Figure 77: Justice Question - Other

While their willingness to report an infraction is at par, just about 20% of our public hospital respondents say they have reported a case before compared with 36% of the private sector respondents. Incidentally, also more (27%) of the private sector providers say it has never crossed their minds to report an infraction compared with just about 15% of our respondents that work primarily in the public sector. It is also noteworthy, that about a third of our respondents operating in the private sector indicate that they have no confidence in the authorities to handle matters adequately compared with just about 12% of their public sector counterparts that feel the same. However, both groups mostly believe they have an obligation to report any misconduct.

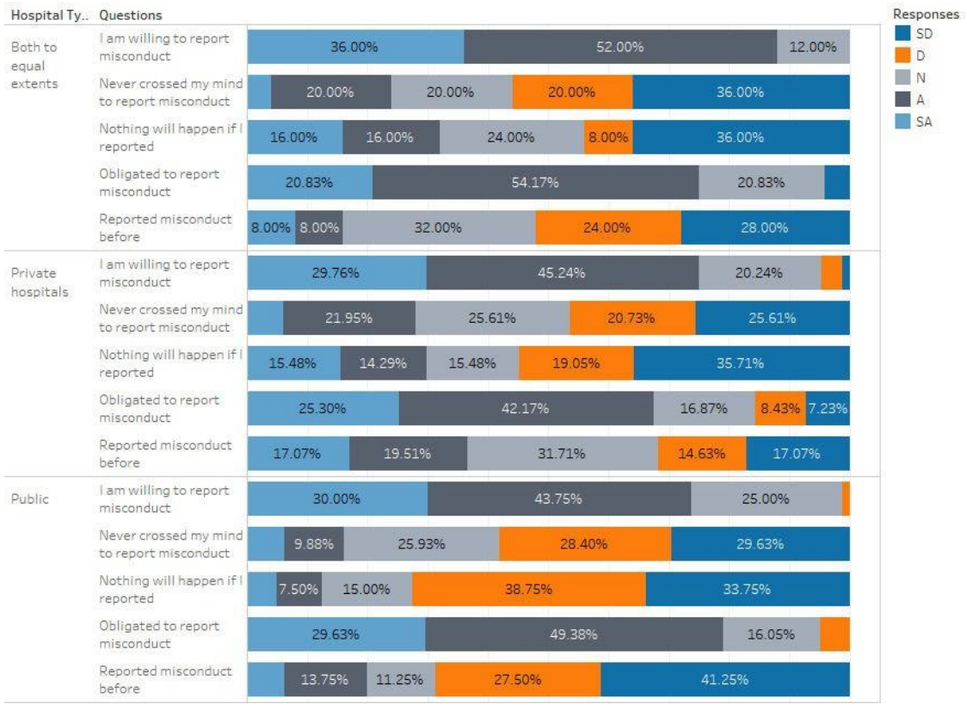
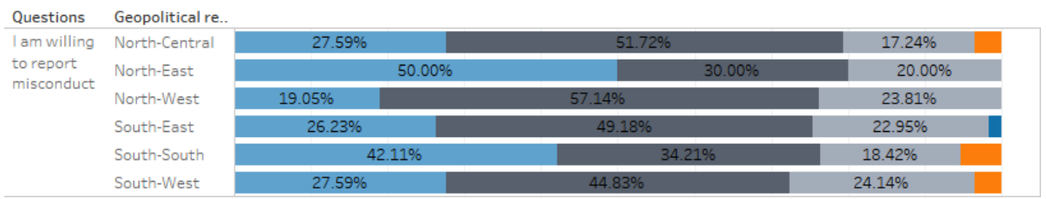


Figure 78: Justice – Other by Hospital type

When we explore these questions along regional lines, we find the willingness to report an infraction is common to about 72-80% of respondents across all the regions with the south-west being the lowest.



However, 38% of our respondents from the north-west have no confidence that such reports will be dealt with appropriately even if they did report a misconduct.

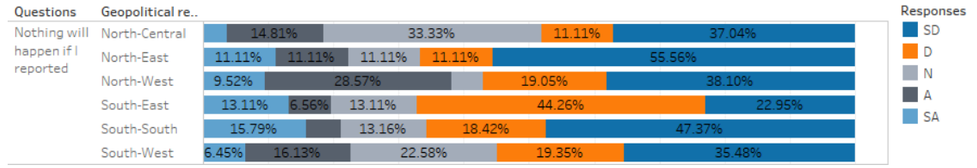


Figure 79: Justice Question – Other/region

While majority believe they have an obligation to report a misconduct across all the regions, we find it curious that as many as 22% of our respondents in the north-east do not think so and about 24% in each of the north-central and north-west are agnostic about that obligation.

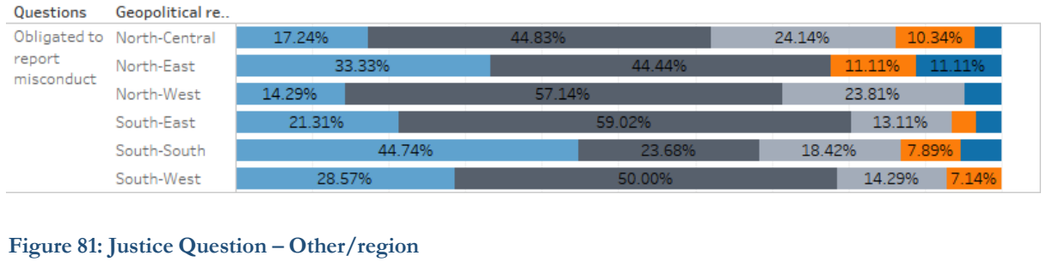


Figure 81: Justice Question – Other/region

20.1 Key Insights

- There are at least two reasons why healthcare professionals may shirk their responsibility to escalate healthcare breaches to the appropriate authorities: that is, they have no confidence that the appropriate authorities will take the required action, ii. they are not conscious of that responsibility.
- The implication is that many ethical breaches could be going on, that could even lead to fatalities, without being accounted for.
- Where such are not reported, there is no chance of a redress or an improvement of the system, contributing to the general failure of the Nigerian healthcare system.

21.1 Health Insurance

One of the core elements of Nigeria's strategy to provide universal health care is the health insurance scheme. We therefore sort the views of our sample population of healthcare professionals of the effectiveness of the scheme.

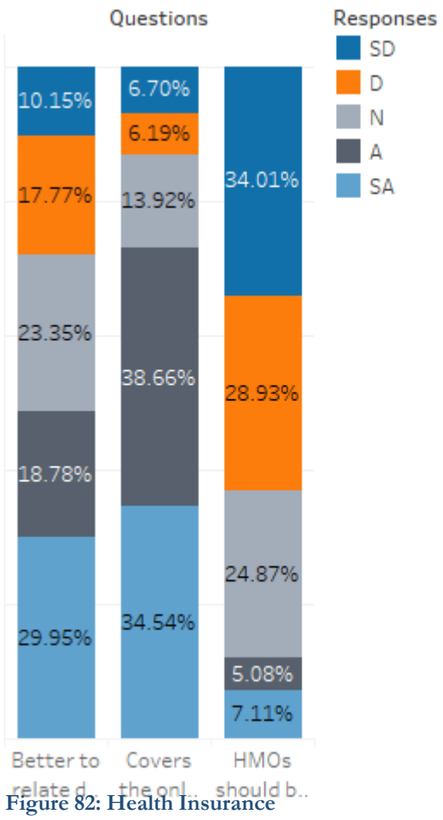


Figure 82: Health Insurance

Nearly half of our sample population believe it is better for patients to deal directly with hospitals (which implies paying out of pocket), than go through the health insurance service. About 73% indicate that health insurance in their experience only covers the most basic healthcare requirements. However, only 12% think it should be scrapped

21.1 Key Insights

- The fundamental principle behind health insurance is valuable. However, its implementation in practice is not adequate to achieve the goals for which it is instituted. Given that both users and healthcare professionals do not think it should be scrapped, all that is required is a system that effectively achieves the objectives of all the stakeholders including the patients, hospitals and health maintenance organisations.

22.0 Annex – How this research was conducted

22.1. The instrument

Questionnaire items were developed after a review of some literature around the four principles that provided the framework for this study and adapted to the Nigerian context.

Pilot
A pilot was conducted in the Lagos Business School. The questionnaire for the user group was administered to staff (security, facility, researchers, front desk officers, faculty) of the school. The purpose of the pilot study was to check for the respondent response time, their perception of the complexity and relevance of questions and typographical errors. The feedback was incorporate into the final instrument.

Measures (Health sector survey - users)
Autonomy: Autonomy was measured using 14-items expressing how patient's right to retain control over their body and the right to choose what medical intervention to accept free of persuasion or coercion by the healthcare professional e.g. "health care professionals should always respect patients' autonomy", "patients have an absolute right to the confidentiality of their medical record", "patients have a right to be told the whole truth about their health situation", and "I believe my healthcare professionals respect my autonomy over my health". The items were structured in five- point Likert scale (1=strongly disagree) to (5= strongly agree).

Beneficence
Beneficence expresses how healthcare professionals do all they can to benefit the patient in each situation. The beneficence items include "My healthcare professionals do their best to improve or maintain my health status", "My healthcare professionals do their best to improve or maintain my health status". The items were structured in five-point Likert scale (1=strongly disagree) to (5= strongly agree).

Non-maleficence
Non-maleficence refers to the obligation of the healthcare professional to refrain from behaviour that can harm the patient and society. The non-maleficence items include "My healthcare professionals have kept me waiting unnecessarily due to their preoccupation with non-medical activities", "A healthcare professional has attended to me before under the influence of alcohol/drugs", "My health condition has been misdiagnosed before". The items were structured in five-point Likert scale (1=strongly disagree) to (5= strongly agree).

Justice
Justice was measured using 12-items expressing how healthcare professionals treat all patients equally regardless of age, social background or status and so on. It also requires healthcare professionals to facilitate the equitable distribution of health resources in their care, including their time, skills, tools and so on. The justice items include "I find that my healthcare professionals always treat me with respect", "In my experience, Nigerian healthcare professionals are generally rude to patients", "My healthcare professionals act as if they are doing me a favour". The items were structured in five-point Likert scale (1=strongly disagree) to (5= strongly agree).

Measures (Health sector survey - professionals):
Autonomy
Autonomy was measured using 15-items expressing how patient's right to retain control over their body and the right to choose what medical intervention to accept free of persuasion or coercion by the healthcare professional for example, "health care professionals should always obtain the patient's consent before any medical intervention", "Patients' autonomy leads to poor decision concerning their health care", "Health care professionals should have the final say in their patients' medical interventions". The items were structured in five-point Likert scale (1=strongly disagree) to (5= strongly agree).

Beneficence
Beneficence expresses how healthcare professionals do all they can to benefit the patient in each situation. The beneficence items include "My colleagues generally do their best to improve or maintain their patient's health status", "Deliberate, continuous learning is quite common among my colleagues in the health sector". The items were structured in five-point Likert scale (1=strongly disagree) to (5= strongly agree).

Non-maleficence
Non-maleficence refers to the obligation of the healthcare professional to refrain from behaviour that can harm the patient and society. The non-maleficence items include "I will not be surprised to learn that some of my colleagues attend to patients under the influence of alcohol or drugs", "I do not expect my colleagues to misdiagnose a patient's condition", "My health condition has been misdiagnosed before". The items were structured in five-point Likert scale (1=strongly disagree) to (5= strongly agree).

Justice
Justice was measured using 10-items expressing how healthcare professionals treat all patients equally regardless of age, social background or status, and so on. It also requires healthcare professionals to facilitate the equitable distribution of health resources in their care, including their time, skills, tools, etc. The justice items include "Healthcare professionals in Nigeria always treat patients with respect regardless of their social status", "Quality healthcare in Nigeria is out of most patients' financial reach". The items were structured in five-point Likert scale (1=strongly disagree) to (5= strongly agree).

Health Industry Survey – Healthcare professionals

S/N	Autonomy
1	Healthcare professionals should always respect patients' autonomy
2.	Healthcare professionals should always obtain the patient's consent before any medical intervention
3.	Patients have an absolute right to the confidentiality of their medical record
4.	Patients have a right to be told the whole truth about their health situation
5	Patients should have the liberty to make decisions about their health care among options presented to them by their health care professional
6.	I do not think that patients' autonomy leads to poor decisions concerning their health care
7.	Patients have the right to receive simple and adequate amount of information from their healthcare professionals, to guide them in making the right choices about their health
8.	My healthcare professional should have the final say about my medical interventions
9.	I feel that my healthcare professional respects my right to make decisions about my health
10.	My health care professional feels very uncomfortable when I ask questions about my health or the recommended interventions
11.	I can recall at least one time when my healthcare professional did not obtain my consent before my treatment
12.	I do not think my healthcare professionals treat my medical history/records with the required level of confidentiality
13.	I believe my healthcare professionals respect my autonomy over my health
14.	Sometimes I feel like my healthcare professional withholds relevant information about my health situation from me

S/N	QUESTIONS ON PRINCIPLE OF BENEFICENCE
1.	My colleagues generally do their best to improve or maintain their patient's health status
2.	Healthcare professionals in Nigeria are quite knowledgeable and skilled about their profession and areas of specialty.
3.	Deliberate, continuous learning is quite common among my colleagues in the health sector.
4.	My colleagues typically scrutinize a patient's medication history before prescribing new medications
5.	My colleagues are always empathetic towards patients
6.	Many of my colleagues don't care enough for the well-being of the patient
7.	When my colleagues are not sure about an intervention, the default is to seek the opinion of other knowledgeable colleagues.

S/N	QUESTIONS ON PRINCIPLE OF NONMALEFICENCE
1.	Even if a patient refuses treatment or fails to comply with medical advice, the health care professional is obligated to do his best for them
2.	My colleagues typically scrutinize a patient's medication history before prescribing new medications
3.	My colleagues will typically prioritize emergency cases whenever the need arises
4.	It is not uncommon to see patients waiting unnecessarily, due to their healthcare provider's preoccupation with irrelevant activities.
5.	I will not be surprised to learn that some of my colleagues attend to patients under the influence of alcohol or drugs.
6.	I do not expect my colleagues to misdiagnose a patient's condition
7.	My colleagues generally keep patients waiting longer than is necessary
8.	When a patient is unconscious or medically unfit to make decisions about their health, a healthcare professional is obligated to do the best they can for the patient's well-being.
9.	In my experience, healthcare professionals in Nigeria take advantage of patients visit to the hospital to advance their interests (e.g., market a product to me, recommend their own/a friend's practice, etc.).
10.	In my experience, it is not uncommon for patients' cases to become fatal due to their inability to pay for hospital services
11.	In my experience, it is not uncommon for patients to be turned back without being attended to, due to their inability to pay for hospital services
12.	It is not a bad idea for patients to give their healthcare professionals gifts from time to time
13.	In my experience, it is not uncommon for patients to be kept in the hospital due to their inability to pay their bills

S/N	QUESTIONS ON PRINCIPLE OF JUSTICE
1.	I find that my healthcare professionals always treat me with respect.
2.	When there has been an emergency concerning another patient, my healthcare professionals have prioritized that case over mine (or vice versa).
3.	In my experience, Nigerian healthcare professionals are generally rude to patients.
4.	Quality healthcare in Nigeria is out of my reach financially
5.	My healthcare professionals act as if they are doing me a favour.
6.	Patients ought to report professional misconduct or any ethical breaches by their healthcare professionals or institutions to the appropriate authorities.
7.	I have reported a healthcare breach / professional misconduct to the appropriate authorities before
8.	It has never crossed my mind that I can report a healthcare breach / professional misconduct to the appropriate authorities.
9.	I do not know any regulatory authority to which I can report an ethical healthcare breach or how to reach them.
10.	Even if I did report an ethical breach / professional misconduct, I doubt that anything will come out of it.
11.	If the need arises, I am willing to sue healthcare professionals/institutions for any breach of their responsibility towards me.
12.	I am generally more comfortable using public hospitals than private hospitals in Nigeria

22.2. Research Design & Analysis

We adopted a concurrent embedded research design, which simply implies that we collected both quantitative and qualitative data almost simultaneously. The primary method which is the quantitative has the secondary method (qualitative) embedded within it. Since health care users and health care providers had surveys administered to, the study ensured that both respondents were offered similar instruments to compare the responses of one group with the other.

Survey Administration
For the survey (questionnaires), three field researchers collected data from seven states across the six geopolitical zones in Nigeria. One focused on the North-Central, North-East and North-West. Another focused on the South-East, South-South and South-West. The third field researcher focused on Ondo state. Selection criteria for each state was based on the population density of the state, assurance of researchers' security and relative ease of logistics. The states visited are:

Zone	State
North-Central	Abuja
North-East	Bauchi
North-West	Kano
South- East	Abia
South-South	Edo
South-West	Ondo, Lagos

The targets (respondents) were patients (users of any health care service) and healthcare professionals. The field researchers distributed both hard copies of the questionnaires and links to the softcopy of the survey. All hardcopies were collected, and data transferred. 700 respondents were set as adequate number appropriate for analysis. As a result, 1,900 hard copy surveys were distributed, 300 soft copy versions were also sent out as links to potential respondents. Eventually, only 1,120 were returned. However, 371 copies were unusable because they were not completed to any reasonable degree. Similarly, for health care professionals, a total of 430 instruments were administered. We were only able to use about 207.

Fifteen professionals from various medical fields were contacted to participate in an in-depth individual interview with a researcher. Questions pertaining to the medical code, address of misconducts and HMOs were addressed. Length of interviews was at an average of fourty five minutes. Twelve interviews were done over the phone and recorded with consent from the interviewees and three were carried out face-to-face. The interviews were transcribed and the data used to contribute to the triangulation the quantitative data.

Generally, survey was self-administered, making it possible to send soft copies of the questionnaires to potential respondents. Although the research team considered that an interviewee administered survey ran the risk of poor interpretation due to low literacy levels in some cases, the use of an interviewer administered survey holds a high risk of interviewer bias as well as extending the available period of the study unduly. Self- administered surveys allow for quick and vast dissemination of the instrument especially in regions where many potential respondents prefer a technology savvy approach to completing the surveys. In areas with very low literacy rates, an interpreter had to be used, but attempt was made to even out the biases. Following the quality of translation testing principles in translation theory, the interviewer utilized a 'knowledge testing' approach to test the quality of translation (Ayodele, 2001). The interviewer paraphrased sampled responses in polar interrogative forms ('yes' or 'no' questions) to the respondents through the interpreter. The interviewer simply sought "Yes or No" responses which would ascertain consistency of response with already completed responses contained in the questionnaire.

For the qualitative interviews, the questions were open ended to facilitate in-depth engagement with the respondent. Interview guides were used to facilitate consistency in the information sought from all interviewees; however, there were follow-up questions that sought for clarity on a case-by-case basis. Electronic recorders were used to capture the responses provided during each interview session and word-for-word transcriptions were done to prevent loss of data due to interpretation bias from the resource executing the transcription.

Before and during the processing of the data for analysis, care should be taken to ensure data is as accurate and consistent as possible. Actively and systematically searching for, detecting and correcting errors is a vital part of any research. Daily entry of data from questionnaires and transcription of audio interviews was used as a measure to minimize the quantity of errors. Incomplete questionnaires, questionnaires with contradicting answers, questionnaires with straight lined responses were removed.

The software used for the analysis were a combination of: Tableau, SPSS, and Excel. These were programmed to highlight rule violations and prevent mistakes.

All relevant research protocols were followed . Each participant in the survey and interview were informed of their rights as a voluntary respondent who retained the right to withdraw their participation in the study at any point. The consent of each interviewee was sought before the interviewers recorded each session electronically.

22.3 Limitation of the study

A random sampling approach was preferred to a non-random sampling technique for questionnaire administration. The use of this technique could and did result in disproportionate representation of the different possible demographics of respondents. Therefore, this is one of the limitations of this study. However, given the objective of the study and the limitation in terms of time and resources, a stratified sample in a population as diverse as the Nigerian population would have introduced perhaps a more problematic bias regarding who was sampled, who was not and why.
Another possible limitation of this is an in-depth consideration of variables such as cultural differences, poverty and the chronically ill. These factors may have some potential to influence perspectives and perception of healthcare practitioners and health service users. However, the general results suggest that the final conclusions may be unlikely to change regarding their experience of ethics in the healthcare sector. It will however be useful to explore these differences further in a more extensive study.

1. It should be noted, that the study is neither clinical nor biomedical in nature, hence, the researchers did not deem it necessary to abide by the intricate guidelines required by the International Ethical Guideline for Health- related Research Involving Humans (CIOMS, 2016) , and the Global Health Ethics (WHO, 2015) .

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