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Rethinking Health Practices For Effective Development In Nigeria: Evidences From Irrua Specialist Teaching Hospital, Edo State

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Abstract

After years of research, we have observed that hospitals in Nigeria have innovated a healthcare delivery practice to relieve the poor patients from critical conditions. This, we call "the Case Note Practice". However, it has only helped the poor patients out of critical conditions instead of permanently reducing their "Burden(s) of Disease" and "Cost(s) of Illness". The practice can be the springboard of a new healthcare delivering model - "The Case Note Model" - in the likes of Beveridge, Bismark and the National Health Insurance, suitable for, and indigenous of Nigeria. This study takes the case of Irrua Specialist Teaching Hospital, a tertiary and referrer hospital located in rural Edo State, Nigeria. It uses the Key Informant Interview in the form of slicing through the organization. It calls for more engagements and international interventions for further research and to assist the hospitals in order to improve on the practice. Such interventions are necessary because under no condition should for example, epidemiological concerns make a woman die or be maternally morbid in the process of bringing another human being to life. The study is a big innovation in the Nigerian healthcare system and can provoke health research for the benefits of the poor patients.

Keywords: Hospitals, Healthcare Model, Out-of-Pocket, Patients

Introduction

Healthcare delivery system across the world needs interventions to succeed since health is a merit good, which is compulsorily consumed by both the rich and the poor. The advanced countries have always devised means to support the health consumptions of their residence since they understand that the demand for higher health stock is a derived demand; for aggregate growth in productivities, economic growth and development. This is so because there is a positive correlation between the health stocks of the residence and national productivity (Igberaese, 2019). Therefore, one strategic way to plan the growth of the economy is to take conscious directed efforts towards making friendly public healthcare policies and invest in the health of the residence. This in turn makes the aggregate work done by the individuals who are in healthy states lead to multiple booms in the economy.

The static Grossman model of healthcare investment implies that improved health stock leads to longevity; the individual will have longer period to contribute to the labour force.

The simple Grossman health model is as follows:

$$H_{t+1} - H_t = I_t - \delta_t H_t \quad (1)$$

Where:

H_{t+1} is the health capital at the beginning of an interval, $_{t+1}$

I_t is the gross investment during the interval t

δ_t is the rate of depreciation that is assumed constant within a given time interval t and exogenously dependent only on an individual's age.

(Nocera & Zweifel, 1998)

The model states that health depreciates with age and that investments have multiplier effects on health and longevity, as such investments reduce sick times and postpone death of the individual into a far future. However, to achieve this, there must be a practical and established system of healthcare delivery that can benefit both the rich and the poor. This is what healthcare models seek to achieve. Therefore, when a country spends its resources on the healthcare of its residence, it is actually to increase national outputs, provided that disabilities of the residence are not yet measured beyond the Instrumental Activities of Daily Living (IADL). Such a country has not only reduced the overall Burden of Disease (BoD) and Cost of Illness (CoI) but has also enabled growth. Nonetheless, Igberaese and Iseghohi (2017) advocates that if disability is already measured beyond the Instrumental Activities of Daily Living (IADL) to the Activities of Daily Living (ADL), the patient need not utilize any

healthcare model and could demand for death to free resources, reduce BoD and CoI. This stage of disability measurement must be avoided in the first place by formulating good healthcare models.

One critical problem is that the government of Nigeria does not formulate oriental healthcare policies for its systems, despite mostly located in the naturally disadvantaged tropic region where most of the highly prevalent diseases are predominant. It is an irony that health demand is far more encouraged in the advanced countries that already have better health stocks than in Nigeria with low health stocks (World Bank, 2020; World health Organization, 2015), making Nigerians sicker by the day. It then implies that only the rich who have laid hold to the nation]s wealth have access to good healthcare, not within the country but outside it. Even when it appears that some people can live long in Nigeria, they merely live long with different disabilities. This is "Life Expectancy" (LE) without "Healthy Life Expectancy" (HALE), otherwise known as Disability Free Life Expectancy (DFLE). Thus, many people in Nigeria live with what Robine, Romieu and Michel (2006); Christensen, Doblhammer, Rau, James and Vaupel (2010) refer to as living long with illness and diseases. Igberaese and Onogbosele (2020) contend that only a few elites have been known to have experienced the "success of success hypothesis" with the application of technologies, since the common wealth of Nigerians is at their disposal to seek healthcare outside the country (Kazeem, 2018).

Whereas the already healthy countries still continue to search for additional ways of encouraging healthcare consumptions and healthcare investments, it is sadden that only the "Out-of-Pocket" Model of healthcare delivery still persists in Nigeria. This has ensured that the elites in the countries transfer incomes to the advanced countries by a shift in healthcare demands to the advanced nations, which can be regarded as economic sabotage. Worst is the wide disparity in the distribution of income for healthcare goods between the rich and poor. Few government officials are unable to exhaust their healthcare budgets from the government but majority of the citizens have little or no budget for healthcare. This surely affects what can be categorized as the third market – the market for healthcare goods. Since a poor man must satisfy consumptions from the second market – the product market – with income from the first market – the labour market- before thinking of healthcare goods, health goods cannot be his priority. The only exemption is when he has become so ill and the illness is already life threatening; in most cases, the healthcare demand would only be made on his behalf by his relatives when he can no longer do so by himself.

Nevertheless, there is an eccentric health practices by some Nigerian government hospitals in their attempts to cover the healthcare model gaps between the advanced countries and Nigerian. This practice is merely a makeshift necessity in sympathy with the poor. This paper is with the hope that this healthcare practice can be improved upon to birth an additional healthcare model that is indigenous to Nigeria, and by

extension, Africa and other developing countries, such that Nigeria, like the others would no longer be associated mostly with the worst healthcare model in the world.

This is the first stage of the study that to about three years of observations of different hospital to birth a new and indigenous healthcare delivery model for the poor. It stems from the concerns about lack of confident public healthcare policies in poor countries. Given available funds in the future, we intend to further the study, gather stakeholders and experts together to brainstorm on possible and constant helping hands to these hospitals and find ways to incorporate private hospitals/clinics that are easily accessible to the poor. We shall also do some contact tracings of poor patients and find ways to empower them to be able to manage their health stocks in order to reduce their BoDs and societal CoIs. Thus, the study covers a wide gap in public healthcare policy of countries with similar economic characteristics as Nigeria. Our hope is that at the end of our series of research and development, we would be able to take it to the next level; make it an oriental health model instead of it being a mere accidental practice. For now, only the out-of-Pocket model was predominant in Nigeria. Two of the other three; the Beveridge model and the Bismarck model are completely absent while National Health Insurance model is very scanty, only few among government employees.

The major purpose of this paper therefore, is to seek ways of improving and bringing to the limelight and recognition of this observed non-oriental health practice with the belief that it would attract global attention for an additional healthcare model for the poor. It is a qualitative study that uses the Key Informant Interview – KII (USAID 1996 cited in BetterEvaluation, 2014) to analyze the challenges and suggest ways of improving on it as a potential healthcare model. Hence, it unlocks the gateway to high health stock for economic growth in Nigeria and other developing countries. It would no longer be said that the poor, who have no money to pay for healthcare are left to die in Nigeria. The study also expands the horizon of knowledge as its literatures explain some of the related issues within the scope of public health intervention, which imposes some obligations on the advanced countries (Gilpin, 2001; Gu; Li; Zheng & Huang, 2018). The study passed through the ethic unit of the studied hospital. Unfortunately for now, the hospital only accepted to grant the KII and has not consented to our request for some of the case notes of benefiting patients for what the management termed “confidentiality”. We believe that they would subsequently do as the research progresses.

2. Review of Related Literature

Burden of Disease (BoD) and Cost of Illness (CoI)

As propounded by Murray (1996) cited in Igberaese, and Iseghohı (2017), Burden of Disease (BoD) is calculated with Disability Adjusted Life Years (DALY); one of the composite measures, which is a health stop-gap measure, DALY is calculated by additions of Years of Life Lost (YLL) to

mortality and Years Lived in Disability (YLD), with a weight factor between zero and one, depending on the severity of the disability. That is:

$$DALY = YLL + YLD \quad (2)$$

Where: YLL is the multiple of the summation of all fatal cases due to healthy outcomes of a specific disease (d_i) and the expected life span of the individual at the age of death (e_i). Hence:

$$YLL = \sum_I d_i \times e_i \quad (3)$$

YLD is calculated by the multiple of the summation or accumulation of all cases and all health outcomes (n_i) by the duration of illness (t_i) and the disability weight of a specific disease (w_i). Hence:

$$YLD = \sum_I n_i \times t_i \times w_i \quad (4)$$

So that if we substitute equations (9) and (10) into equation (8), we have:

$$DALY = \sum_I d_i \times e_i + \sum_I n_i \times t_i \times w_i \quad (5)$$

Cost of Illness (CoI) is the accumulation of; Direct Healthcare Cost (DHC) – costs of: general consultations, specialist consultation, hospital attendance (in-patients or out-patients or both), drugs, rehabilitation and other disease progressions prior the restoration of full health, for "each health care outcome of a specific disease and each medical health service"; Direct Non-Healthcare Cost (DNHC) – for "each direct non-health care outcome of a specific disease and each non-health care service", the DNHC, and Indirect Non-Healthcare Cost (INHC), which is the value of lost production resulting from the work absence, whether temporarily or permanently as a result of short term or long term disability or premature death. INHC also includes the lost productivity from sickness leave in the case of short term disability and that of a caregiver of the sick person. It does not include Indirect Healthcare Cost (IHC), which is the future savings on health care cost as a result of premature death (Oostenbrink 2004, cited in Igberaese & Iseghohi, 2017).

However, Oostenbrink (2004) believe that there is no need to include all DNHC (which is cost incurred on travelling, additional cost incurred on diapers, medical expenditure on other illness different from the specific disease, but discovered during the treatment of the specific disease or co-payment for drugs and other informal cases, like motivation for a caregiver as a result of disability resulting from the specific disease) in the advanced countries since they are very negligible and relatively small when compared to the other costs. We hold that this is not so in the developing countries of Nigeria where these costs are still very high because of the lack of infrastructure.

In the second instance, we should add the Indirect Non-Healthcare Cost (INHC). Hence, in the all, we have:

$$CoI = DHC + DNHC + INHC \quad (6)$$

$$DHC = \Sigma_i (\Sigma_i m_i \times p_i \times mc_i)_1 \quad (6a)$$

$$DNHC = \Sigma_j (\Sigma_j r_j \times q_j \times rc_j)_1 \quad (6b)$$

$$INHC = \Sigma (\Sigma_{sk} \times U_k \times Vk)_1 \quad (6c)$$

Therefore, in the Nigerian context, Cost of Illness to be reduced with good health models are:

$$CoI = \Sigma_i (\Sigma_i m_i \times p_i \times mc_i)_1 + \Sigma_j (\Sigma_j r_j \times q_j \times rc_j)_{1+} \Sigma (\Sigma_{sk} \times U_k \times Vk)_1 \quad (7)$$

Where:

m_i is number of cases requiring health care
p_i is the required health care service unit per case
m_i is the cost per health care service unit.
r_j is the number of cases requiring non-health care service
q_j is the required non-health care service unit per case
rc_j is the cost per non-health care service unit.
S_k is the number sickness leave
U_k is the duration of sickness leave and;

V_k is the wage cost per day.

Thus, investment in healthcare models should be seen as an aggregate investment since it has the effect of stimulating any of the desired macroeconomic goals of employment, economic growth, price stability and equitable distribution of income.

Murray and Oostebrink on DALY and CoI respectively can be said to be products of their western environments, not of Nigeria. We hold the view that DNHCs are not negligible in Nigeria. For example in the case of the President of Nigeria's illness that kept him in a London hospital for six month in 2018, cost of transportations; on presidential jets, and those of his caregivers were huge sums. And since such costs are expected to be backed up by source documents, they should be included in the CoI analysis. Again, from what was spent, supposed future savings can be calculated if he had died and then, ascertain the Indirect Healthcare Costs. Therefore, IHC should thus be included in the CoI analysis.

Measurements of Disability and Demand for Death

As already noted, this is when such disabilities are already measured by Activities of Daily Living (ADL), where the individual needs a caregiver to do everything in his daily life. At this stage, morbidity and even mortality would be severe. It is the most severe case of disability; without being able to be involved in feeding, bathing, and dressing, moving from bed to chair or from one chair to the other, among others by himself. Igberaese and Onogbsele (2020) hold that when disability is already measured by ADL, such individual is not only consuming excessive medical goods, but also denying both his caregivers and family the contributions they would have made to economic growth and development, even as he would

never be able to make any of such contributions. Moreover, resources are merely being wasted in keeping him alive. The less severe measure of disability is the Instrumental Activities of Daily Living (IADL). At this, the patient cannot use instrument by himself; (referring to disabilities affecting a broad range of activities, such as telephone use, shopping, housekeeping, preparation of food, doing laundry, use of various types of transport, handling of drugs, and management of finances)

Demand for death was propounded by Igberaese, Ogheneovo, and Iseghohi in 2017, who extended the Gruenberg (1997) "Failure of Success (FoS) Hypothesis cited in Igberaese and Iseghohi (2017) and the DALY calculation". They were worried that Healthy Life Expectancy (HALE), a prolonged life that is accompanied by a similar extension of a healthy life, was never emphasized in Nigeria. Rather, Nigerians emphasize mere Life Expectancy; a prolonged life not accompanied by similar healthy life – full of disabilities. That is, longevity does not imply a healthy life for productivity and contributions to growth and development. They saw the demand for death as a possible remedy for excessive BoD and CoI, when disability is already measured beyond the IADL and have reached the ADL. They found that the cases of Nigerians is entirely a validation of the failure of success hypothesis, just as it is also found that many have demanded death to end BoDs and CoIs, but that they were not empirically recognized or reported.

Demand for death is categorized into direct and indirect: (i) direct demand for death is when the individual with a specific disease eats or injects a poisonous substance into his body system, either by himself or through the assistant of another person, say a physician or non-physician or a clinician. However, the individual can only remain healthy at death if the death is sold to him by an expert physician. (ii) indirect demand for death is when the individual with the specific disease deliberately ignores the advice of a medical practitioner against certain foods or drinks that are capable of accelerating the death of that individual. Indirect demand for death can also occur when the individual refuses to take or be administered drugs that could shift his death time into the future or he opts for voluntary discharge from the hospital against the advice of a medical practitioner, in the case of in-patient, or refuses to keep doctor's appointments, in the case of out-patient.

Countries should thus not wait for residence to demand death before health investments are made since health investment is not what should be left to individuals. This is because as important as health goods are; they are unlike the other product market goods whose immediate needs are so self-manifest for the individual to deserve a top position in his scale of preference. For example, hunger would make a family head immediately make foods a top priority; the fear of stress of trekking to work every day will make a man put the constant repairs of his car on top of his budget, even if he has signs of ailments. However, many people would not think of adding to their health stocks before they are

completely broken down. There is not so much awareness and resources to fix bad health condition that is yet visible, let alone nipping it in the bud. Thus, it is a subordination of general interest to that of individual interest for any manager of a country to believe that it is the individual's responsibilities to take care of his own health needs. Good enough, the partial coverage in the product markets can easily be corrected in the health goods market through population health intervention. This should make public interventions easier in favour of the poor.

When death is demanded at ADL measured disability, DALY will be reduced. The YLD would be reduced and tend towards zero. DALY will thus be equal to only YLL, simply be the number of years of life lost due to mortality. Then, the DALY equation would simply decompose to be:

$$DALY = YLL \quad (8)$$

$$\text{Thus, } DALY = \Sigma_I \, d_i \times e_i \quad (9)$$

However, Murray (1996) did not see this, since their environment hosts many healthcare models and citizens rarely or never get to ADL measured disability. This is a big reduction in BoD because the only loss becomes the productivity the individual would have engaged in if he had not died of the specific disease before the age he was normally expected to die. It has removed the entire burden that he and the relatives, including that of his caregiver, would have borne if he had not died, but continued to live in the state of ADL disability. Demand for death would increase IHC with premature death. DHC approaches zero, DNHC also approaches zero while INHC remains constant (not increasing) after the time of demand. The analysis would then include IHC. Then, for each healthcare outcome of a specific disease and each medical health service, Σ (Σ mi × pi × mci) approaches zero. For each direct non-healthcare outcome of a specific disease and each non-healthcare service, Σ (Σ_i r_j × q_j× rc_j)$_1$ approach zero.

The loss of productivity from sickness leave of individual and that of a third party taking care of the sick individual, Σ (Σi us_k × V_k)$_1$ remains constant. And IHC, which is the savings from the future cost approaches infinity.

This is a great gain from demand from death, as resources can be channeled to other productive uses. Oostenbrink, (2004) could not see this, because costs are negligible in their regions since of their governments responsive are more governments to infrastructures developments and functional insurance systems.

Review of the Existing Models of Healthcare Delivering

Four models of healthcare delivering are presently known to exist in literature: These are the Beveridge model; the Bismarck Model, the National Health Insurance Model and the Out-of-Pocket model.

The Beveridge Model

This model, formulated in 1948 was named after William Beveridge and it is mostly applicable in high income countries (Kutzin, 2011). Beveridge was a reformer and he designed the National Health Service system of Britain. In the Beveridge Model, government uses tax payment to finance and provide healthcare in much the same way it provides like security and public library. Most hospitals and clinics are owned by government, doctors are employees of the government even though there are some who are not, but collect their fees from government. Nobody gets a doctor's bill and the government, as a sole payer, is in control of what a doctor can charge. Examples of countries using this model are Britain, Cuba, New Zealand, Spain, and most countries of the Scandinavia. Hong Kong has varied it because the people have refused to give up health control since the taking over by China of the Colony from Britain in 1997 (Reid, 2009).

The Bismarck Model

This model is named after the Prussian Chancellor, Otto von Bismarck, the man who invented the welfare state, as part of effort to unify Germany in the 19th century. It is Social Health Insurance founded in 1883. There is a pre-existing "sickness fund", which is the insurer in an insurance system. This fund is financed by the employer and employee through deduction from payroll. Doctors and hospital are mostly private and there is tight regulation, which gives government more control and to device a way to cover everybody, though it is to keep workers healthy for productivity. It is basically European heritage, but its practice is very familiar to Americans. It is practiced in Germany, the Netherlands, France, Japan, Belgium and Switzerland. It is also practiced to some extent in Latin America (Reid, 2009; Kutzin, 2011).

The National Health Insurance Model

The National Health Insurance Model has both elements of the Beveridge and Bismarck models. Private-sector providers are used, but only the government-run insurance programmes, which every citizen pays into. There's no need for marketing, and as such, no financial intention to deny claims and there is no profit. The universal insurance programmes are cheaper and much simpler to administer than American Bismarck model, where insurance is for-profit. NHI system is practiced in Canada, South Korea and Taiwan (Reid, 2009; Kutzin, 2011). Nigeria has also attempted to adopt it, with very limited degree of coverage and success so far.

The Out-of-Pocket Model

In this system, no real organized healthcare system operates. Individuals pay for healthcare from their pockets, while doctors charge according to their discretions. So, many people could live a whole life without access to a doctor but a village healer using herbs, whose efficacies are subjects of probabilities. The rule is that the rich accesses healthcare, while the poor remains sick or dies if he or she cannot pay to live long. It is indeed,

not really a model. About 160 countries of the world, especially the rural regions of Nigeria, China, India and South America practice this system (Kutzin, 2011, 2013). "They may have access, though, to a village healer using home-brewed remedies that may or not be effective against diseases".

Reid (2009) writes that America practices all four models "…in our fragmented national healthcare apparatus. When it comes to treating veterans, we are Britain or Cuba. For Americans over the age of 65 on Medicare, we are Canada. For working Americans who get insurance on the job, we are Germany" (Reid, 2009; Kutzin, 2011, 2013).

The Observed Case Note Model Of Healthcare Delivering

Anything that removes the major disadvantage of the Out-of-Pocket model should be accorded recognition and be improved upon. The observed practice reflects the actual relationship between the health practitioners and their patients in the hospitals; at least in principles and devoid of value and ethical judgments. After all, positivist economists do not possess special competence in analyzing the issues of equity. The paper will hope to identify these areas for improvements in the observed models.

The Case Note Practice/Model

The Practice is not of oriental designs. In it, patients, especially those on emergencies and pregnant women are not abandoned to die Irrua Specialist Teaching Hospital (ISTH), a government tertiary level of healthcare delivering, is one of the hospitals in Nigeria in which this practice was observed. Patients are treated with the resources available to the hospital without asking for immediate payments, except he or his relatives can afford to do so. All the costs of treatments are written down on the patient's case note as treatment continues, until the stage where the illness is no longer life threatening. Since the hospitals do not get additional supports from the government, it is limited to saving the life of the emergency patient and the deliveries of pregnant women; nothing further. It is not to make the patients fully recover. There are cases when the patient would be stabilized enough to give his relatives a clue on how to source for money. Moreover, the relatives, being reasonably sure that the patient's survival rate is high, are encouraged to help out with the cost of treatments till the patient is discharged from the hospital. Furthermore, the relatives are given enough time by the hospital management to look for the money, especially if they are able to upset the costs of the first phrase (when in emergency situation). The objective of the "Case Note Practice" is to save the life of the patient from the life threatening situation, and deliver the pregnant woman, after which his relatives are expected to look for money for further treatments.

Most times, the hospitals are not able to continue treatments beyond a defined stage since the little resources available would be rationed among

many poor families in this manner. Moreover, there are still some patients who die because of the lack of funds to continue the treatments, which become losses to the hospitals because at that point, emotion would play a major role. Yet, the burden of the disease still continues if even the patient has fully recovered from the illness or died. This is because most families have to work hard for a long time to pay back what they had borrowed to offset the direct costs of the illness. In some cases, the hospital would be compelled to give reasonable discount or write off some debts, especially if the patient is extremely poor or does not survive. Even with the limitations, it is an innovation upon the Out-of-Pocket model since a patient is not abandoned to die for his lack of resources for treatment. Besides, it has encouraged more access of the poor population to doctors and enhanced utilization of hospital resources.

It is important to stretch how it is also used for maternal cases. The hospital ensures that the pregnant woman is attended to and is delivered of her baby safely, irrespective of her insurance or income statuses, which are predominantly low among the poor women. The new baby is well taken care of too, as if she has offset all costs of delivery and post-delivery. Nobody is denied treatment or attention simply because she has no money. Nevertheless, a very embarrassing situation emerges thereafter, as she is not discharged from the hospital till all bills are offset. She is detained in a separate reserved small room with other women with similar indebtedness to the hospital. In some cases, women from poor families spend up to nine months in the hospital's detention room with their new babies. This embarrassing situation usually makes women go against doctors' advice of vagina delivery in the labour room since the bills therefrom is much cheaper than that of cesarean section. That is, they risk the indirectly demand for deaths by refusing doctors' advice. In some cases, the relative might go borrowing to offset the direct costs of treatments for mother and baby. In this case, the burdens linger as they would need to work hard for a long time to be able to pay their debts. If only all the poor women diagnosed not to be able to go through the normal process of vagina delivery can be funded fully by public tax! There is always a threshold to determine who is as poor. Then, maternal morbidity and mortality would be greatly reduced.

No matter how crude this model may seem; that a mother is not allowed to enjoy her joy of motherhood till her bills are paid by someone, it is still advantageous over the Out-of-Pocket model. The first and chief of them is that lives are saved irrespective of income and insurance statuses. All complicated cases are treated without abandoning both mother and baby to die from poverty. The relatives of the woman have enough time to work and gradually offset the bills, as the hospitals allow payments in installments. In a few cases, patients get money from the indigent funds, and public spirited individuals on humanitarian visits to the hospitals also take up some of the bills.

Data Presentation And Analysis

The Case Note Practice is not of oriental designs but it have been mostly put in use by the management of ISTH for those who have no money for immediate payment for emergency healthcare, and in maternal cases of poor women whose families cannot immediately afford the medical costs required for their deliveries. The questions generally asked are three:

i. Is the practice working in resolving the health issues of the poor who could not immediately pay hospital bills? This, every respondent answered "YES"

ii. What are the challenges with the practice?

iii. What are the solutions if it would transform into a healthcare model for the poor patients?

We use pseudo names for correspondents to protect them.

Dr. A: A former Edo State Chairman of Nigerian Medical Association said:

i. "The government does not give sufficient funds and most hospital managements do not reach out to public spirited individuals and corporate bodies for help".

ii. "The government should increase the subvention of the hospitals. Hospital managements can, for the sake of these patients, contact some civil organizations with a view to bailing the patients and women out".

Mr. B: A high ranking personnel of the public relation unit of the hospital.

i. "Some of the parents who cannot pay usually escape from the hospital after treatments or deliveries".

ii. "There should be a sickness fund to which every company in the country is made to pay a minimum percentage of the profit".

Dr. C: A Consultant Gynecologist in the hospital.

i. "The hospital is overstressed and cannot cope with the practice because the Primary Healthcare Centers (PHCs) are not working effectively; women do not go there because there are no doctors and facilities there".

ii. "Government should first pay attentions to the PHC and then, increase the medical bills of the rich who often prefer delivering in teaching hospitals to offset the medical bills of the poor who go to the primary healthcare centers. That way, anybody who still comes to a secondary and tertiary hospital with a referrer would be deem rich".

Mrs. D: A social worker with the hospital.

i. *"The hospital bills are too much. I worry when sometimes patients are made to pay for the treatments they do not receive".*

ii. *"The hospital can write off the bills of all poor patients if the management selects priorities and if the government makes such policy".*

Mr. E: A senior personnel of the account unit.

i. *"Part of the problems is the corruption of senior government officials and board members who often compel management to give them large amount of money at any visit to the hospital".*

ii. *"If corruption is minimized with a little increase in subvention for the hospital, the hospital can take care of all emergency and caesarean deliveries for poor patients.*

Dr. F: A senior member of the hospital management.

i. *"The hospital is often not left alone to manage its funds. I do not know what you can make of that".*

ii. *"If the hospital is given a good level of freedom, I am sure that somehow, we can ration what we generate to cover the poor. In addition, the government should increase the subvention for the hospital to take the pressure away from the patients"*

The challenges, as seen from **A** to **F** are insufficient funds, dishonesty of the patients themselves who escape from hospital without payments, overstressed hospital facilities, outrageous hospital bills and corruption by government officials.

Suggestions for Improvements on the Healthcare Delivering Practice Observed

Our observed healthcare delivering practice in Nigerian hospitals is surely helping out in saving the lives of poor patients, and as such, great improvement on the Out-of Pocket model. However, it is not yet a national policy binding on all government hospitals. Therefore, stakeholders should be encouraged to gather and brainstorm on the associated concerns with a view to ensuring a new health model from the practice. The government of Nigeria should be prepared to make it a national policy with more funding, given the outcomes of the stakeholders' meetings.

In the main time, the government and indeed, all public health concerns should collaborate with these hospitals in terms of funding. The government and the international health concerns must step up because

no woman should die in the process of bringing another life to this world, when the country is blessed competent gynecologists. No child who could become the best president of the country should die from minor infant disease when the country is blessed with competent pediatricians. No old person who has served the country diligently should die of minor age-related diseases when the country is blessed with competent geriatricians.

Specifically, the Federal Government of Nigeria should be obliged to increase the subventions of Irrua Specialist Teaching Hospital and the other hospitals presently in the practice for an expansion of the practice pending the outcomes of the stakeholders' meetings; to cover more patients and for a whole treatment rather than just for the emergency periods. With good subventions from the government, treatments can be full while the patient would be discharge, provided he provides minimum standard guarantor(s) that he would gradually pay off all bills within a specified period of time. In the case of any death of the patient during treatment, the corps may not be released to his relative without similar guarantor(s) until all bills are upset.

The government, not just the hospitals, should launch special fund to cover these women so that no woman in this category should be detained after being delivered. Substantial interventions by world health bodies would also make reasonable rationing among the many poor patients possible. It would also ensure that what would be left unpaid becomes minimal that hospitals would prefer their detention room as wards, thereby increasing their carrying capacities.

Above all and for emphasis, international agencies concerned with healthcare production and delivery for effective development should sponsor colloquiums, workshops and other forums among health stakeholders and researchers where the views and postulations of these stakeholders in public health are harvested and refined with a view to ensuring all round improvements and sustainability of this practice, thereby making it a health model.

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