Rethinking the pathway to universal health coverage in nigeria

Editorial: Rethinking the Pathway to Universal Health Coverage in Nigeria

Keywordsuniversal health coverage, transactional paradigm, relational paradigm

Introduction

Universal health coverage (UHC) has become the number one aspiration for health care delivery in many countries although progress towards it remains elusive to most (1). Indeed, evidence shows that achieving progress towards UHC improves population health (2-5) and confers social, economic and political benefits (5-7). What is less clear though is the pathway to its achievement, especially in low and middle income countries. This paper has a dual purpose: 1) to explore, with reference to the Nigerian context, the meaning and limitations of a transactional paradigm as one approach to organizing health system reforms towards goals such as the UHC, and 2) to propose an alternative and more promising approach based on the relational paradigm.

Achieving anything has to begin with clarifying its meaning. Interestingly, the meaning and scope of UHC remains shrouded in ambiguity. It is however agreed to be consistent with principles of distributive justice (8), right to health (9, 10), and socio-economic risk protection (8). As a concept, it is considered to have evolved from the 1978 Alma-Ata Declaration and similar movements towards health equity (11, 12). One could say that it has however come of age since its adoption as a key part of the sustainable development goals in 2015 (12-14). According to the World Health

Organization (WHO), UHC proposes that “ all people have access to services and do not suffer financial hardship paying for them” (11).

The Transactional Paradigm

From the foregoing, UHC is clearly a revolutionary aspiration. As such, rather than considering isolated functional level strategies, we have chosen more disruptive thinking. Our approach questions the overall logic behind the adoption, success or failure of specific strategies. It is based on the argument that although a tactical interventions such as improving financial risk-sharing mechanisms may lead to incremental ‘ improvements in’ the health system (15-17), the UHC challenge could benefit more from the crafting and testing of systems level theories of change. This is more likely to lead to ‘ improvements on’ the system and accelerate progress towards this revolutionary vision.

Although there are hundreds of variations in health systems globally, it is be possible (within limits) to categorize them based on general patterns. Our categorization is based on how health systems strengthening is organized, in adaptation to internal and external forces, to produces two alternative conceptual models. This has been adapted from another field, marketing theory and practice (18, 19), for thinking about the fundamental set of assumptions guiding health systems development or reformation. The adaptation of these models also bring into consideration conclusions from studies about internal and external forces that influence the orientation that health systems adopt to achieve improvements (16, 20, 21).

The first model is what we call ‘ the transactional paradigm’. This model suggest healthcare as a luxury commodity driven mainly by market forces with minimal influence from the political and social spheres (22). It suggests that if supply (opportunity to access treatments) is scaled-up then uptake and population health outcomes will also automatically improve, with little or no need for political or social interactions in this process. It therefore adopts a health system strategy that concentrates on scaling opportunities for such “ point-of-care” transactions without developing critical relationships among key actors. This is seen for instance in the indiscriminate building of hospitals without prior needs assessment.

The result is a health system characterized by minimal and fragmented governance/financial protection, development and deployment of resources in line with vertical service delivery, and a focus on facility-based, acute, episodic, and curative treatments that lack patient-centeredness. Such health systems may have evolved to solve fragmented and disease-focused health problems. However, the UHC aspiration may always remain unattainable for these systems given its much broader view of health outcomes, care, and the preconditions.

A Nigerian Perspective

Nigeria provides a typical health system driven by the transactional paradigm. This most populous and diverse African nation has struggled for the past 59 years since its independence to translate its huge natural resource fortunes into significant decline in poverty or improvement in population health outcomes.

The most recent WHO health system ranking places the Nigerian health system at 187 th out of 191 global health systems. This indicates the country's dismal overall health system performance particularly with respect to its responsiveness, level and distribution of health in population, and fairness of financial contribution (23). It may also be considered as determined by the degree of optimization and/or alignment of underlying mechanisms driving the health system performance (24, 25). For instance, internal conditions of the system are such that governance is guided by weak evidence base (26); financing reflects an insufficient expenditure on health (3. 7% of GDP), with 74% of total expenditure on health coming from the private spending (27); growth in a number of health worker cadres (particular nurses and midwives) that is not keeping pace with population growth, and high disparities in service delivery continue to exist (26). These combined with unconducive political, social, economic contexts come short of preconditions suggested for progress towards UHC (16, 21, 26, 28).

A look back at the historical basis of the situation reveals an erratic system evolution leading to a reactive short-term orientation. This could have been influenced by the context of complex and largely unpredictable political, economic and social variables (29). It can be argued that across the several reforms within its history, the focus on healthcare as a commodity to be mass produced with little or no recourse to social-political considerations is a consistent theme. It begins during the colonial era with the introduction of the western model of care to operate in parallel with the traditional model. This probably is the origin of segmentation and fragmentation of the Nigerian health system. The period 1880 – 1945 saw a nationwide scaling of this

unintegrated western facility based system as seen in the building of several health care facilities. Since 1945, the country’s post-colonial health system reforms appear to have remained shackled to an old way of thinking that aligns with the transactional perspective. Consequently, progress towards the new vision of UHC have been have remained stunted (26, 29, 30). But how can it then unshackle itself?

Transitioning to UHC through a Shift to the Relational Paradigm

Without invalidating the relevance of some fundamental elements of the transactional paradigm, we propose an alternative paradigm. This alternative, termed relational paradigm, offers a broader perspective that accommodates UHC requirements. It considers health care as a social right with political and economic value. It therefore prioritises the constructive interaction among social, political, and economic actors and forces. Its underlying assumption is that if relationships among health care actors are enabled and nourished in the process of scaling supply, then outcomes in health care (coverage, uptake, resilience), population health (functionality and health related quality of life) and development (financial and social protection) will improve (31-33). This therefore translates into health system strategies that improve social welfare by balancing stakeholder power and interest through transparency, accountability, and responsibility setting mechanisms.

There are several likely benefits that could justify this approach as a better precursor for UHC. First, it should be more effective at pulling all relevant stakeholders together towards the greater good, making risk sharing more

feasible (34). Second, it could be better at leveraging the participation and commitment of all these stakeholders to address barriers to access and utilization (16, 21). Third, it appears more likely to create better value for investment due to the continuous alignment of stakeholder interest (14, 31).

But what practical relevance does this offer to health systems like that of Nigeria in accelerating progress towards UHC? In our opinion, this conceptual tool can be of relevance to several healthcare actors. In addition, it is a call for increased participation and commitment from all key stakeholders. It could serve as thinking tool for researchers in considering association of relevant inherent constructs. Healthcare activist may find it handy as a coherent system for explaining the basis of and need for constructs such as integrated governance, financial risk sharing, public private partnership, and a person–centred service delivery. Finally, policy makers may see its relevance in designing and evaluation of policy frameworks, while practitioners consider it as a practice guide in some respect.

Conclusion

Evidence shows that progress can be made towards UHC even by low and middle income countries (20). We suggest that in considering the corresponding determinants of health systems performance, it is possible and perhaps critical to consider the overall logic together with individual health system reform strategies. We propose that thinking through paradigms such as the ones presented herein, could also enable the formulation and combination of more appropriate and coherent strategic options towards achieving UHC.

Finally, we admit that while we see great prospects for this approach to thinking about and pursuing UHC, the underlying assumptions will require strong validation and contextualization through more rigorous research.

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