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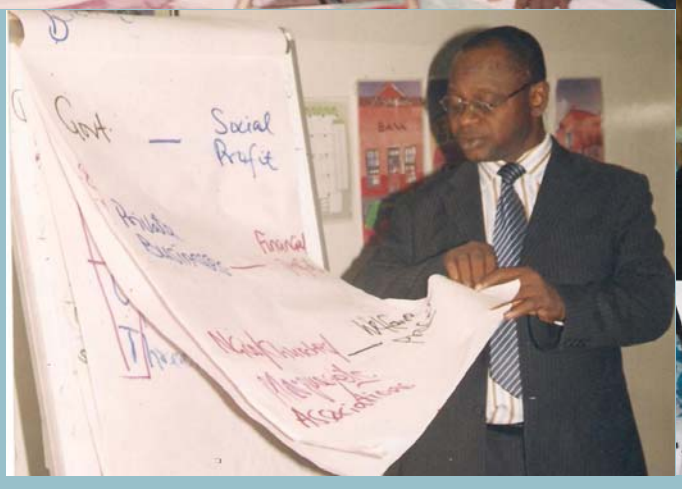
# FINANCING AND BUSINESS DEVELOPMENT NEEDS OF PRIVATE HEALTH CARE PROVIDERS IN NIGERIA

## MARKET RESEARCH REPORT

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**Market Research Series Report #3**

Market Research Series: The Banking on Health project has developed a series of country-specific market research reports on the private health sector. This market research was prepared for the Private Sector Partnerships-*One* project (PSP-*One*) in Nigeria and examines private health care providers' financing and business development needs. It also explores service provision, focusing on reproductive health and family planning services. This market research is developed for a number of audiences. It provides information to financial institutions to use for developing loan products and designing marketing strategies. This market research is also used to design business development services for the private health sector. This market research is also shared with policy makers who are interested in engaging the private health sector.

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# FINANCING AND BUSINESS DEVELOPMENT NEEDS OF PRIVATE HEALTH CARE PROVIDERS IN NIGERIA

## MARKET RESEARCH REPORT

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# ACRONYMS

| | |
|---|---|
| **ACPN** | Association of Community Pharmacists of Nigeria |
| **ARV** | Antiretroviral |
| **CBN** | Central Bank of Nigeria |
| **CHAN** | Christian Health Association of Nigeria |
| **CME** | Continuing medical education |
| **CMRG** | Communication and Marketing Research Group |
| **CPR** | Contraceptive prevalence rate |
| **DHS** | Demographic and Health Survey |
| **FCT** | Federal Capitol Territory |
| **GDP** | Gross domestic product |
| **GSK** | Glaxo Smith Kline |
| **HMO** | Health maintenance organization |
| **IUD** | Intrauterine device |
| **MFI** | Microfinance institution |
| **MoH** | Ministry of Health |
| **NAFDAC** | National Agency for Food and Drug Administration and Control |
| **NGO** | Nongovernmental organization |
| **NHIS** | National Health Insurance Scheme |
| **PCN** | Pharmaceutical Council of Nigeria |
| **PHM** | Pharmacists |
| **PMTCT** | Prevention of mother-to-child transmission |
| **PMV** | Patent medicine vendors |
| **PPP** | Public-private partnership |
| **PSP-*One*** | Private Sector Partnerships-*One* |
| **SFH** | Society for Family Health |
| **SME** | Small medium enterprises |
| **SMEEIS** | Small and Medium Industries Equity Investment Scheme |
| **SPSS** | Statistical Package for the Social Sciences |
| **STI** | Sexually transmitted infection |
| **THT** | Total Health Trust |
| **TOT** | Training of trainers |
| **USAID** | United States Agency for International Development |
| **WHO** | World Health Organization |

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PSP-*One* is USAID's flagship project (GPO-I-00-04-00007-00, Task Order One) to increase the private sector's provision of high-quality reproductive health, family planning, and other health products and services in developing countries. PSP-*One* is led by Abt Associates in consortium with Family Health International, IntraHealth, Population Services International, Tulane University School of Public Health and Tropical Medicine, Banyan Global, O'Hanlon Consulting, Dillon Allman & Partners, and Forum One Communications. The research for this report was made possible through the support of USAID/Nigeria.

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Banyan Global took the photographs on the cover of this report, which are photographs of providers being trained in Lagos.

Kimberley McKeon of Banyan Global wrote this report.

# EXECUTIVE SUMMARY

## OBJECTIVE

This report describes research conducted to assess the business development needs, particularly financial and training, of private health care providers in Nigeria, focusing on providers offering reproductive health and family planning services. This information will guide the development of a program started in 2007 to expand access to finance for the private health sector. Specifically, this report's findings will provide market data to assist banks and microfinance institutions to develop loan products and marketing strategies for the private health sector, provide a needs assessment and additional background for a training course for private health care providers on financial management, and inform government policies on working with the private health sector.

## METHODS

In 2007 a sample of 1,773 licensed private medical providers was surveyed in five Nigerian states where the PSP-*One* project was implementing activities: Federal Capital Territory, Lagos, Kano, Nasarawa, and Bauchi. Survey respondents were primarily medical providers but also included business managers hired by nonclinical owners of private health facilities. Two questionnaires, one for medical doctors, nurses, and midwives who offer family planning services and the second for pharmacists and patent medicine vendors (PMVs), were pretested with a subsample of 30 private medical providers. The survey then was conducted using one-on-one interviews at the private health care providers' places of business. Monitoring was conducted regularly to ensure the data's integrity. In the analysis, regional differences in opinions or disparities by type of medical provider are noted where significant. In addition, a literature review was conducted to examine government statistics and published articles and papers.

## FINDINGS

Private physicians, nurses, and midwives offer a broad range of medical services, including in priority public-health areas such as family planning and reproductive health, HIV/AIDS, tuberculosis, malaria, and maternal and child health care. In all five Nigerian states surveyed, 97 percent of providers offer at least one family planning service. Pharmacists indicated that they provide slightly more services regarding the sale of over-the-counter drugs than PMVs do for prescribed drugs. Price, service, and reputation are the major factors that influence pharmacists' decisions when purchasing drugs from distributors and wholesalers.

Although most private medical providers have large overhead expenses because they must pay for expenses such as offices and medical equipment, most of them are profitable. Survey respondents indicated that the greatest constraints they face in growing their medical businesses are patients' inability to pay and a lack of financing. Only 10 to 15 percent of private providers reported that they applied for financing from a financial institution in the past three years. Almost 40 percent of all private provider groups indicated interest in obtaining financing within the next year, though the survey did not explore how interest rates might affect that intent.

Survey respondents indicated that clinical training and, in the case of pharmacists and PMVs, pharmaceutical updates are their most important training needs. They also showed interest in additional areas of training, however, including access to finance and business management. Many PMVs, nurses, and midwives are interested in training that would clarify government regulations on private health practices.

## CONCLUSIONS

Private providers in Nigeria already offer several priority public-health services, including services related to reproductive health, family planning, and HIV/AIDS, and most of them report that they are profitable. Greater access to finance, however, is needed for the private health sector to grow and improve its quality of care. That the private sector is large and has not accessed much financing represents a market opportunity for Nigeria's financial institutions. In addition, clinical training that is available to public-sector providers should be extended to the private sector to improve the quality of its services as well. Business management training on how to manage costs and services is important for all private provider groups.

# 1. INTRODUCTION

Private health care providers worldwide cite their inability to access finance as one of the key impediments to growth and improvement.[1] For these businesses, as with all enterprises, credit is an engine for expansion.

While many health care providers want to access finance to increase their outreach and improve their services, banks in many countries are not interested in lending to this sector. Financial institutions often view health as a public good, not a business opportunity, and they may not understand the business models in the sector, preferring to lend to more familiar businesses, such as those in the trade and manufacturing sectors. Banks that require security may not be interested in the type of collateral that health care providers offer. The businesses themselves, often run by clinicians with little business management experience, may not be able to produce the bankable business plans needed to obtain financing.

The more financial institutions that reach out to the health care market, the more likely it is that providers of health products and services will be offered favorable terms that meet their financing needs. To assess the market's potential and possibly view financing for the sector more favorably, these institutions require market information and, in some cases, training in marketing and lending to the sector.

The United States Agency for International Development (USAID)-funded Banking on Health project expands access to financing for private health providers in developing and transitional economies. Banking on Health works with financial institutions to promote health-sector lending and with private health providers to improve their businesses and ability to access financing.

Private Sector Partnerships-*One* (PSP-*One*) is USAID's flagship project to increase the private sector's provision of high-quality reproductive health, family planning, and other health products and services in developing countries. At the request of USAID/Nigeria, PSP-*One* developed a strategy to expand and improve the provision of family planning and reproductive health products and services in that country's private health sector. As part of this strategy, PSP-*One* proposed working with banks and providers to expand access to financing. Banking on Health provides technical oversight of the access-to-finance work with financial institutions in Nigeria to promote health-sector lending. It also helps private health providers to improve their businesses and ability to access financing. PSP-*One* began working in Nigeria in 2006, conducting a preliminary assessment of the financial and private health sectors. This review revealed that access to financing was a constraint in Nigeria and information about the sector was lacking.

[1] International Finance Corporation 2008.

PSP-*One* and Banking on Health designed this study to further guide the development of a program to expand access to financing for the private health sector. The research was intended to provide PSP-*One* with information about private health care providers' business practices for use in developing and refining a business-training curriculum to improve the viability of medical practices and prepare providers to access financing. The results of this survey and research also will inform financial institutions in Nigeria about how to best target the private health sector and provide the products and services these businesses need to expand and improve. The research is intended to provide information to policy makers that are interested in partnering with the private health sector. The main objectives of this research are to:

- provide market data to assist banks and microfinance institutions (MFIs) to develop loan products and marketing strategies for the private health care sector
- supply additional information for a training course developed for private health providers on financial management and access to finance to grow or improve their practices
- inform government policies on health promotion with the private sector

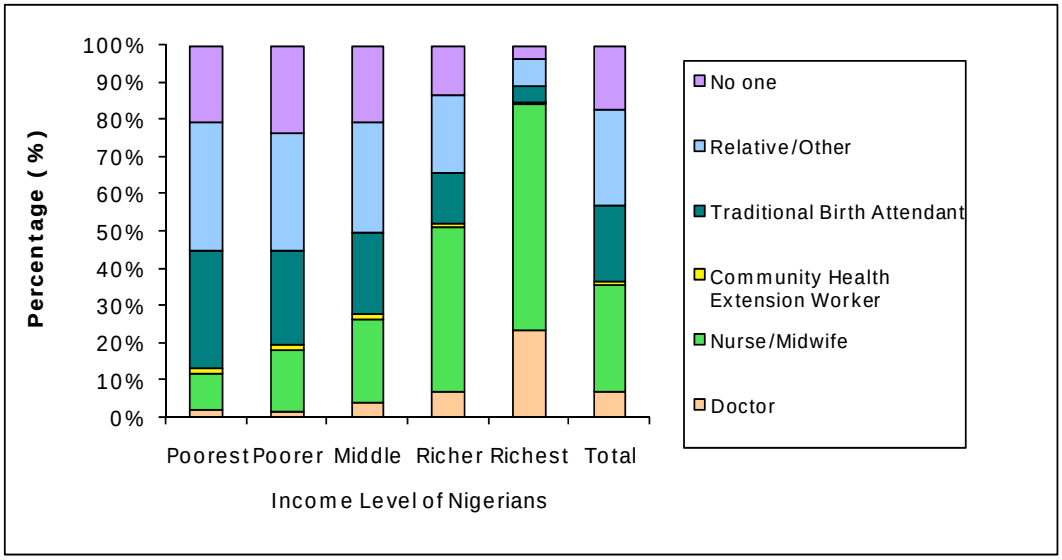
# 2. BACKGROUND

## 2.1 THE NIGERIAN HEALTH CARE SYSTEM

Despite large budgetary expenditures in the health sector, the health status of most Nigerians is low. The mortality rate for children under 5 years old is estimated at 201 per 1,000 live births; maternal mortality is about 800 per 100,000 live births; total fertility is 5.7 children per woman; there is only an 8 percent prevalence of modern contraceptive methods; adult HIV prevalence is estimated at 3.1 percent; and immunization rates are low, with only 13 percent of 1 year olds receiving all of their recommended vaccinations.[2] Public hospitals are poorly equipped and often experience stockouts of essential supplies and medications, and the cost of treatment is prohibitive. Skilled midwives and birth attendants are scarce. Doctors go on prolonged strikes over poor pay and poor working conditions that paralyze the hospital system, forcing patients to seek other means of health care.

These outcomes suggest the health care system is struggling, and service and consumption indicators demonstrate that neither the public- nor private-sector health systems function effectively. Consumers pay a high share of their health expenditures, with 67 percent of such costs being paid out-of-pocket compared to 26 percent by the government and 7 percent by the private sector (private insurance and employers).[3] Too often consumers forgo treatment or pay unskilled providers for care. For example, no treatment is sought for 31 percent of children with a fever or symptoms of an upper respiratory infection, 20 percent of children with diarrhea receive no treatment, and 66 percent of deliveries occur in the home with only 35 percent of home deliveries attended by a skilled provider.[4] While this behavior is especially true for the poor, unassisted deliveries or deliveries attended by unskilled providers occur in all income groups. As shown in Figure 1, even in the wealthiest quintile of the population close to 20 percent of deliveries take place with unskilled providers.

**FIGURE 1: ASSISTED DELIVERIES IN NIGERIA BY INCOME LEVEL (2003 DEMOGRAPHIC AND HEALTH SURVEY)**




[2] Barnes, Chandani, and Feeley 2006.
[3] Ibid.
[4] Ibid.

A key determinant of health in general and reproductive health in particular is educational status, particularly for females. Nigeria faces major challenges in this area, with gross enrollment rates for males about 25 percent greater than for females and significant gender gaps in educational attainment and literacy.[5]

Another major problem is that many people in Nigeria cannot afford to buy the common drugs used to combat disease. Faced with this dilemma, Nigerians are compelled to depend on private drug shops and itinerant medicine vendors for the purchase of ethical drugs.

Nigeria's federal government is considering a public-private partnership (PPP) to address the challenges in the health sector. One aspect of the PPP is that technical assistance will be given to all tertiary hospitals to mobilize the private sector in their operating areas to encourage investments through which the hospitals will acquire the optimal equipment, infrastructure, and other facilities necessary for service delivery. The National Health Insurance Scheme (NHIS) the federal government initiated is an example of its intent to partner with the private sector. The federal government is contracting health maintenance organizations (HMOs), which in turn contract private providers to offer a basic package of care to federal workers. Given the private health sector's potential to partner with the government in achieving health outcomes and the increased interest from the Nigerian government in working with the private sector, PSP-*One* and Banking on Health's research is timely.

## 2.2 PRIVATE HEALTH SECTOR

### 2.2.1 PRIVATE CLINICAL SERVICE PROVIDERS

In Nigeria it is difficult to quantify the number of service providers operating in the private sector as distinct from those working in the public sector. The WHO estimated that 35,000 physicians and 210,000 nurses and midwives in the public and private sectors are registered in Nigeria,[6] and PSP-*One* estimated that the private sector has 11,473 physicians and 56,400 nurses and midwives.[7] The Association of Community Pharmacists of Nigeria (ACPN) states that it only has 1,000 active practicing pharmacists. For both products and services, there is a shortage of delivery points relative to the population size, especially where the disease burden is greatest, outside the major cities. As with all statistics in Nigeria, national averages mask large regional variances. Using the records of registered nurses and midwives, PSP-*One* estimated the density in Jigawa state to be 6.75 nurses and midwives per 100,000 people, far fewer than the national average of 170.[8]

Unlike the public sector, which has well-defined structures and entry points, the private health sector is loosely organized. In Nigeria few private providers operate in groups or corporate settings, which would allow for sharing resources and economies of scale. The exceptions to this generalization are the HMOs and faith-based organizations that are a part of the Christian Health Association of Nigeria (CHAN). CHAN has more than 350 member institutions, and many of them share the benefits of procuring drugs and supplies through a common pharmacy network. HMO networks do not pool procurement or share facilities, but they are beginning to share training resources.[9]

Although the majority of the population goes to the private sector for its reproductive health needs, most registered providers are in the public sector. This finding should be qualified by noting that many providers who are registered in the public sector also practice in the private sector, either formally or informally. This behavior makes it difficult to quantify precisely the number of service providers operating in the private sector as distinct from those in the public sector. Even determining the number

[5] National Population Commission, Federal Republic of Nigeria 2004.
[6] Barnes, Chandani, and Feeley 2006.
[7] Ibid.
[8] Ibid.
[9] Ibid.

of providers practicing in the public or private sector is problematic because registration lists are not updated systematically and there is no mechanism or incentive for verifying that registered providers actually practice. In a country that is losing significant quantities of health providers to overseas employment, death, and attrition, registration statistics likely overestimate the number of providers practicing.

### 2.2.2 NATIONAL HEALTH INSURANCE SCHEME

Nigeria launched the NHIS in 2005. It provides a basic package of care for federal workers delivered through HMOs. The scheme is designed to make health care more affordable, accessible, and equitable, thereby minimizing the incidence of untimely death and many cases of self-medication due to lack of access to health care. About 24 HMOs in Nigeria contract with the NHIS. These HMOs in turn contract with providers, serving as the interface between clients and health providers. More than 80 percent of all health providers participating in the NHIS are from the private sector. The NHIS system is based on a capitation payment (fixed sum per person regardless of services) to accredited primary care providers for most of the basic benefit package. The NHIS establishes the capitation and the fee schedules for drugs, tests, and referrals. HMOs process and pay capitation and fee-for-service claims. The HMOs receive 15 percent of the total premiums as an administrative fee, with 1.5 percent returned to NHIS for regulation.[10]

The selected primary care provider is a gatekeeper for referral services, which the HMO pays fee-for-service out of a portion of the full premium set aside for these costs. Family planning consultation is included in the primary care capitation. Family planning supplies are not an NHIS benefit, but the provider can charge fees for intrauterine device (IUD) insertions and sterilizations. All well-child care and treatment for routine childhood illnesses are included in the primary care capitation. The NHIS covers essential drugs, with the patient to pay a 10 percent copayment and the provider to pay the remaining 90 percent out of the capitation.[11]

### 2.2.3 PHARMACISTS AND PATENT MEDICINE VENDORS

As mentioned previously, the ACPN only has 1,000 active practicing pharmacists. Society for Family Health (SFH), a nonprofit social-marketing firm that provides family planning products in Nigeria, estimates there are approximately 200,000 patent medicine vendors (PMV) operating in Nigeria, although it is hard to identify a reliable source of data for this figure. The impetus for creating the PMV practice was to expand access to basic medicines in rural, underserved areas. The Ministry of Health (MoH) drove this action and it initially was responsible for issuing PMV licenses. But that duty proved controversial, especially as PMVs in urban areas proliferated because of the lack of enforcement of the licensing guidelines. As with other facilities, licenses are issued at the state level and there is no authority systematically aggregating data at the national level. Issuing of PMV licenses has passed from the MoH to the Pharmaceutical Council of Nigeria (PCN), which has been reluctant to issue licenses. The PCN published a list of drugs PMVs can dispense that does not include antibiotics or drugs requiring prescriptions. According to the Patent Medicine Vendors Association, a large number of PMVs are operating with their license applications pending for more than a year.[12]

### 2.2.4 MEDICAL ASSOCIATIONS

Most providers are members of their respective professional associations, but the associations' chapters vary significantly in their effectiveness. Typically each state has a chapter in addition to the national body. In theory all associations offer opportunities for continuing medical education (CME), conduct advocacy work on issues of significance to their members, and encourage adherence to quality standards. Most

[10] Ibid.
[11] Ibid.
[12] Ibid.

members of professional associations work in the public sector and have their membership fees deducted directly from their salaries. Private-sector providers contribute a much smaller share of the revenues of professional associations. As a result, issues of interest to private-sector providers are a low priority.[13]

### 2.2.5 REGULATORY ASPECTS OF PRIVATE PRACTICE

In general the scopes of practice for service providers are defined and do not constitute a constraint to private-sector development. The MoH has a clear designation of reproductive health responsibilities, printed in the booklet *National Family Planning and Reproductive Health; Guidelines and Standards of Practice*.[14]

As mentioned, the PCN now regulates PMVs. The PCN is making a more concerted effort to ensure adherence to the laws defining PMVs' scope of practice. PMVs have no minimum professional training requirement although some have community health extension worker qualifications or nurse or midwife training.[15]

The Nursing and Midwifery Council of Nigeria licenses nurses and midwives. Midwifery is a higher qualification for nurses who already have been registered. A nurse midwife can undertake the full scope of practice the council permits in his or her own private facility. This treatment includes well-child and reproductive health care and treatment of minor illness, but it also extends to malaria and common infectious diseases. There is a list of primary care drugs that the registered midwives may prescribe, stock, and dispense.[16]

Nurses and midwives must have and renew a practicing certificate every three years, and they must attend one approved workshop in each three-year period to qualify. The Nursing and Midwifery Council of Nigeria approves training programs. No computerized list of registered nurses or midwives with practicing certificates exists, so any information about this group's size depends on getting data on public-sector postings plus data on licensed private practices from the states.[17]

A nurse may open a private nursing home and a midwife may open a private maternity home after five years of registration and service in the public or private sectors. Each state's health department, not the Nursing and Midwifery Council of Nigeria, issues the licenses for private facilities. The private nursing homes may be outpatient-only practices, but they can have beds. And a maternity home does perform deliveries. States can enforce standards in excess of those the Nursing and Midwifery Council of Nigeria establishes, controlling the homes' scope of practice, so there are discrepancies across states.[18]

Almost all states have a supervisory requirement involving physicians, which in practice means that nurse midwives pay physicians a consulting or supervision fee. Unfortunately the lack of clarity around how much supervision is required constitutes a constraint for some nurse midwives wishing to establish their own practices. Such costs can hinder profitability. These arrangements appear to be completely open to negotiation between the proprietor of the nursing clinic and the physician, with the physician having an advantage in the negotiation because the clinic must have some arrangement to satisfy the supervision requirement.[19]

The Medical and Dental Council registers physicians. Renewal of registration (via a practicing certificate) is required every two years, according to the acting registrar, with 24 hours of CME required in each renewal period. The council also approves the institutions that are qualified to conduct CME. The MoH

[13] Ibid.
[14] Ibid.
[15] Ibid.
[16] Ibid.
[17] Ibid.
[18] Ibid.
[19] Ibid.

or nongovernmental organizations (NGOs) administer most clinical update training, especially regarding family planning. MoH training programs nominally are open to the private sector, but no systematic mechanisms exist for identifying and recruiting private service providers for inclusion in government- or donor-supported training.[20]

### 2.2.6 FAMILY PLANNING AND REPRODUCTIVE HEALTH IN THE PRIVATE SECTOR

According to the most recent Demographic and Health Survey (DHS), the contraceptive prevalence rate (CPR) is only 8.9 percent for modern methods, despite years of USAID and other group's investment in family planning programs. Yet even at this low level, this rate masks large discrepancies in contraceptive use among different segments of the population. Among sexually active unmarried women, for example, the use of modern methods is 38.6 percent. Modern method CPR in the Northeast is 4.2 percent while it is 23.1 percent in the Southwest. CPR for married women with no formal education is 2.3 percent and 21.7 percent for women with higher education.[21]

Knowledge of family planning methods is low among women with little education and in certain parts of the country. Only 60 percent of women in the Northeast can cite even one modern method of contraception, and 56.3 percent of women were not exposed to any family planning messages through any media for the year prior to the 2003 DHS. In the Northeast, 76.6 percent of women did not hear any family planning messages.[22]

The lack of progress in improving national CPR can be attributed to:

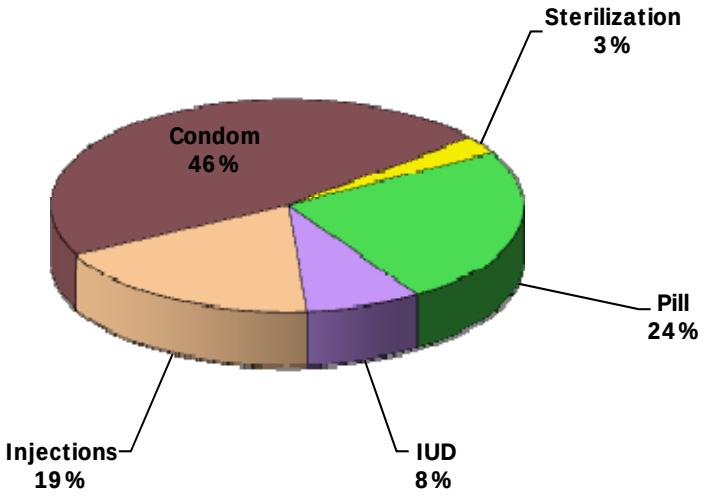
- traditional values in favor of large families
- religious views against contraception and birth control, especially in the north
- women's low educational attainment
- inconsistent training of providers in contraceptive technologies and counseling
- weakness in the public-sector system and the complexity of the federal system that makes contraceptive logistics and financing difficult

Nevertheless practitioners agree that emphasizing the reduction of maternal morbidity and mortality makes the most compelling case for family planning to Nigerians. This approach has quieted outright antagonism to birth-spacing messages and made it more acceptable for providers and couples to discuss contraception. Moreover, SFH's research showed a high correlation between couple communication and family planning.[23]

The private sector has filled some of the gaps the public sector could not satisfy in supplying contraceptives to Nigerian consumers, especially through the national social-marketing program. The importance of social marketing and the private sector is reflected in the existing method mix (Figure 2). Condoms and pills, which are available in retail outlets and socially marketed, account for 70 percent of methods used. The next most popular method, injectable contraceptives, is also sold through the social-marketing program.[24]

[20] Ibid.
[21] National Population Commission, Federal Republic of Nigeria 2004.
[22] Ibid.
[23] Barnes, Chandani, and Feeley 2006.
[24] National Population Commission, Federal Republic of Nigeria 2004.

**FIGURE 2: NIGERIAN CONTRACEPTIVE METHOD MIX (2003 DHS)**




Demand for products and services in the private, commercial sector is too low in the aggregate to speak of a national market for the private-sector provision of reproductive health products and services. As the aforementioned regional disparities show, however, in some states and among some population segments, there are viable markets for commercial suppliers. In other states there is a nascent market being built with social marketing and other subsidized interventions. And in still other areas, it is probably more accurate to describe a premarket phase in which basic acceptance of birth-spacing principles and knowledge of contraceptives has to be built.

One simple measure of the contraceptive security of supplies is the number and diversity of entities manufacturing or importing contraceptives into a country. By this measure, Nigeria is doing well with a variety of government, donor, NGOs (such as SFH), and commercial entities bringing contraceptives into the country. Nigeria is not doing as well on other measures, however, such as distribution systems, information systems, forecasting, policy, gross domestic product (GDP) per capita, poverty level, and other demand and use criteria. On this aggregate score, Nigeria was the ninth worst of the 57 countries reviewed in PSP-*One*'s 2006 assessment.[25] This index has a bias toward public-sector systems, but the policy and demand criteria are relevant for the private sector, and Nigeria scores poorly in those areas as well.

In some markets, gaps in the public-sector supply system create opportunities for private-sector providers to offer contraceptives. With the exception of the social-marketing program, however, commercial sources of supplies have not achieved significant market share. Social-marketing products dominate their respective markets. According to SFH, its condoms have a 73.8 percent share of the total market, its oral contraceptive has a 79.5 percent share, and its injectable has a 61.3 percent share (in this case the total market means all commercial and public sales and distribution).[26]

Another problem that constrains the sustainable supply of contraceptives is that product delivery points are insufficient. The number and coverage of pharmacies and product delivery points are too low to reach potential users. SFH estimates that its products are sold in 300,000 outlets nationwide.[27] The bulk of these venues, however, are PMVs and nontraditional outlets selling condoms. The PCN reports 2,639 registered pharmacies as of the end of 2005. Even with demand at low levels, if sales of oral

[25] Barnes, Chandani, and Feeley 2006.
[26] Population Services International 2005.
[27] Society for Family Health 2005.

contraceptives (for first-time users) and injectables are to be restricted to pharmacies, the number of outlets is insufficient to maintain reasonable access to them. No amount of investment by contraceptive manufacturers will address this issue; instead one must look at the factors that discourage the creation of more retail pharmacies—including lack of financing.[28]

### 2.2.7 HIV/AIDS

At the end of 2007 Nigeria was estimated to have 2.6 million people living with HIV. The estimated HIV-prevalence rate (ages 15 to 49) at that time was 3.1 percent. Out of the 2.6 million people living with HIV, it is estimated that 13 percent receive antiretroviral (ARV) therapy.[29]

Several factors have been linked to the rapid spread of HIV in Nigeria, including a lack of sexual health information and education, stigma and discrimination, poor health care services, low condom use, poverty, low literacy, and low status of women.

### 2.2.8 QUALITY OF HEALTH CARE IN THE PRIVATE SECTOR

Government and donor resources have been focused on the public sector, and the main strategies addressing quality have involved increasing and strengthening supervision and training. Thus most of the evidence about quality in the private sector is partial and anecdotal. Paradoxically, the private sector in Nigeria seems to provide both the best and worst quality in health care. In Lagos and other major cities, some of the private hospitals and clinics serving the upper-income groups offer the best care in the best facilities with the most well-trained staff in the country. The vast majority of private-sector care and out-of-pocket expenditures, however, are spent on providers at the other end of the spectrum: traditional birth attendants, community health workers, PMVs, traditional healers, and quack doctors.

Quality monitoring and assurance among private service providers is mostly theoretical. State ministries of health, which issue licenses, are responsible for ensuring that facilities comply with regulations, but in reality ministries have few resources to conduct quality control and monitoring activities. The fees received for licensing are supposed to fund continuing education, advocacy, and monitoring. The professional associations also are expected to play a role in assuring quality. Large chapters of the National Medical Association have committees on ethics and discipline that investigate complaints against licensed providers. Grievances are rare, however, and investigations and sanctions infrequent.[30]

Professional associations' CME activities also improve quality, but they are offered on an opportunistic basis and not in response to needs assessments. NGO-sponsored CME activities are the exception to this tendency; SFH, for example, has designed training strategies around documented provider needs. Pharmaceutical companies also sponsor CME and some contraceptive manufacturers have supported CME in the reproductive health area.[31]

The only mechanisms for quality assurance in the private sector are through the routine renewal of licenses and verification that educational requirements have been met. The NHIS manages an accreditation system and establishes the standards for selecting providers. It focuses on facility infrastructure, without any assessment of provider knowledge or service quality. NHIS has prioritized rolling out the scheme and extending coverage to as many providers as possible, as long as they demonstrate a valid facility license and professional (medical council) registrations.[32]

[28] Barnes, Chandani, and Feeley 2006.
[29] Joint United Nations Programme on HIV/AIDS, World Health Organization, and United Nations Children's Fund 2008.
[30] Barnes, Chandani, and Feeley 2006.
[31] Ibid.
[32] Ibid.

### 2.2.9 QUALITY CONTROL OF PHARMACEUTICAL PRODUCTS

Product quality is verified in two main ways: the first method is ensuring drug purity, which the National Agency for Food and Drug Administration and Control (NAFDAC) regulates, and the second approach is ensuring that pharmaceutical products are stored, handled, shipped, and sold in conditions that protect their efficacy, which is the PCN's domain. NAFDAC is a national government agency with a staff and budget the government supports. While the government requires the PCN to issue licenses and monitor licensed facilities, it is not a government agency and receives little or no government budget support; it is expected to perform its job with the proceeds from licensing fees. Ensuring the proper handling and storage of drugs requires significant resources. As funded, PCN does not have adequate resources. Besides the zoning problem of PMVs, many of them sell drugs not on the approved list and store and repackage drugs in a manner inconsistent with policy.[33]

Drug counterfeiting and quality control have been serious problems in Nigeria. NAFDAC has addressed these problems through vigorous enforcement, including publicized product seizures, prosecutions, and inspections. NAFDAC's mandate includes not only drugs, but also food and other consumables. Thus far, NAFDAC has not built sufficient capacity to test more than a small number of lots of imported or manufactured drugs. Its principle approach has been to lot test a manufacturer to qualify it for a NAFDAC registration. Once registered, if a manufacturer produces a substandard lot, it is unlikely that NAFDAC would be able to stop its distribution.[34]

## 2.3 FINANCING OPTIONS FOR THE PRIVATE HEALTH SECTOR

While there are creditworthy borrowers in the private health care sector, Nigerian commercial banks are reluctant to lend to them because of several factors including would-be borrowers' lack of collateral, the lack of knowledge about the private health sector and lending to small and medium enterprises (SMEs), as well as private providers' lack of financial-management skills. Other factors such as high interest rates and short loan durations discourage creditworthy borrowers from applying for loans.

### 2.3.1 LACK OF COLLATERAL BY BORROWERS

The Central Bank of Nigeria (CBN) requires 100 percent collateralization of all loans, although there is flexibility in defining collateral. For instance, collateral can include the assets being financed. Some major banks are flexible in this regard, although other banks only will consider immovable assets. Collateral requirements often range from 100 to 200 percent of the loan amount, depending on whether they are immovable (such as a personal house or building) or moveable property (such as a vehicle or machinery).

Most SME private health care providers operate out of rented facilities or are reluctant to pledge family homes as collateral. Most commercial banks do not view medical equipment and health care providers' other operating assets as acceptable collateral.

### 2.3.2 HIGH INTEREST RATES AND INSUFFICIENT LOAN DURATIONS

In recent years the market has largely driven interest rates with the CBN influencing the level and direction of rate movements through changes in its maximum rediscount rate. This approach, however, has been diluted through an agreement between the CBN and commercial banks in which banks will keep their lending rates no more than 4 percent greater than the maximum rediscount rate. Fees, such as management and commitment ones, are not limited. Whatever is mutually agreed upon between a bank and a customer is what is negotiated in the loan terms. Consequently, restrictions on lending rates have not encouraged banks to increase SME lending.

[33] Ibid.
[34] Ibid.

The prime lending rate ranged from 16.5 percent to 18.21 percent in October 2007,[35] depending on available collateral and the credit history of the borrower. Loan durations range from working capital (less than 12 months) to tenors of three years for equipment and technology finance for the oil industry and other major companies. Nigerian banks have extended long-term loan facilities to large pharmaceutical companies and a few hospitals that had sufficient collateral, but otherwise they have had little loan exposure to the health care sector. Corporate and commercial lending, along with investment in government securities, accounts for most bank assets. Due to heightened macroeconomic risk and volatility, a high percentage of deposits are kept in liquid assets. Reflecting the guidelines of the CBN, at least 40 percent of bank assets must be liquid. Banks' cost of funds ranges from 8 to 15 percent.[36] The CBN, however, has reduced its cash-reserve requirement, reducing the cost of funds, which will have a positive effect on interest rates. Inflation, however, is forecast to average around 9 percent in 2009.[37]

### 2.3.3 LACK OF KNOWLEDGE ABOUT THE HEALTH CARE SECTOR AND EXPERIENCE LENDING TO SMES

Commercial banks have not performed a substantial amount of SME lending because of several disincentives. Therefore they lack the knowledge and experience to extend and manage SME loans (most private health providers are SMEs). The Central Bank of Nigeria for the purposes of its Small and Medium Enterprises Equity Investment Scheme (SMEEIS) defines SMEs as enterprises with assets not exceeding 1.5 billion naira (excluding land), with no upper or lower limit in staff numbers.[38] Total bank credit as a ratio to GDP is about 20 percent, which is low even for a developing country. To encourage SME development, banks are required to reserve 10 percent of their annual after-tax income in SMEEIS in addition to their lending activities. Land and working capital are excluded from assets. Banks are not able to acquire more than 40 percent of an SME. The exposure to the health care sector under SMEEIS has focused on large equity investments, such as the rehabilitation of a pharmaceutical company, rather than investing in the smaller businesses that constitute the majority of private health care firms. The large pharmaceutical companies (the 11 listed on the Nigerian Stock Exchange) and a few large private hospitals are not SMEs, but they constitute the majority of most Nigerian banks' health care loan exposure.[39]

### 2.3.4 ASYMMETRIC INFORMATION ABOUT BORROWERS

Lending to the health care sector is estimated at less than 5 percent of banks' total loan portfolio. Lenders interviewed indicated that there was little interest in the sector as banks focus on SMEs that generate demonstrated cash flow in the short term, such as trading activities related to importing. Although the CBN has a borrower database, it only applies to larger corporate borrowers, not the SME category of borrowers (which includes the vast majority of health care businesses). In addition, no central land registry exists, making it difficult to document ownership of real estate for use as collateral. Most bankers interviewed had little knowledge of the health care sector or understanding of changes in the delivery of health care in Nigeria that could present lending opportunities, such as the NHIS. The NHIS system is based on a capitation payment (fixed sum per person regardless of services) to accredited primary care providers for most of the basic benefit package. NHIS establishes the capitation and fee schedules for drugs, tests, and referrals. HMOs process and pay capitation and fee-for-service claims. Participation by a physician in an HMO could lead to more predictable income and increased profitability for him or her, assuming the provider manages the practice well.

[35] Central Bank of Nigeria official website.
[36] Ibid.
[37] Private Sector Partnerships-*One* 2008.
[38] Central Bank of Nigeria 2006.
[39] Private Sector Partnerships-*One* 2008.

### 2.3.5 LACK OF MANAGEMENT SKILLS FROM POTENTIAL BORROWERS

One major problem from the perspective of the banks is that few health care businesses have financial statements, much less audited ones (although this percentage is likely higher in comparison to many other SME sectors). While many health care providers do not have audited financial statements or business plans, many of them have been in business for more than 10 years and have grown their businesses during that time from internally generated funds.

## 2.4 PSP-*ONE* NIGERIA

At the request of USAID/Nigeria, the PSP-*One* project developed a strategy to expand and improve the provision of family planning and reproductive health products and services in the private health sector.

PSP-*One* noted that the introduction of the NHIS presented an opportunity to address the needs of private providers and to encourage them to promote family planning and other preventive care. The PSP-*One* project in Nigeria expects to succeed by addressing two needs of private providers: learning how to manage their practices differently with more clients under a fixed monthly capitation fee and providing them with technical updates in key preventive care areas of family wellness (family planning, malaria, nutrition, and routine immunization).

PSP-*One* initiated the project in late 2006, partnering with one of the leading HMOs, Total Health Trust (THT). One of the first HMOs in Nigeria, THT started in 1990 and now has more than 3,000 provider clinics and specialists among its enrolled providers. Providers include individual physicians, primary health clinics, maternity homes, and mission and private hospitals. With financial and technical support from PSP-*One*, THT took the lead in training providers in managed care and family wellness and in partnering with SFH, providing a unique opportunity of linking the trained providers to uninterrupted access to qualitative health products.

The project commenced work with one of its partners, the Association of General and Medical practitioners of Nigeria (AGPMPN) to obtain accreditation for maternal, child and family wellness and access to finance training curriculums under the continuing medical education of the Medical and Dental Council of Nigeria. Obtaining this accreditation will increase the pool of trainers in the two courses offered by PSP-*One* that will further help sustain the project's impact beyond the life of the project and allow AGPMPN and HMCAN to charge a fee to cover the training's costs. PSP-*One* has expanded the program to nine HMOs to increase the pool of trainers, which will help scale up the managed-care family-wellness training.

At USAID/Nigeria's request, PSP-*One* assessed the interest of commercial banks for private health sector credit-enhancement instruments. It also identified the constraints to health-sector lending and the role that a Development Credit Authority guarantee could have in mitigating them. Based on its findings, in August 2007, PSP-*One*, with technical oversight from the Banking on Health project, prepared a package of technical assistance consisting of three components:

- conduct market research on the private health sector to use to train financial institutions and private providers and to inform policy makers
- develop and rollout a business training program for private health providers
- train financial institutions in lending to the private health sector

In August 2007, Banking on Health conducted a training of trainers (TOT) program in Lagos in business and financial management for THT trainers, physicians, and nurses who will become master trainers for their medical groups. An additional TOT program was held in late 2007 in Abuja that also included pharmacists. More than 54 trainings of private providers were held in 2007 and 2008. PSP-*One*, with input from Banking on Health, also has initiated work with local banks to increase lending to the health

sector so private providers have access to credit to expand and improve their medical practices. In addition, two financial institutions developed products specifically for pharmacists, nurses, and midwives. Workshops were held in February 2008 for commercial banks and MFIs on marketing and product development for the small-scale health care sector, incorporating the research findings from this report. In addition, a private-sector trade fair was held in August 2008 to develop better business linkages between private providers and suppliers, including financial institutions. This survey report represents the results of the market research on the private health sector to inform the trainings and provide demographic information on the private health sector for financial institutions to encourage lending to the sector.

# 3. RESEARCH METHODS

## 3.1 OVERVIEW

PSP-*One* commissioned Communication and Marketing Research Group (CMRG) Limited, a Nigerian market-research consulting firm with experience in market research related to the health care sector, to conduct the market-research surveys. The quantitative study consisted of two surveys of private health care providers: one sample group consisted of physicians, nurses, and midwives (grouped together for the analysis) and the other sample group consisted of pharmacists and PMVs.

The private health care providers surveyed were located in five Nigerian states (Lagos, Federal Capitol Territory (FCT), Kano, Bauchi, and Nasarawa) where the PSP-*One* project initially operated. In all, 1,773 surveys were fully completed with a 100 percent response rate.

## 3.2 SAMPLING POPULATION AND FRAME

The target population for this survey was all registered private physicians, nurses, midwives, pharmacists, and PMVs in the Nigerian states of Lagos, FCT, Kano, Bauchi, and Nasarawa who offer family planning and reproductive health services in their practice. The objective was to select a random representative sample of these providers.

A limitation of this study is that a comprehensive and up-to-date sampling frame from which a random sample could be selected did not exist. The sampling frame, a list of registered health providers in each of the three provider groups (pharmacists and PMVs, nurses and midwives, and doctors), was constructed from various sources, including the NHIS, a list of registered pharmacists with which SFH (the largest provider of contraceptives in Nigeria) works, the Association of Community Pharmacists and the Pharmaceutical Society of Nigeria (pharmacists), the Nigerian Patent Medical Vendors Association (PMVs), the National Association of Nigerian Nurses and Midwives (nurses and midwives), and the Association of General and Private Medical Practitioners of Nigeria (doctors). In some cases, it was difficult to obtain membership lists from organizations or comprehensive lists of providers did not exist.

The original target sample size was 1,500 health providers. It was calculated that this quantity would yield an effective sample of more than 50 responses from each segment of health providers in each of the study states. This minimum sample per segment per state would in turn yield reliable results at the 95 percent confidence level. An additional provision for a non-response rate of 15 percent was made, bringing the total planned target sample size to 1,725 contacts in order to yield 1,500 interviews (Table 1).

**TABLE 1: PLANNED SAMPLE SIZE BY PROVIDER TYPE**

| Provider type | Desired sample size | Provision for non-response | Planned total contacts to achieve desired sample size |
|---|---|---|---|
| Physicians | 500 | 75 | 575 |
| Nurses and midwives | 400 | 60 | 460 |
| Pharmacists | 300 | 45 | 345 |
| PMVs | 300 | 45 | 345 |
| TOTAL | 1,500 | 225 | 1,725 |

Greater sample sizes were allotted to provider types that offer family planning and reproductive health services as part of their clinical services compared to those who sell reproductive health products. In each state, the sample allocated to each health-provider segment was proportional to its size. Once each segment's state frame was compiled, the segment's state population was divided by the segment's allotted state sample to arrive at a sampling interval that was used to systematically select a sample after a random start. When the number of providers in a state sampling frame was fewer than the planned number of interviews, all of the listed members were included in the sample.

During the fieldwork it became apparent that the provider lists the medical associations and organizations supplied did not contain a sufficient number of providers to satisfy recruitment criteria. Therefore the interviewers developed lists of private clinics and hospitals located in Lagos, FCT, Kano, Bauchi, and Nasarawa. Providers were recruited from locations known to provide family planning services. A sufficient provider sample for each of the groups of interest was obtained from a combination of providers specified in the initial sampling frame and additional ones recruited based upon their location. When the original sampling frame did not contain sufficient providers, the sampling frame was sampled exhaustively and additional providers were recruited from clinics and hospitals in the manner specified previously. If the sampling frame contained a sufficient number of providers, a systematic sampling method was used.

Table 2 provides for each state the total number of providers on the sample frame, the number of interviews conducted from the sample frame, and the number of interviews that were done using providers not on the initial sampling frame. The respondents totaled 401 physicians, 419 nurses and midwives, 400 pharmacists, and 553 PMVs. In all, 1,773 interviews were conducted.

**TABLE 2: SAMPLING FRAME AND INTERVIEWS ACHIEVED BY STATE AND PROVIDER TYPE**

| | Number of members on available sample frame | Number of interviews conducted from frame | Number of interviews done outside frame | Total number of interviews |
|---|---|---|---|---|
| **Lagos sample** | | | | |
| Physicians | 571 | 109 | 0 | 109 |
| Nurses and midwives | 12 | 2 | 107 | 109 |
| Pharmacists | 458 | 109 | 0 | 109 |
| PMVs | 3,714 | 112 | 0 | 112 |
| Total | | | | 439 |
| **FCT (Abuja, the state's capital) Bauchi sample** | | | | |
| Physicians | 43 | 31 | 78 | 109 |
| Nurses and midwives | 11 | 7 | 102 | 109 |
| Pharmacists | 218 | 109 | 0 | 109 |
| PMVs | 249 | 108 | 0 | 108 |
| Total | | | | 435 |
| Bauchi sample | | | | |
| Physicians | 45 | 21 | 8 | 29 |
| Nurses and midwives | 47 | 23 | 0 | 23 |
| Pharmacists | 18 | 15 | 17 | 32 |
| PMVs | 91 | 44 | 70 | 114 |
| Total | | | | 198 |

| | Number of members on available sample frame | Number of interviews conducted from frame | Number of interviews done outside frame | Total number of interviews |
|---|---|---|---|---|
| **Nasarawa sample** | | | | |
| Physicians | 55 | 31 | 14 | 45 |
| Nurses and midwives | 17 | 11 | 58 | 69 |
| Pharmacists | 31 | 20 | 27 | 47 |
| PMVs | 88 | 54 | 56 | 110 |
| Total | | | | 271 |
| **Kano sample** | | | | |
| Physicians | 63 | 54 | 55 | 109 |
| Nurses and midwives | 13 | 9 | 100 | 109 |
| Pharmacists | 41 | 32 | 71 | 103 |
| PMVs | 832 | 109 | 0 | 109 |
| Total | | | | 430 |

## 3.3 SURVEY METHODOLOGY

Two draft survey questionnaires were developed with input from CMRG . They consisted of 90 primarily multiple-choice questions for physicians, nurses, and midwives and 99 questions for pharmacists and PMVs. Topics included demographic, business, and financial information, as well as opinions about obstacles, opportunities, and future plans. The two questionnaires were pretested with a subsample of 30 private medical facilities; these data were not included in the results.

Respondents were recruited in advance with follow-up calls and visits to remind them and confirm interview dates. Interviewers administered the questionnaire face-to-face with providers. All interviews were conducted at respondents' businesses or office premises. It took an average of 55 minutes to complete a questionnaire as respondents had to occasionally attend to customers and other callers. All respondents who agreed to participate completed the interview.

In all, 10 CMRG teams across the five survey locations conducted the fieldwork. Each team consisted of one project officer, one team leader, and six interviewers. All survey teams were trained before the fieldwork began. All interviewers used to conduct data collection were graduate interviewers with years of experience in executive and business-to-business interviews. They worked under supervisors, using the group interviewing technique in which they focused on and completed interviews in one area before moving to another one. Fieldwork was checked by quality-control officers who back checked a sample of the questionnaires randomly picked from the lot, and monitoring was conducted regularly to ensure the data's integrity.

## 3.4 DATA ANALYSIS

Data entry was done in QPS 2002 in ASCII format and exported to the Statistical Package for the Social Sciences (SPSS) and Microsoft Excel for analysis. Data were analyzed using the SPSS for Windows, 2006. Frequency distributions were calculated, and the relationships among certain variables were analyzed by type of medical provider and state.

## 3.5 LITERATURE

A literature review was conducted to gather information about developments that impact the sector, such as government initiatives and policies. Sources for this review included government statistics from articles and reports.

# 4. GENERAL RESULTS OF THE SURVEY OF PRIVATE MEDICAL PROVIDERS

## 4.1 CHARACTERISTICS OF PRIVATE MEDICAL PROVIDERS

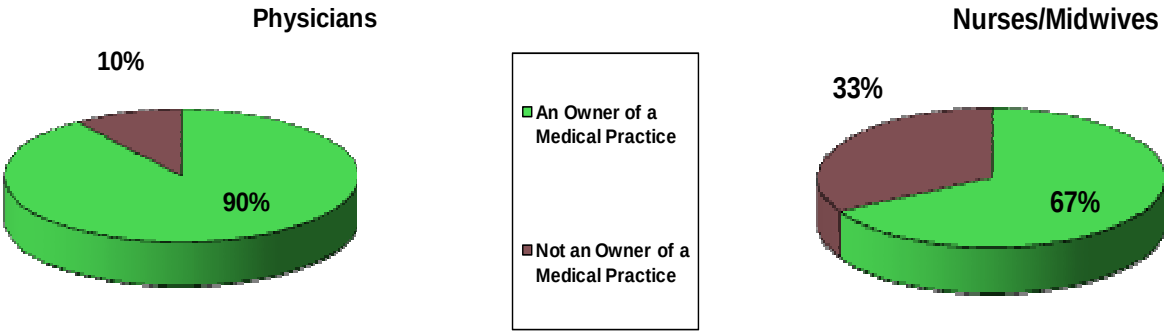
### 4.1.1 SEX

Approximately 67 percent of the respondents were male and 33 percent female. More than half (53.7 percent) of nurses and midwives were female, as were 23.8 percent of pharmacists, 14.6 percent of PMVs, and 10.5 percent of physicians.

### 4.1.2 MEDICAL OWNER RESPONDENTS

Survey respondents were not necessarily the owners of the health care facilities, although as Figure 3 indicates almost all physicians and approximately two-thirds of nurses own their practices. Some of the respondents were medical employees of the private health practices. Pharmacists and PMVs were not asked this question.

**FIGURE 3: PROPORTION OF PHYSICIANS AND NURSES/MIDWIVES WHO OWNED THEIR PRIVATE MEDICAL PRACTICES**




## 4.2 LOCATION

As shown in Table 3, most of the respondents practice in urban areas (81 percent of physicians, 72 percent of nurses and midwives, 85 percent of pharmacists, and 75 percent of PMVs).

**TABLE 3: PROPORTION OF PRIVATE PROVIDERS WITH URBAN VERSUS RURAL PRACTICES BY STATE AND PROVIDER TYPE**

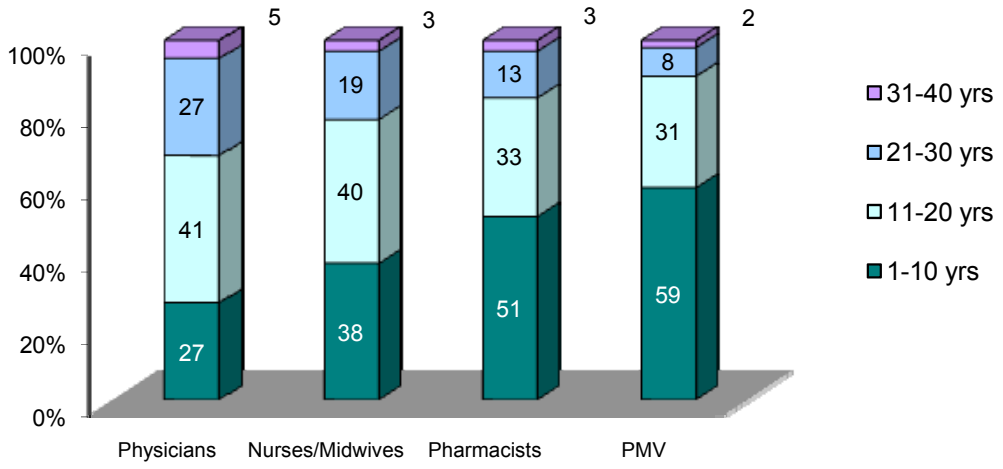
| | Average (%) | | Lagos | | FCT | | Nasarawa | | Bauchi | | Kano | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Urban | Rural | Urban | Rural | Urban | Rural | Urban | Rural | Urban | Rural | Urban | Rural |
| Physicians | 81 | 19 | 100 | 0 | 72 | 28 | 64 | 36 | 55 | 45 | 85 | 15 |
| Nurses and midwives | 72 | 28 | 100 | 0 | 53 | 47 | 64 | 36 | 43 | 57 | 73 | 27 |
| Pharmacists | 85 | 15 | 100 | 0 | 80 | 20 | 64 | 36 | 81 | 19 | 91 | 9 |
| PMVs | 75 | 25 | 100 | 0 | 54 | 46 | 76 | 24 | 70 | 30 | 75 | 25 |

## 4.3 CHARACTERISTICS OF PRIVATE PRACTICE

### 4.3.1 YEARS OF EXPERIENCE

The private medical providers surveyed are experienced in their fields. Physicians and nurses and midwives, in general, had more years of experience compared to pharmacists and PMVs. More than half of pharmacists and PMVs had 1 to 10 years of experience. Physicians averaged 17 years of experience, nurses 15 years, pharmacists 12 years, and PMVs 11 years (Figure 4).

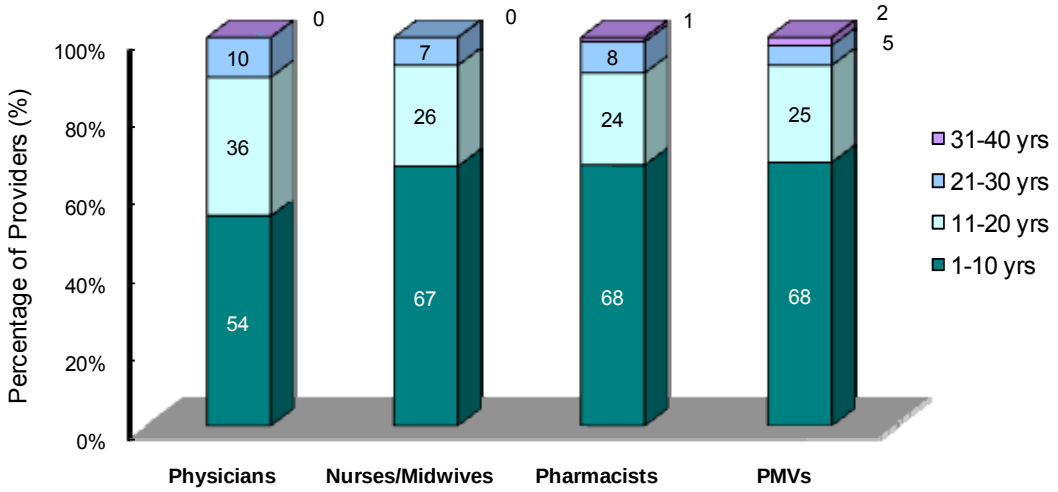
**FIGURE 4: YEARS OF MEDICAL PRACTICE EXPERIENCE BY PROVIDER TYPE**




### 4.3.2 EXPERIENCE AS PRIVATE PROVIDERS

Private providers had an average of more than nine years of private-sector experience. Almost half (46 percent) of physicians in this survey had 11 or more years of experience in the private sector (Figure 5). In addition, a comparison of the mean years of medical experience to mean years of private medical practice indicates that while physicians, nurses, and midwives went into private practice after five to six years of professional experience, pharmacists and PMVs did so after just two to three years.

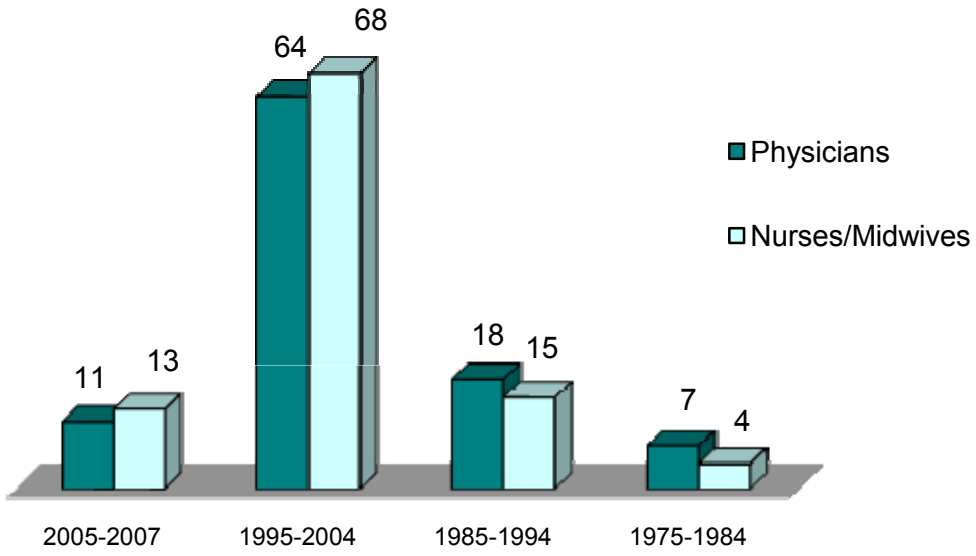
**FIGURE 5: YEARS OF EXPERIENCE AS A PRIVATE MEDICAL PROVIDER**




## 4.3.3 YEARS OF OPERATION OF MEDICAL PRACTICES

Figure 6 confirms the growth of private health facilities in the past 15 years, as the majority of private physicians (75 percent) and nurses and midwives (82 percent) began operating their medical facilities between 1995 and 2007. This growth is likely the result of the deterioration of public health facilities as operating conditions for public-health workers worsened, especially during the Sani Abacha regime (1993 to 1998).

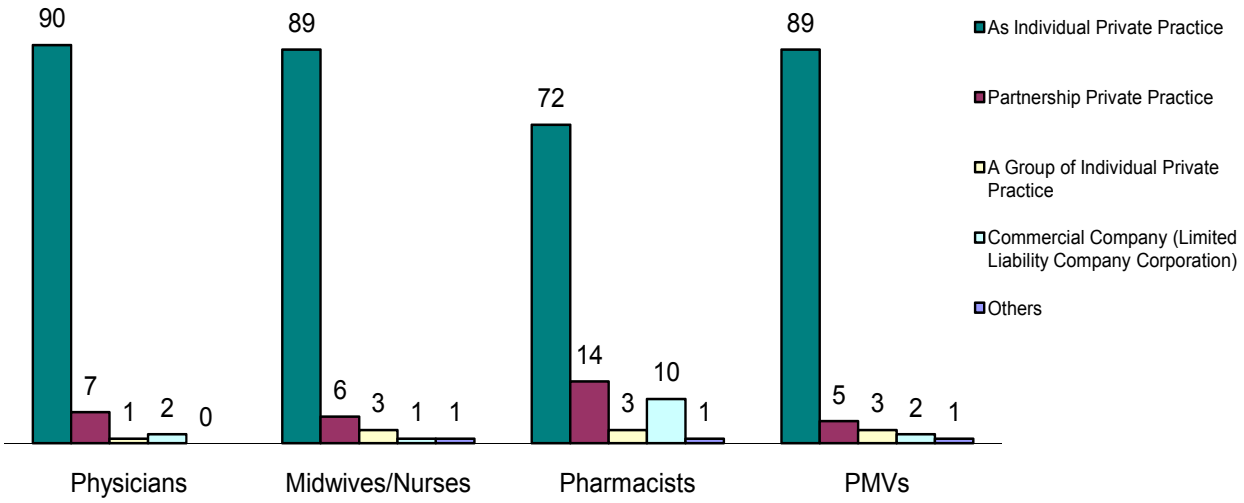
**FIGURE 6: YEARS OF OPERATIONS FOR PRIVATE MEDICAL FACILITIES**




## 4.3.4 TYPE OF MEDICAL PRACTICE

Most private medical- and pharmacy-related health practices in Nigeria are sole proprietorships owned by individuals (Figure 7). Other forms of ownership are not common. This tendency has business-performance and access-to-credit ramifications as overhead costs are greater in sole proprietorships and banks often assess a higher lending risk to such businesses.

**FIGURE 7: HOW PRIVATE PRACTICES ARE REGISTERED AS BUSINESSES**




### 4.3.5 EMPLOYEES OF MEDICAL PRACTICES

Private providers generate employment in Nigeria. The vast majority of physicians, nurses, midwives, and pharmacists have employees working for them (Table 4). The majority of PMVs, however, do not have employees.

Most physicians employ six or more full-time workers; half of them have between one and five part-time staff members. A majority of nurses and midwives also have one to five full-time employees, but they are almost evenly divided between those who have part-timers and those who do not. The majority of pharmacists employ one to five full-time workers, although they are divided almost evenly between those who have part-time employees and those who do not. Of those PMVs who have employees, most have between one and five of them. A majority of PMVs do not have part-time employees. Most of the full-time employees working with private providers are professional health workers (data not shown).

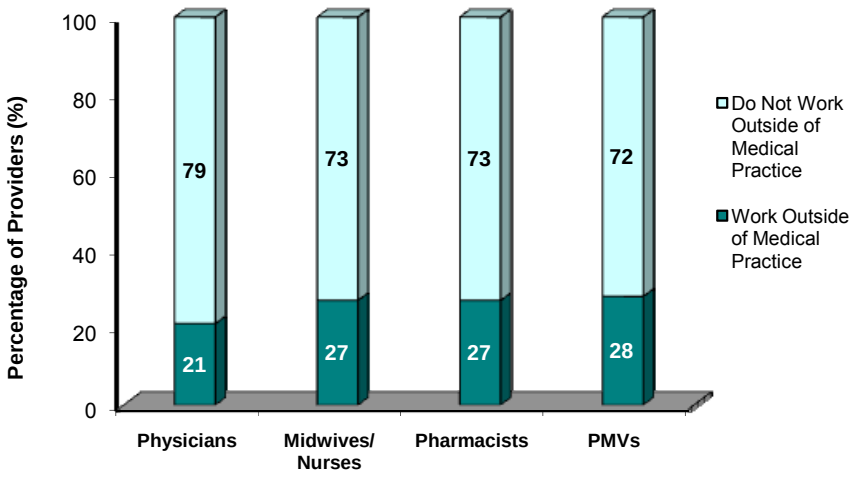
**TABLE 4: PROPORTION OF PRIVATE PROVIDERS WITH EMPLOYEES AND THE DISTRIBUTION OF THEIR NUMBER OF EMPLOYEES AND EMPLOYMENT STATUS BY PROVIDER TYPE**

| | **Physicians (n=401)** | | **Nurses and midwives (n=419)** | | **Pharmacists (n=400)** | | **PMVs (n=553)** | |
|---|---|---|---|---|---|---|---|---|
| N (%) with at least one employee | 383 (96%) | | 377 (90%) | | 373 (93%) | | 228 (41%) | |
| **Number of full-time and part-time employees** | **Full-time %** | **Part-time %** | **Full-time %** | **Part-time %** | **Full-time %** | **Part-time %** | **Full-time %** | **Part-time %** |
| 0 employees | 0 | 45 | 0 | 52 | 7 | 51 | 14 | 61 |
| 1-5 employees | 22 | 50 | 53 | 47 | 77 | 48 | 81 | 38 |
| 6-10 employees | 42 | 5 | 32 | 1 | 13 | 1 | 5 | 1 |
| More than 10 employees | 36 | 0 | 15 | 0 | 3 | 0 | 0 | 0 |

### 4.3.6 WORK OUTSIDE OF PRACTICE

Almost three-fourths of private providers do not work outside of their private practices (Figure 8). Most private providers also indicated that they rent the facilities for their practices.

**FIGURE 8: PRIVATE MEDICAL PROVIDERS WHO WORK OUTSIDE OF MEDICAL PRACTICE**

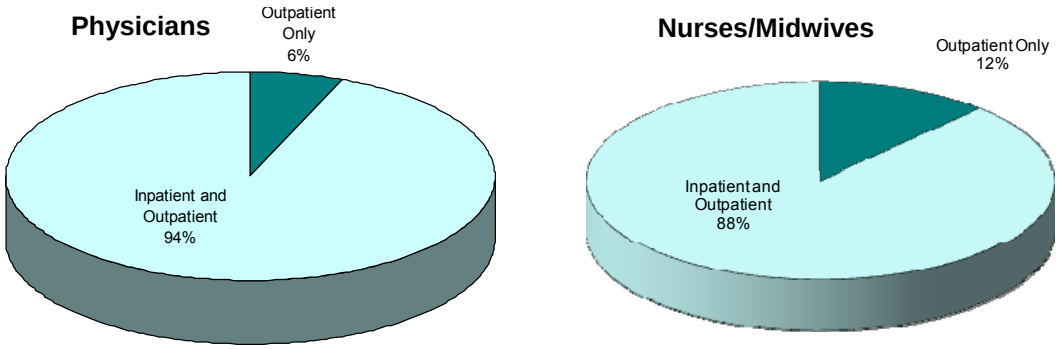



## 4.4 CAPACITY OF PRIVATE HEALTH PRACTICES

### 4.4.1 INPATIENT AND OUTPATIENT FACILITIES

Physicians and nurses overwhelmingly have both inpatient and outpatient medical facilities (Figure 9). Physicians, nurses, and midwives (40 percent) were more likely than pharmacists and PMVs (12 to 13 percent) to own their own facilities.

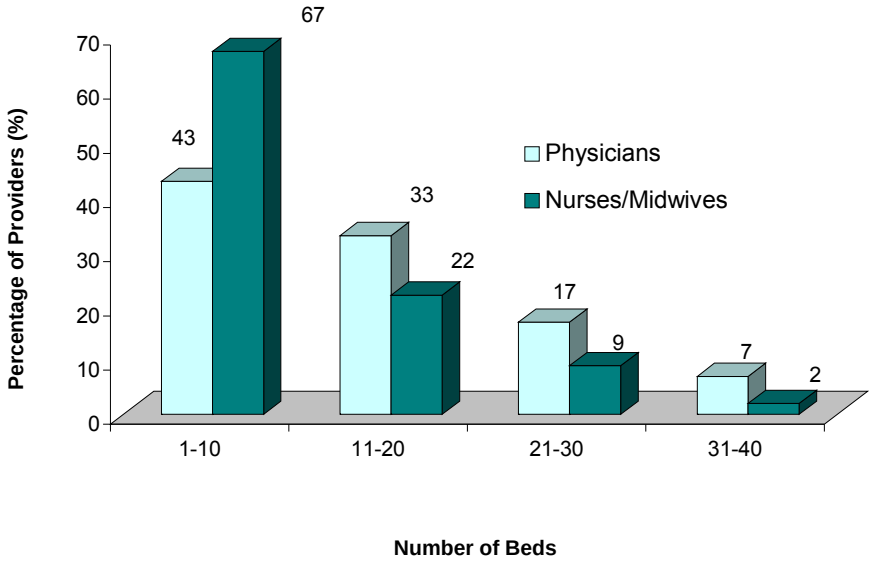
**FIGURE 9: INPATIENT AND OUTPATIENT FACILITIES OF PHYSICIANS, NURSES, AND MIDWIVES**



### 4.4.2 NUMBER OF BEDS

The largest percentage of physicians, nurses, and midwives have between one and 10 beds in their medical practices (Figure 10). The median numbers of beds were 15 for physicians and 10 for nurses and midwives.

**FIGURE 10: NUMBER OF BEDS FOR PHYSICIANS, NURSES, AND MIDWIVES**




### 4.4.3 MAJOR MEDICAL SERVICES PRIVATE PROVIDERS OFFERED

Private physicians offer a variety of essential major medical services, with 97 percent of them offering family planning, 37 percent offering HIV/AIDS treatment, and 84 percent sexually transmitted infection (STI) treatment (Table 5). A high proportion of physicians in all states offer family planning. The services offered do not vary significantly across the five states where physicians were surveyed with the exception of Nasarawa in which physicians provide fewer major services. The base number of providers for Nasarawa and Bauchi, however, are low.

**TABLE 5: PROPORTION OF PRIVATE PHYSICIANS PROVIDING SPECIFIC TYPES OF MEDICAL SERVICES BY STATE**

| Services | Total physicians | Lagos | FCT | Nasarawa | Bauchi | Kano |
|---|---|---|---|---|---|---|
| Base number | 401 | 109 | 109 | 45 | 29 | 109 |
| **Percent** | % | % | % | % | % | % |
| Family planning | 97 | 96 | 100 | 87 | 100 | 97 |
| Maternity care | 89 | 92 | 92 | 76 | 90 | 88 |
| HIV/AIDS treatment | 37 | 32 | 42 | 18 | 38 | 44 |
| Malaria treatment | 95 | 98 | 91 | 96 | 97 | 95 |
| Pediatric care | 83 | 95 | 82 | 56 | 69 | 88 |
| STI treatment | 84 | 89 | 82 | 80 | 93 | 82 |
| Curative care | 95 | 98 | 91 | 96 | 97 | 95 |

The majority of private nurses and midwives also offer major medical services but as with physicians, fewer services are offered in Nasarawa state (Table 6). For example, 84 percent of nurses and midwives offer family planning in Nasarawa compared to an average of 97 percent across the five regions, 62 percent offer STI treatment compared to an average of 70 percent and 13 percent offer HIV treatment compared to an average of 19 percent.

**TABLE 6: TYPES OF MEDICAL SERVICES NURSES AND MIDWIVES PROVIDE, INCLUDING BY GEOGRAPHIC STATE**

| Services | Total nurses and midwifes | Lagos | FCT | Nasarawa | Bauchi | Kano |
|---|---|---|---|---|---|---|
| Base number | 419 | 109 | 109 | 69 | 23 | 109 |
| **Percent** | % | % | % | % | % | % |
| Family planning | 97 | 100 | 100 | 84 | 100 | 100 |
| Maternity care (prenatal and postnatal care) | 83 | 85 | 94 | 68 | 87 | 79 |
| HIV/AIDS treatment | 19 | 42 | 17 | 13 | 22 | 16 |
| Malaria treatment | 93 | 97 | 88 | 88 | 96 | 95 |
| Pediatric care | 67 | 82 | 66 | 61 | 78 | 66 |
| STI treatment | 70 | 78 | 81 | 62 | 78 | 56 |
| Curative care | 93 | 97 | 88 | 88 | 96 | 95 |

Pharmacists' primary services are dispensing prescriptions and over-the-counter drugs (Table 7). Only in Nasarawa and Bauchi do the majority of pharmacists act as wholesale providers of drugs to pharmacists.

**TABLE 7: TYPES OF SERVICES PROVIDED BY PHARMACISTS BY STATE**

| Services | Total pharmacists | Lagos | FCT | Nasarawa | Bauchi | Kano |
|---|---|---|---|---|---|---|
| Base number | 400 | 109 | 109 | 47 | 32 | 103 |
| **Percent** | % | % | % | % | % | % |
| Drug dispensary for prescribed drugs | 94 | 90 | 98 | 98 | 100 | 91 |
| Sale of over-the-counter drugs | 96 | 92 | 100 | 98 | 100 | 94 |
| Sale of non-drug related items | 74 | 73 | 79 | 51 | 88 | 75 |
| Wholesale provider of drugs to pharmacists | 44 | 50 | 37 | 74 | 69 | 25 |

Despite regulatory restrictions regarding dispensing ethical (prescribed) drugs in all states, with the exception of Bauchi, more than two-thirds of PMVs in the other states are distributing these drugs and most of them also sell over-the-counter drugs (Table 8). Non-drug sales are a major service for PMVs in all states except Nasarawa. Nine to 26 percent of PMVs are wholesale suppliers of drugs to pharmacists.

**TABLE 8: TYPES OF SERVICES PROVIDED BY PMVS BY STATE**

| Services | Total PMVs | Lagos | FCT | Nasarawa | Bauchi | Kano |
|---|---|---|---|---|---|---|
| Base number | 553 | 112 | 108 | 110 | 114 | 109 |
| **Percent** | % | % | % | % | % | % |
| Drug dispensary for prescribed drugs | 71 | 70 | 93 | 95 | 6 | 94 |
| Sale of over-the-counter drugs | 95 | 96 | 98 | 85 | 98 | 97 |
| Sale of non-drug related items | 67 | 91 | 61 | 33 | 81 | 67 |
| Wholesale provider of drugs to pharmacists | 15 | 9 | 18 | 26 | 10 | 14 |

### 4.4.4 TYPES OF FAMILY PLANNING SERVICES PRIVATE PROVIDERS OFFER

In all five Nigerian states surveyed, 97 percent of providers offer at least one family planning service. At least 82 percent of physicians, nurses, and midwives in all five survey states offer contraceptive pills and injectable contraceptives (Table 9). Of all physicians, 71 percent offer IUD insertions, but this proportion varies across states, ranging from 41 percent in Nasarawa to 90 percent in Lagos. Fewer providers in all five states offer longer-term family planning services, such as tubal ligations and vasectomies.

**TABLE 9: TYPES OF FAMILY PLANNING SERVICES PRIVATE PROVIDERS OFFER BY PROVIDER TYPE AND STATE**

| Services | Total physicians (P) | Total nurses and midwives (N) | Lagos | | FCT | | Nasarawa | | Bauchi | | Kano | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | P | N | P | N | P | N | P | N | P | N |
| Base number | 375 | 403 | 101 | 108 | 104 | 108 | 37 | 56 | 28 | 23 | 105 | 108 |
| **Percent** | % | % | % | % | % | % | % | % | % | % | % | % |
| Contraceptive pills | 92 | 89 | 94 | 83 | 91 | 91 | 84 | 82 | 96 | 91 | 91 | 97 |
| IUDs | 71 | 47 | 90 | 69 | 71 | 49 | 41 | 21 | 61 | 35 | 66 | 39 |
| Injectable contraceptives | 89 | 91 | 90 | 94 | 91 | 90 | 92 | 93 | 93 | 83 | 82 | 91 |
| Condoms | 80 | 78 | 83 | 92 | 88 | 81 | 59 | 66 | 82 | 78 | 75 | 68 |
| Tubal ligations | 33 | 17 | 30 | 14 | 38 | 31 | 35 | 18 | 50 | 13 | 26 | 6 |
| Vasectomies | 19 | 11 | 16 | 10 | 26 | 16 | 16 | 13 | 36 | 9 | 12 | 6 |
| Other | 1 | 1 | 0 | 1 | 3 | 1 | 0 | 0 | 0 | 0 | 0 | 1 |

### 4.4.5 HIV/AIDS-RELATED SERVICES PRIVATE PROVIDERS OFFERED

Although the public sector has more providers, the private sector also plays an important role in HIV/AIDS service delivery. In all five states surveyed, at least half of the physicians offer HIV/AIDS testing to their clients. And, with the exception of Bauchi and Kano, 30 to 34 percent of nurses and midwives in each of the states also offer testing services. More than 60 percent of physicians in all five survey states provide HIV/AIDS counseling. Approximately half of all private physicians also provide prevention of mother-to-child transmission (PMTCT) services (49 percent) and more than one-third of them provide ARV therapy (37 percent overall, although only 18 percent in Nasarawa) despite the availability of free ARVs in the public sector.

**TABLE 10: HIVAIDS-RELATED SERVICES PRIVATE PROVIDERS OFFER BY PROVIDER TYPE AND STATE**

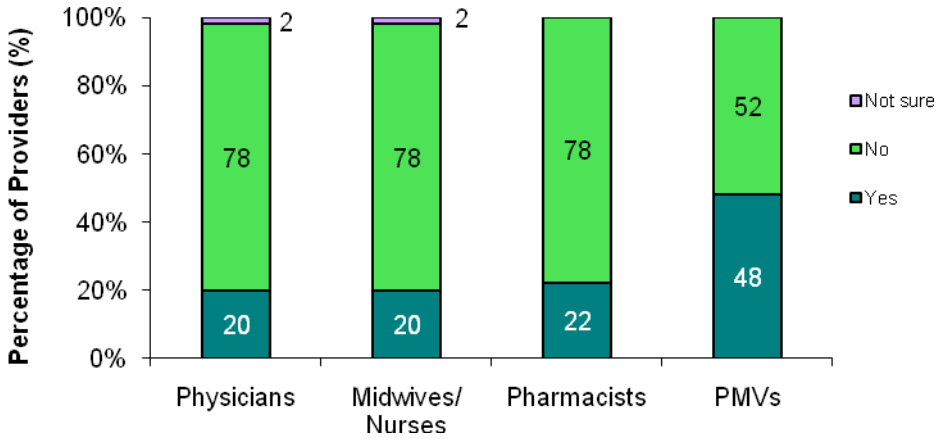
| Services | Total physicians (P) | Total nurses and midwives (N) | Lagos | | FCT | | Nasarawa | | Bauchi | | Kano | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | P | N | P | N | P | N | P | N | P | N |
| Base number | 370 | 346 | 101 | 93 | 104 | 102 | 40 | 50 | 26 | 23 | 99 | 78 |
| **Percent** | % | % | % | % | % | % | % | % | % | % | % | % |
| HIV/AIDS testing | 59 | 27 | 62 | 30 | 62 | 34 | 56 | 30 | 66 | 22 | 50 | 17 |
| ARVs | 37 | 19 | 32 | 28 | 42 | 17 | 18 | 13 | 38 | 22 | 44 | 16 |
| HIV/AIDS counseling | 67 | 62 | 61 | 69 | 68 | 83 | 71 | 54 | 76 | 83 | 68 | 36 |
| PMTCT | 49 | 53 | 41 | 40 | 49 | 66 | 56 | 46 | 38 | 70 | 58 | 55 |

## 4.5 REGULATORY ASPECTS OF PRIVATE MEDICAL PRACTICES

### 4.5.1 WHETHER GOVERNMENT REGULATIONS ARE AN OBSTACLE

With the exception of PMVs, more than three-fourths of private providers indicated that government regulations are not an obstacle in managing a medical practice (Figure 11).

**FIGURE 11: OPINION ON WHETHER GOVERNMENT REGULATIONS CONSTITUTED AN OBSTACLE TO MANAGING A MEDICAL BUSINESS BY PROVIDER TYPE***

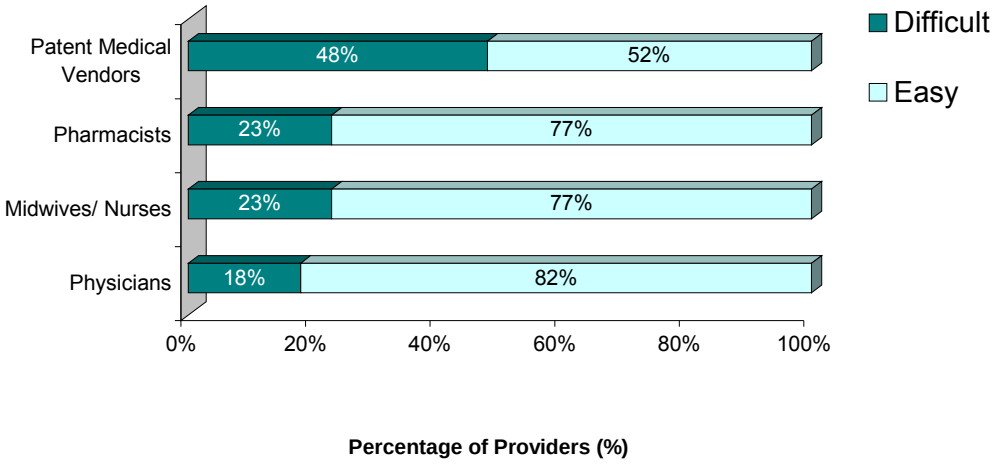



*For pharmacists and PMVs, this graph displays the proportion who felt it was difficult to obtain a license.

### 4.5.2 DIFFICULTY IN OBTAINING A LICENSE FOR PRIVATE MEDICAL PRACTICE AND PHARMACY BUSINESS

Approximately half of PMVs think that obtaining a license to operate a pharmacy business is difficult (Figure 12). This sentiment may reflect that the responsibility for licensing PMVs was transferred back to the PCN in 2003, which has slowed down the issuing of licenses considerably in an attempt to control the localization of PMVs. Most pharmacists, nurses, midwives, and physicians felt that obtaining a license was easy.

**FIGURE 12: PROPORTION OF PROVIDERS STATING THAT OBTAINING A LICENSE FOR PRIVATE PRACTICE IS DIFFICULT OR EASY BY PROVIDER TYPE**




### 4.5.3 REASONS FOR DIFFICULTY ENCOUNTERED IN REGISTERING A PRIVATE MEDICAL PRACTICE

Providers who described the process of registering a health business as difficult cited several reasons for that sentiment; more than 50 percent of them indicated that the major difficulty was meeting mandatory physical requirements. Scheduling a visit from licensing inspectors and meeting staffing requirements were the other major problems cited.

**TABLE 11: REASONS FOR DIFFICULTY ENCOUNTERED IN REGISTERING A PRIVATE MEDICAL PRACTICE, CLINIC, OR HOSPITAL BY PROVIDER TYPE***

| | Physicians | Nurses and midwives | Pharmacists | PMVs |
|---|---|---|---|---|
| Base number | 69 | 95 | 90 | 265 |
| **Percent** | % | % | % | % |
| Difficulty in meeting physical facility requirements | 57 | 58 | 68 | 58 |
| Difficulty in scheduling a visit from licensing inspectors | 52 | 57 | 44 | 51 |
| Difficulty in meeting staffing requirements | 49 | 47 | 38 | 43 |
| Difficulty in completing application for license | 41 | 41 | 39 | 47 |
| Difficulty in passing inspection | 30 | 41 | 39 | 45 |

| | Physicians | Nurses and midwives | Pharmacists | PMVs |
|---|---|---|---|---|
| Corruption among government officials | 4 | 3 | 0 | 0 |
| Approved license not released | 4 | 1 | 0 | 0 |
| Financial problems | 0 | 0 | 3 | 4 |

*Question allowed for multiple responses

## 4.6 MEDICAL BUSINESS INDICATORS

### 4.6.1 ESTIMATED HOUSEHOLD INCOME OF PROVIDERS

Household income includes medical business income and other sources of income, such as from spouses' income. Self-reported estimated monthly household income ranges widely for private medical providers in Nigeria, but as the survey results demonstrate, all provider groups reported having household earnings that were greater than their average monthly household expenses.

**TABLE 12: AVERAGE MONTHLY TOTAL HOUSEHOLD EARNINGS (INCLUDING MEDICAL BUSINESS INCOMES) AND AVERAGE TOTAL HOUSEHOLD EXPENSES FOR PHYSICIANS, NURSES, AND MIDWIVES**

| | Average monthly household incomes (including medical business income) | | Average monthly household expenses | |
|---|---|---|---|---|
| | Physicians | Nurses and midwives | Physicians | Nurses and midwives |
| Base number | 388 | 408 | 388 | 408 |
| **Percent** | % | % | % | % |
| Less than or equal to N25,000[40] ($192) | 4 | 10 | 13 | 29 |
| N25,001 to N50,000 ($193-$385) | 7 | 23 | 27 | 35 |
| N50,001 to N75,000 ($386-$577) | 8 | 14 | 15 | 13 |
| N75,001 to N100,000 ($578-$769) | 14 | 15 | 13 | 7 |
| N100,001 to N125,000 ($770-$961) | 12 | 11 | 7 | 3 |
| N125,001 to N200,000 ($962-$1,538) | 14 | 9 | 10 | 3 |
| N200,001 to N300,000 ($1,539-$2,308) | 15 | 6 | 3 | 3 |
| N300,001 and greater (above $2,309) | 17 | 7 | 4 | 4 |
| Not sure | 9 | 6 | 8 | 5 |

The total monthly household income of 72 percent of the physicians is more than N75,000 ($577). In fact, 32 percent of them gross more than N200,000 per month ($1,539). In terms of monthly expenses, 55 percent of physicians incur expenses up to N75,000 ($577).

[40] OANDA, The Currency Site

The majority of nurses and midwives (62 percent) earn up to N100 000 ($769) per month, and 64 percent of them incur expenses not exceeding N50,000 ($385).

### 4.6.2 ANNUAL BUSINESS PROFIT

Forty-three percent of physicians reported an annual profit of more than N300,000 ($2,308) in 2006, while 62 percent of nurses and midwives reported an annual monthly profit of less than N300,000 ($2,308) (Table 13). Physicians, nurses and midwives are reinvesting in their businesses, with 24 percent of physicians reinvesting more than N300,000 ($2,308) in 2006. Data for pharmacists and PMVs are not shown because analysis showed that the categories were too broad for meaningful interpretation.

**TABLE 13: AVERAGE ANNUAL PROFIT REPORTED IN 2006 AND AMOUNT RE-INVESTED IN MEDICAL PRACTICE FOR PHYSICIANS, NURSES, AND MIDWIVES**

| | Average annual profit in 2006 | | Amount of 2006 profit reinvested in business | | |
|---|---|---|---|---|---|
| | **Physicians** | **Nurses and midwives** | | **Physicians** | **Nurses and midwives** |
| Base number | 387 | 408 | | 388 | 408 |
| **Percent** | **%** | **%** | | **%** | **%** |
| N50,001–N75,000 ($386-$577) | 7 | 17 | 0 –N25,000 ( 0-$192 ) | 7 | 11 |
| N75,001–N100,000 ($578-$769) | 5 | 9 | 25 001–N50,000 ($193-$385) | 5 | 14 |
| N100,001–N125,000 ($770-$961) | 5 | 9 | 50,001–N75,000 ($386-$577) | 6 | 9 |
| N125,001–N200,000 ($962-$1,538) | 11 | 14 | 75,001–N100,000 ($578-$769) | 5 | 10 |
| N200,001–N300,000 ($1,539-$2,308) | 12 | 13 | 100,001–N125,000 ($770-$961) | 9 | 8 |
| N300,001 and greater (above $2,308) | 43 | 22 | 125,001–N200,000 ($962-$1,538) | 18 | 10 |
| No profit | 1 | 2 | 200,001–N300,000 ($1,539-$2,308) | 11 | 10 |
| Loss | 1 | 0 | 300,001 and greater (above $2,308) | 24 | 12 |
| Not sure | 15 | 14 | Not sure | 15 | 16 |

## 4.7 CONSTRAINTS TO GROWTH AND EXPANSION PLANS

The survey asked private health providers what they think are the constraints to growth of their medical practices. Respondents cited patients' inability to pay and the lack of access to financing as the major hindrances to the profitable operation of a medical or pharmacy business in Nigeria (Table 14). In addition, more than half of PMVs mentioned increased competition from the private sector, and more than a third of pharmacists and PMVs considered stockouts and government regulation constraints to growth. PMVs probably consider government regulation a problem because the PCN has made licensing of PMVs more difficult in the last few years.

**TABLE 14: CONSTRAINTS TO THE PROFITABLE OPERATION OF A MEDICAL PRACTICE BY PROVIDER TYPE***

| | Physicians | Midwives and Nurses | Pharmacists | PMVs |
|---|---|---|---|---|
| Base number | 378 | 399 | 400 | 553 |
| **Percent** | % | % | % | % |
| Patients' inability to pay | 77 | 83 | 62 | 73 |
| Lack of access to financing | 65 | 73 | 64 | 81 |
| Lack of patient visits | 35 | 40 | 29 | 46 |
| Increased competition from the private sector | 34 | 42 | 46 | 53 |
| Increase competition from the public sector | 29 | 35 | 33 | 41 |
| Lack of accounting skills | 26 | 24 | 27 | 32 |
| Lack of specific clinical skills | 19 | 28 | 19 | 38 |
| Lack of good or dedicated employees | 20 | 18 | 27 | 25 |
| Lack of marketing skills | 19 | 17 | 20 | 25 |
| Difficulty finding suppliers | 15 | 17 | 19 | 28 |
| Stockouts | NA | NA | 38 | 48 |
| Excessive government regulations | NA | NA | 42 | 44 |
| Lack of marketing skills | 19 | 17 | 20 | 25 |

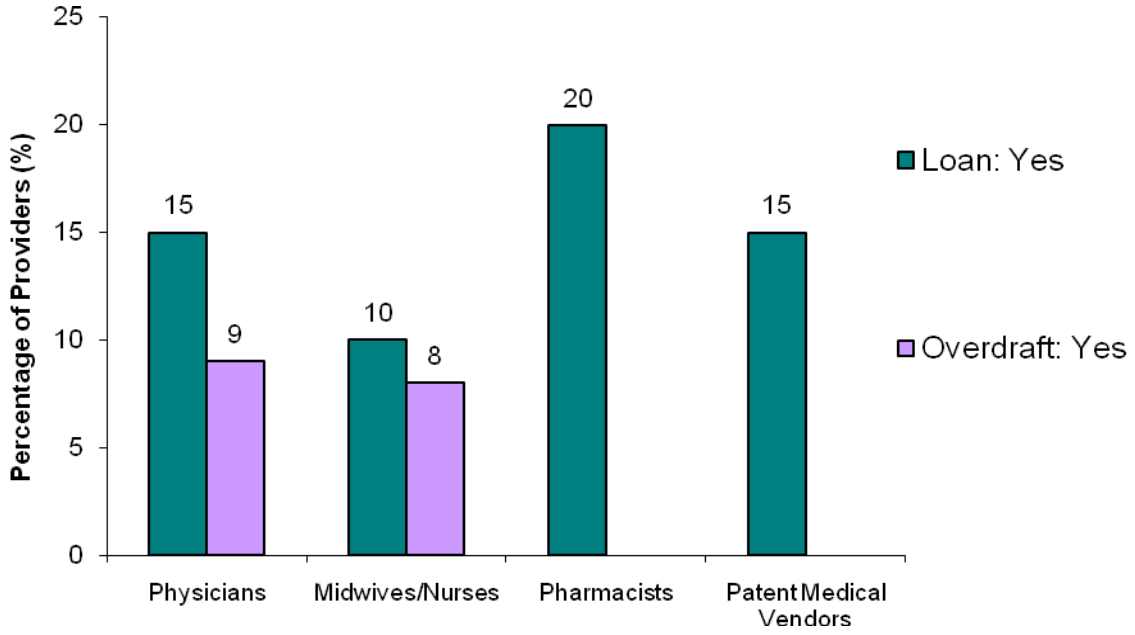
*Question allowed for multiple responses

## 4.8 FINANCE NEEDS ASSESSMENT

### 4.8.1 CREDIT EXPERIENCE

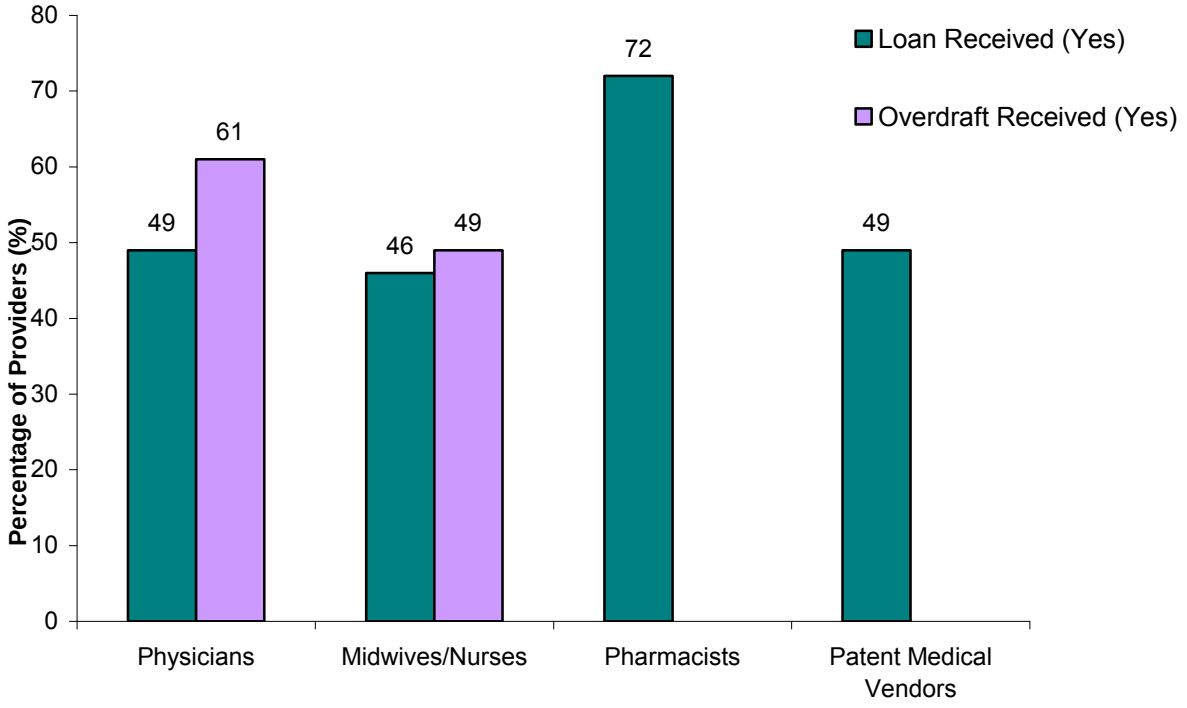
Private medical providers do not have extensive credit experience with financial institutions. Only 15 percent of physicians and PMVs and 10 percent of nurses and midwives have applied for business loans in the past three years, with only slightly more pharmacists (20 percent) applying for credit (Figure 13). Usage of overdraft credit is even more rare: less than 10 percent for physicians, nurses, and midwives (pharmacists and PMVs were not asked this question).

**FIGURE 13: PROPORTION OF PROVIDERS APPLYING FOR LOANS AND OVERDRAFTS IN THE LAST THREE YEARS BY PROVIDER TYPE**




Of those private providers who applied for a business loan in the past three years, pharmacists were the most successful in securing one with a 72 percent success rate (Figure 14). Other private provider groups were not as fortunate with just fewer than half of nurses and midwives (46 percent), physicians (49 percent), and PMVs (49 percent) receiving loans. A greater proportion of physicians received overdrafts than nurses and midwives (61 versus 49 percent).

**FIGURE 14: PROPORTION OF PROVIDERS RECEIVING LOANS AND OVERDRAFTS APPLIED FOR BY PROVIDER TYPE**




## 4.8.2 USE OF MOST RECENT LOANS IN THREE YEARS

The business loans and overdrafts secured were used for equipment and drug purchases as well as to expand medical facilities (Table 15). Use of the loan for personal reasons was significant for physicians (24 percent) and nurses and midwives (28 percent).

**TABLE 15 : USE OF MOST RECENT BUSINESS LOANS AND OVERDRAFTS IN THE LAST THREE YEARS***

| | Physicians | | Nurses and midwives | | Pharmacists | PMVs |
|---|---|---|---|---|---|---|
| | **Overdraft** | **Loan** | **Overdraft** | **Loan** | **Loan** | **Loan** |
| Number who received a loan or overdraft | 36 | 29 | 33 | 18 | 58 | 42 |
| **Percent** | % | % | % | % | % | % |
| Expanding clinic or pharmacy | 62 | 62 | 69 | 72 | 16 | 21 |
| Buying equipment | 68 | 76 | 63 | 89 | 3 | 7 |
| Offering new services | 55 | 48 | 69 | 83 | 7 | 12 |
| Purchasing drugs | 45 | 52 | 81 | 89 | 19 | 24 |
| Renovating clinic or pharmacy | 35 | 45 | 63 | 83 | 7 | 14 |
| Purchasing contraceptive products | 32 | 31 | 63 | 61 | 10 | 17 |
| Purchasing land | 23 | 24 | 19 | 22 | 7 | 5 |
| Hiring staff | 14 | 28 | 31 | 50 | 5 | 10 |
| Constructing a medical clinic or pharmacy | 22 | 14 | 13 | 16 | 3 | 5 |

| | Physicians | | Nurses and midwives | | Pharmacists | PMVs |
|---|---|---|---|---|---|---|
| | Overdraft | Loan | Overdraft | Loan | Loan | Loan |
| Number who received a loan or overdraft | 36 | 29 | 33 | 18 | 58 | 42 |
| **Percent** | % | % | % | % | % | % |
| Buying a medical clinic or pharmacy | 0 | 21 | 19 | 28 | 5 | 7 |
| Purchasing ARVs | 5 | 31 | 13 | 33 | | |
| Using it for a personal reason | 9 | 24 | 6 | 28 | 5 | 19 |

* Question allowed for multiple responses.

### 4.8.3 PERSONAL LOAN RECEIVED WITHIN THE PAST THREE YEARS AND LOAN USE

As was the case in regards to medical business loans, only a small fraction (10 to 12 percent) of private medical providers had received a personal loan in the past three years. The loans were mostly used to finance education, rent, or the purchase of home appliances and cars (Table 16). A large proportion of nurses and midwives also purchased land.

**TABLE 16: PERSONAL LOAN RECEIVED WITHIN THE PAST THREE YEARS AND LOAN USE***

| | Physicians | Nurses and midwives | Pharmacists | PMVs |
|---|---|---|---|---|
| Base number | 388 | 408 | 400 | 553 |
| | n (%) | n (%) | n (%) | n (%) |
| Received personal loan in last three years | 38 (10%) | 48 (12%) | 44 (11%) | 53 (10%) |
| **Loan used for:** | % | % | % | % |
| Education for self or someone else | 42 | 29 | 43 | 28 |
| Rent a building | 29 | 25 | 27 | 30 |
| Buy home appliances | 21 | 23 | 14 | 25 |
| Buy a car | 26 | 17 | 16 | 6 |
| Buy land | 5 | 29 | 16 | 15 |
| Roof house | 5 | 2 | 0 | 0 |
| Trade or purchase drugs | 5 | 2 | 5 | 6 |
| Support my pharmacy business | NA | NA | 5 | 4 |

*Question allowed for multiple responses.

### 4.8.4 FREQUENCY OF BUSINESS LOAN APPLICATIONS AND REASONS FOR LOAN DENIAL

On average, private medical providers who applied for credit did so twice during the past three years, with no difference among provider types. Of the providers who never received any of the business loans they applied for, the primary reason for their denial was a lack of collateral. This result was true for all provider types. However, the percentage of providers indicating that they did not know the reason for loan denial was significant for all provider groups ( 27% of physicians, 38% of nurses and midwives, 32% of pharmacists and 44% of PMVs).

**TABLE 17: FREQUENCY OF LOAN APPLICATIONS AND REASONS FOR LOAN DENIAL***

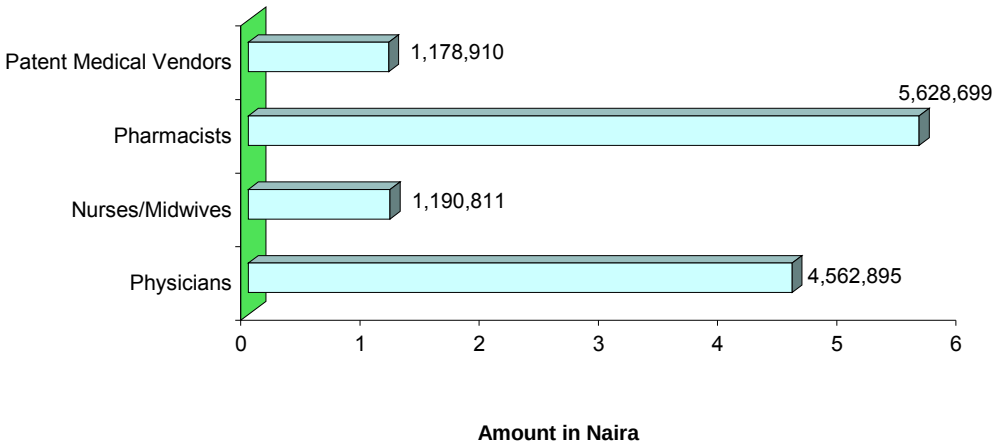
| Private provider | Physicians | Nurses and midwives | Pharmacists | PMVs |
|---|---|---|---|---|
| Average number of times applied for a loan in the past three years | n=59 | n=39 | n=80 | n=85 |
| | 2 | 2 | 2 | 2 |
| Average number of times received loans in the past three years | n=29 | n=18 | n=80 | n=85 |
| | 1 | 2 | 1.2 | 0.9 |
| Reasons loan was denied by the bank or rejected by borrower | n=30 | n=21 | n=22 | n= 43 |
| | **n (%)** | **n (%)** | **n (%)** | **n (%)** |
| Lack of collateral | 16 (53) | 7 (33) | 6 (27) | 15 (35) |
| Lack of credit history | 0 | 2 (10) | 0 | 2 (5) |
| Incomplete or inaccurate loan application | 2 (7) | 1 (5) | 2 (9) | 4 (9) |
| High interest rate | 2 (7) | 1 (5) | 0 | 0 |
| Did not understand bank policy | 1 (3) | 2 (10) | 0 | 0 |
| Could not make monthly payment | 1 (3) | 0 | 2 (9) | 1 (2) |
| Do not know | 8 (27) | 8 (38) | 7 (32) | 19 (44) |

*Question allowed for multiple responses.

### 4.8.5 AVERAGE AMOUNT OF ALL OUTSTANDING LOANS

Fifteen physicians, five nurses and midwives, 14 pharmacists, and 15 PMVs reported that they owed money on at least one loan. The average amount outstanding from all loans obtained is about N5 million ($43,478) for physicians and slightly more than N1 million ($8,695) for nurses and midwives. For pharmacists and PMVs the average is N5.6 million ($48,696) and N1.2 million ($10,435) respectively (Figure 15).

**FIGURE 15: AVERAGE AMOUNT OF ALL OUTSTANDING LOANS BY PROVIDER TYPE**




### 4.8.6 VALUE AND TERMS OF RECENT BUSINESS LOANS

The majority of medical providers, with the exception of PMVs, paid at least N30,000 ($231) in monthly loan payments (Table 18). Most nurses and midwives paid at least N20,000 ($154) monthly. The majority of pharmacists paid more than N50,000 ($385) in monthly loan payments.

**TABLE 18: AMOUNT OF MONTHLY PAYMENT ON MOST RECENT BUSINESS LOANS**

| Medical provider | Physicians | Nurses and midwives | Pharmacists | PMVs |
|---|---|---|---|---|
| Base number | 29 | 18 | 14 | 15 |
| **Number (percent)** | **n (%)** | **n (%)** | **n (%)** | **n (%)** |
| N10,000 and less ($77 or less) | 6 (21) | 1 (6) | 2 (14) | 7 (47) |
| N10,001–19,999 ($78-$154) | 2 (7) | 1 (6) | 0 | 2 (13) |
| N20,000–29,999 ($155-$231) | 3 (10) | 6 (32) | 1 (7) | 0 |
| N30,000–39,999 ($232-$308) | 0 | 2 (11) | 0 | 1 (7) |
| N40,000–49,999 ($309-$385) | 0 | 1 (6) | 0 | 0 |
| N50,000–59,999 ($386-$462) | 11 (38) | 3 (17) | 2 (14) | 3 (20) |
| N60,000 and greater ($463 or more) | 7 (24) | 4 (22) | 9 (65) | 2 (13) |

### 4.8.7 REPAYMENT PERIOD FOR THE MOST RECENT LOANS AND OVERDRAFTS PHYSICIANS, NURSES, AND MIDWIVES OBTAINED

The tenor of the majority of private provider loans is less than one year, which makes it difficult to expand a health facility or purchase expensive medical equipment (Table 19). Thirty-one percent of the physicians and 17 percent of nurses and midwives secured loans with a tenor more than one year.

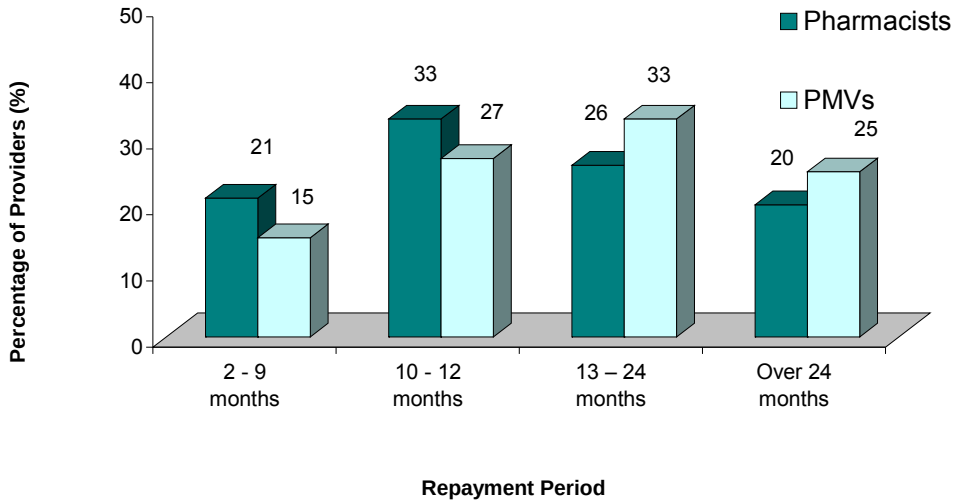
**TABLE 19: REPAYMENT PERIOD FOR THE MOST RECENT BUSINESS LOANS AND OVERDRAFTS PHYSICIANS, NURSES, AND MIDWIVES OBTAINED**

| | Overdraft | | Loan | |
|---|---|---|---|---|
| | **Physicians** | **Nurses and midwives** | **Physicians** | **Nurses and midwives** |
| Number who obtained the credit | 22 | 16 | 29 | 18 |
| **Number (percent)** | **n (%)** | **n (%)** | **n (%)** | **n (%)** |
| 1–4 months | 10 (45) | 9 (56) | 9 (31) | 5 (28) |
| 5–8 months | 11 (50) | 4 (25) | 6 (21) | 6 (33) |
| 9–12 months | 1 (5) | 3 (19) | 5 (17) | 4 (22) |
| More than 12 months | 0 | 0 | 9 (31) | 3 (17) |

### 4.8.8 REPAYMENT PERIOD FOR MOST RECENT BUSINESS LOANS PHARMACISTS AND PMVS OBTAINED

All 14 pharmacists and 15 PMVs with business loans in the past three years provided information on their loan repayment period. The majority of pharmacists (54 percent) reported that their most recent loan tenor was a year or less, while 20 percent had more than 24 months to repay the loan (Figure 16). In general, PMVs were more likely to have loans with slightly longer tenors; 58 percent reported having at least 13 months to repay their loan.

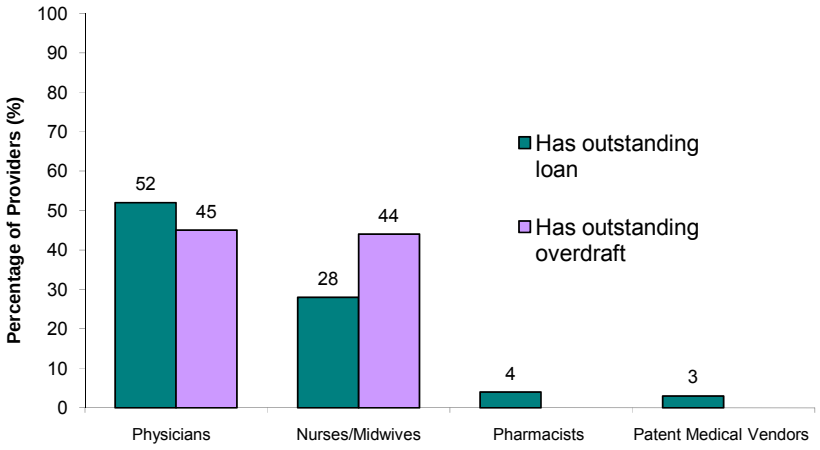
**FIGURE 16: REPAYMENT PERIOD FOR MOST RECENT BUSINESS LOANS PHARMACISTS AND PMVS OBTAINED**



### 4.8.9 INCIDENCE OF LOANS AND OVERDRAFTS OUTSTANDING

About half of the physicians who ever had received a loan or overdraft have outstanding credit (Figure 17). Most nurses and midwives have no outstanding loans, but close to half of them are making payments on overdraft facilities. Virtually all pharmacists and PMVs have no outstanding credit, which is surprising given the high turnover and cash flow in a pharmacy or PMV facility.

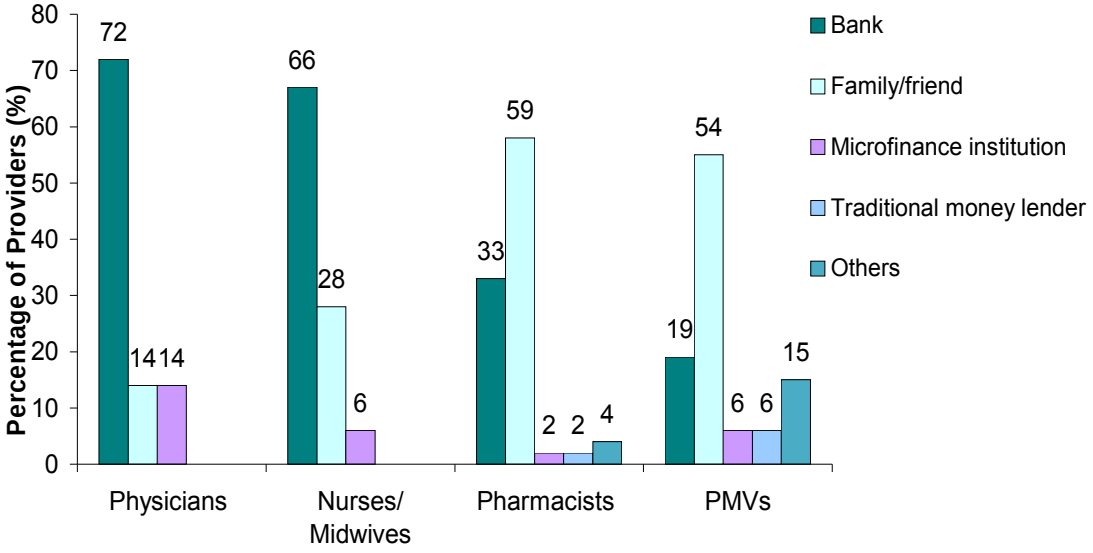
**FIGURE 17: INCIDENCE OF LOANS AND OVERDRAFTS OUTSTANDING BY PROVIDER TYPE**




### 4.8.10 SOURCES OF LOANS OBTAINED

Banks were the major source of loans (business and personal) for physicians, nurses, and midwives (Figure 18). For pharmacists and PMVs, however, family and friends provided the highest number of loans.

**FIGURE 18: SOURCES OF LOANS OBTAINED BY PROVIDER TYPE**



### 4.8.11 FINANCIAL INSTITUTIONS FINANCING PRIVATE HEALTH CARE PROVIDERS

Among the banks and MFIs that provided loans, First Bank, Diamond Bank, Skye Bank, Zenith Bank, and Union Bank were foremost among Nigerian lenders to private health providers (Table 20).

**TABLE 20: SOURCE OF MOST RECENT BUSINESS OR PERSONAL LOAN IN THREE PAST THREE YEARS AMONG THOSE WHO OBTAINED LOAN AT BANK OR MFI BY PROVIDER TYPE**

| | Physicians | Nurses and midwives | Pharmacists | PMVs |
|---|---|---|---|---|
| Base number | 22 | 13 | 16 | 13 |
| **Number (percent)** | **n (%)** | **n (%)** | **n (%)** | **n (%)** |
| First Bank | 5 (22) | 2 (14) | 3 (19) | 0 |
| Diamond Bank | 5 (22) | 1 (8) | 0 | 0 |
| Skye Bank | 1 (5) | 3 (23) | 0 | 0 |
| ADB | 0 | 3 (23) | 0 | 0 |
| UBA | 3 (14) | 0 | 0 | 0 |
| Intercontinental Bank | 2 (9) | 0 | 1 (6) | 0 |
| Asso Saving & Loan | 2 (9) | 0 | 0 | 0 |
| Union Bank | 0 | 0 | 1 (6) | 3 (23) |
| Zenith Bank | 0 | 0 | 3 (19) | 0 |
| Oceanic Bank | 0 | 0 | 2 (13) | 0 |
| Co-operative Bank | 1 (5) | 1 (8) | 0 | 1 (8) |
| Community Bank | 0 | 1 (8) | 0 | 0 |
| Profund Securities (Nigeria) Ltd. | 1 (5) | 1 (8) | 0 | 0 |
| Other | 2 (9) | 1 (8) | 6 (37) | 9 (69) |

### 4.8.12 SOURCES OF CREDIT OTHER THAN LOANS

Generally credit purchases are not extended to private health providers except for drug supplies (Table 21). The majority of physicians, nurses, midwives, and PMVs, however, reported that they cannot obtain credit for drug purchases. Furthermore most physicians, nurses, and midwives cannot obtain credit to purchase medical supplies or equipment. Lack of access to credit is a major constraint to the operation and expansion of private medical businesses in Nigeria.

**TABLE 21: ACCESS TO SUPPLIER CREDIT FOR COMMODITIES BY PROVIDER TYPE**

| | | Physicians | Nurses and midwives | Pharmacists | PMVs |
|---|---|---|---|---|---|
| Base number | | 388 | 408 | 400 | 553 |
| **Percent** | | **%** | **%** | **%** | **%** |
| Drug supplies | Yes | 36 | 30 | 59 | 47 |
| | No | 64 | 70 | 41 | 53 |
| Medical supplies | Yes | 24 | 18 | 28 | 15 |
| | No | 76 | 82 | 72 | 85 |
| Medical equipment | Yes | 17 | 14 | | |
| | No | 83 | 86 | | |

### 4.8.13 CREDIT PERIOD GRANTED BY SUPPLIER

For private medical providers who receive credit from medical suppliers, a substantial proportion of all provider types (41 to 43 percent) were granted only a credit period of up to 30 days (Table 22). Even for more expensive purchases, such as medical equipment, many providers still receive that amount of time to pay. This trend is another example of how credit terms are not flexible to meet the business needs of private medical providers, as longer-term credit should be available for major purchases.

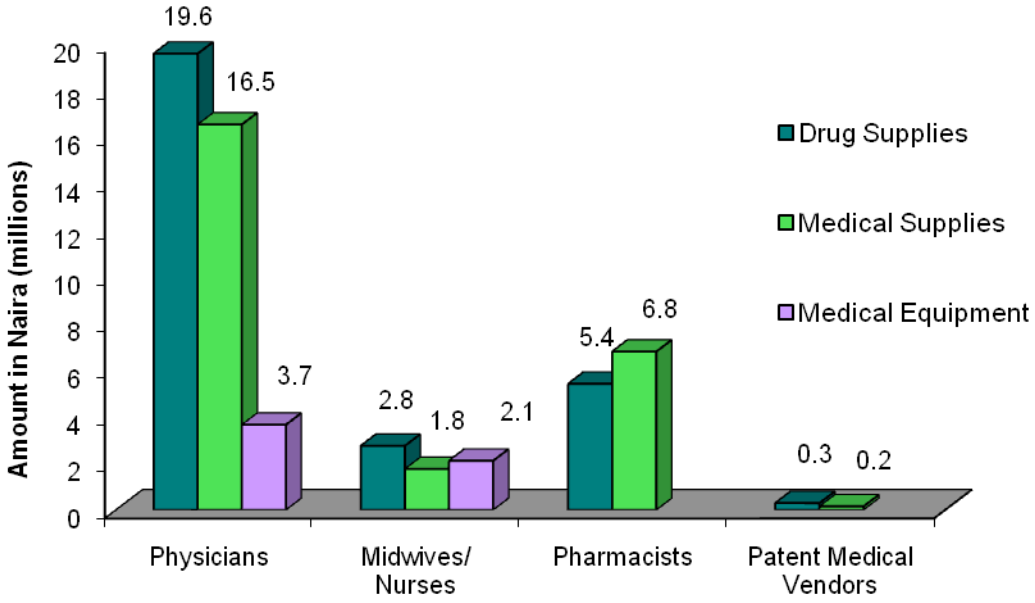
**TABLE 22: CREDIT PERIOD GRANTED BY SUPPLIER TO PRIVATE PROVIDERS BY PROVIDER TYPE**

| | Credit time | Physicians | Nurses and midwives | Pharmacists | PMVs |
|---|---|---|---|---|---|
| Base number:<br>Those who received credit for:<br>drug supplies (DS)<br>medical supplies (MS)<br>medical equipment (ME) | | DS: n=141<br>MS: n=92<br>ME: n=67 | DS: n=123<br>MS: n=73<br>ME: n=56 | DS: n=235<br>MS: n=113 | DS: n=261<br>MS: n=84 |
| **Percent** | | % | % | % | % |
| Drug supplies | 30 days | 56 | 66 | 40 | 48 |
| | 31–90 days | 6 | 6 | 3 | 7 |
| | More than 90 days | 1 | 2 | 0 | 0 |
| | Varies with suppliers | 27 | 17 | 35 | 20 |
| | Other | 10 | 10 | 22 | 25 |
| Medical supplies | 30 days | 42 | 41 | 42 | 43 |
| | 31–90 days | 19 | 23 | 15 | 17 |
| | More than 90 days | 0 | 4 | 1 | 2 |
| | Varies with suppliers | 32 | 26 | 42 | 38 |
| | Other | 7 | 6 | 0 | 0 |
| Medical equipment | 30 days | 26 | 39 | | |
| | 31–90 days | 22 | 22 | | |
| | 91–180 days | 8 | 5 | | |
| | 181–365 days | 15 | 14 | | |
| | Depends on cost of equipment | 24 | 20 | | |
| | Other | 5 | 0 | | |

## 4.8.14 AVERAGE AMOUNT OF SUPPLIER CREDIT OUTSTANDING

Physicians have the greatest amount of outstanding supplier credit purchases, particularly for drug and medical supplies (Figure 19). Pharmacists have more outstanding supplier credit purchases compared to PMVs, who had the lowest average amount of supplier credit outstanding among all provider types.

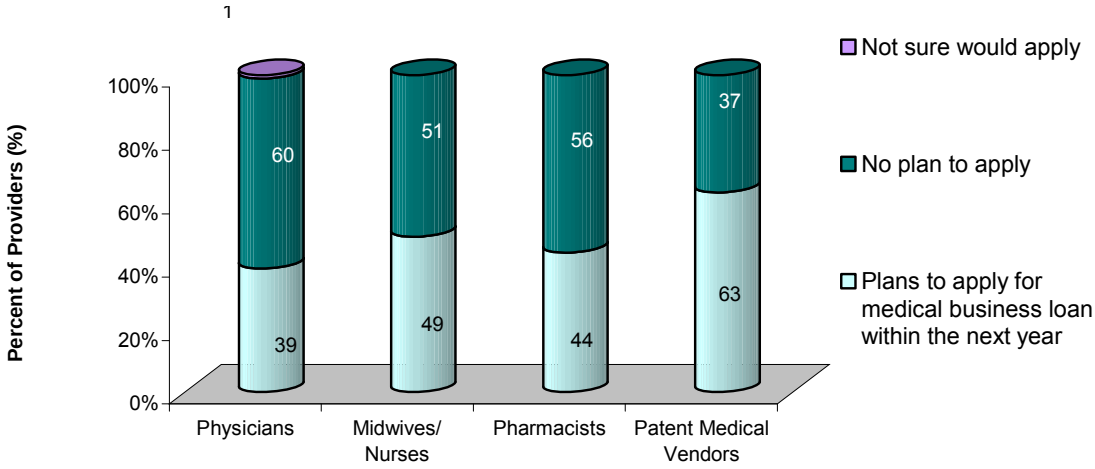
### FIGURE 19: AVERAGE AMOUNT OF SUPPLIER CREDIT OUTSTANDING BY PROVIDER TYPE



## 4.8.15 INTEREST IN A FUTURE LOAN

Sixty-three percent of PMVs planned to apply for a medical business loan within the next year, but the other provider groups indicated less interest (44 percent of pharmacists, 49 percent of nurses and midwives, and 39 percent of physicians) (Figure 20).

**FIGURE 20: PLANS TO APPLY FOR MEDICAL BUSINESS LOANS WITHIN THE NEXT YEAR BY PROVIDER TYPE**




For private providers not interested in applying for a business loan in the next year, high interest rates are the major deterrent followed by not wanting to borrow money (Table 23). Between one-third and one-half of providers not interested in applying for a business loan said that they do not need one. Respondents may not have been aware that interest rates had dropped in the last year in Nigeria until the recent financial crisis. Financial institutions should be aware of this thinking as well as the need to demonstrate how a loan could be used to expand or finance equipment for a private provider's medical business.

**TABLE 23: REASONS FOR LACK OF INTEREST IN APPLYING FOR A MEDICAL BUSINESS LOAN BY PROVIDER TYPE***

| | Physicians | Nurses and midwives | Pharmacists | PMVs |
|---|---|---|---|---|
| Number not interested in applying for loan next year | 232 | 208 | 223 | 204 |
| **Percent** | % | % | % | % |
| High interest rates | 52 | 61 | 53 | 46 |
| Do not like to borrow money | 42 | 41 | 38 | 38 |
| Do not need a loan | 43 | 34 | 49 | 34 |
| Concerned about difficulty of repaying a loan | 28 | 30 | 25 | 30 |
| Do not have collateral | 13 | 20 | 16 | 31 |
| Bad experience with borrowing in the past | 11 | 13 | 10 | 17 |
| Do not want to offer collateral | 10 | 12 | 9 | 11 |
| Someone I know had problems after taking a loan | 13 | 15 | 18 | 17 |

*Question allowed for multiple responses.

## 4.8.16 INTENDED AMOUNT OF A FUTURE LOAN

The median amount of money that physicians would like to borrow was N2 million ($15,385), and 45 percent of them stated that they would be able to repay more than N30,000 ($231) each month (Table 24). For nurses and midwives, the median amount they would like to borrow was N1.5 million ($11,538). Twenty-four percent of them could repay N2,501 to 5,000 ($19-$38) monthly and 21 percent could repay more than N30,000 ($231) monthly.

Pharmacists and PMVs had lower median amounts they would like to borrow N800,000 ($6,154) and N500,000 ($3,846). Most pharmacists (70 percent) and many PMVs (38 percent) stated that they would be able to repay more than N6,000 ($46) per month for a loan.

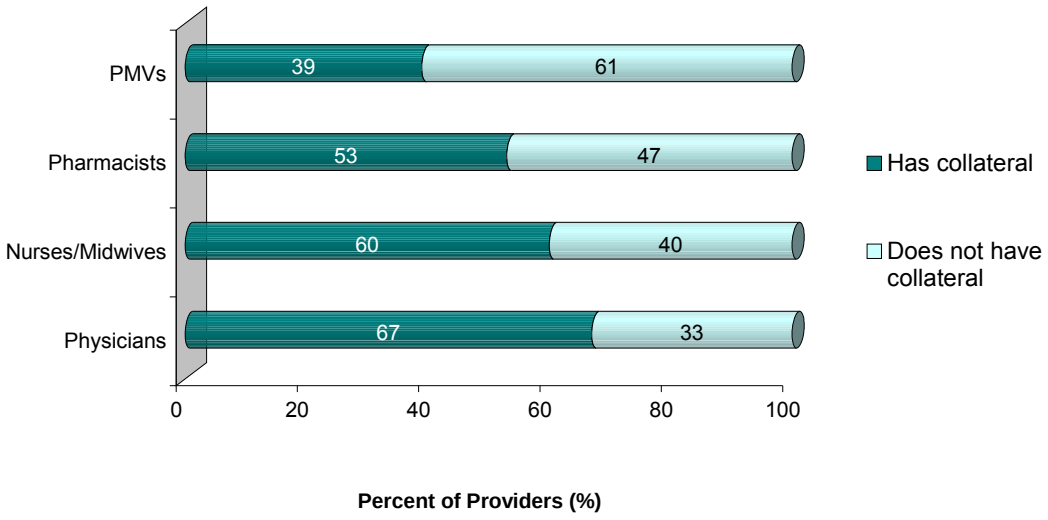
### TABLE 24: AMOUNT PROVIDERS WOULD LIKE TO BORROW AND REPAY IF GRANTED A LOAN BY PROVIDER TYPE

| | Physicians | Nurses and midwives | Pharmacists | PMVs |
|---|---|---|---|---|
| Number who indicated interest to apply for loan next year | 156 | 201 | 176 | 349 |
| Median amount would like to borrow for medical or pharmacy business | N2 million ($15,385) | N1.5 million ($11,538) | N800,000 ($6,154) | N500,000 ($3,846) |

## 4.8.17 COLLATERAL

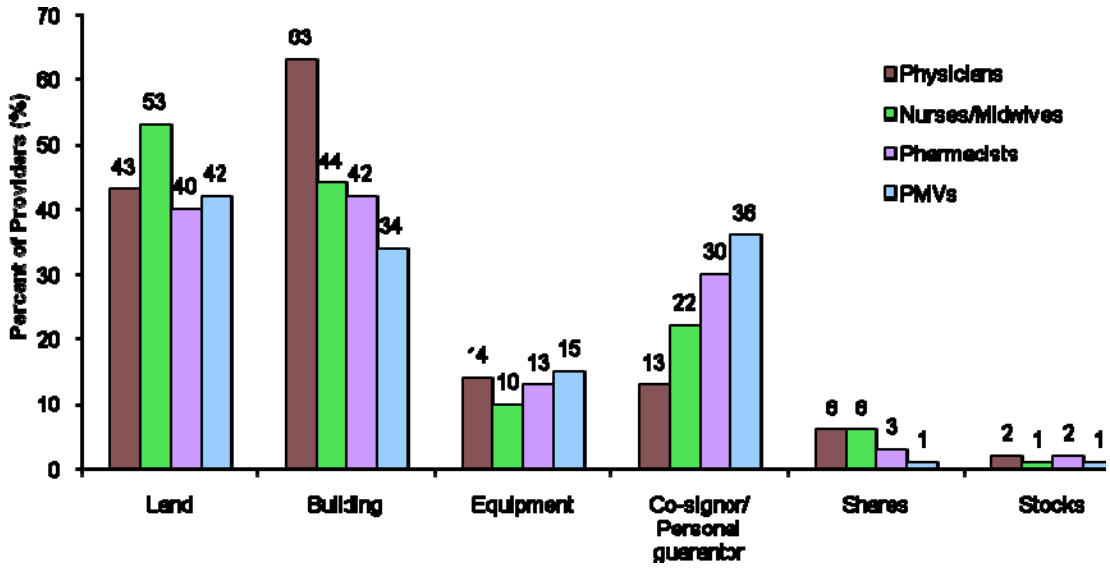
Most physicians, nurses, midwives, and pharmacists have collateral, which is an important consideration in approving loans for financial institutions (Figure 21).

### FIGURE 21: PRIVATE PROVIDER COLLATERAL FOR LOANS



Land, buildings, and personal guarantors are the major types of collateral for all provider groups (Figure 22).

**FIGURE 22: TYPE OF COLLATERAL BY TYPE OF PRIVATE PROVIDER**




*Question allowed for multiple responses.

## 4.9 DRUG PURCHASES: PHARMACISTS AND PATENT MEDICAL VENDORS

### 4.9.1 SOURCES OF SUPPLY FOR DRUGS PURCHASED BY PHARMACISTS AND PMVS

In addition to asking questions about financing, the survey also examined drug purchases for pharmacists and PMVs.

Prominent suppliers of drugs to the pharmacists and PMVs are Lambo Pharmaceutical Ltd.; Emzor, Evans, May & Baker; and Glaxo Smith Kline (GSK) (Table 25). These suppliers have national distribution networks and are headquartered in Lagos.

### TABLE 25: SOURCES OF SUPPLY FOR DRUGS PURCHASED BY PHARMACISTS AND PMVS BY STATE

| PHM=pharmacy | All | | Lagos | | Abuja | | Nasarawa | | Bauchi | | Kano | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | PHM | PMV | PHM | PMV | PHM | PMV | PHM | PMV | PHM | PMV | PHM | PMV |
| Total Number of Providers | 400 | 553 | 109 | 112 | 109 | 108 | 47 | 110 | 32 | 114 | 103 | 109 |
| | % | % | % | % | % | % | % | % | % | % | % | % |
| Lambo Pharmaceutical Ltd. | 24 | 29 | 8 | 20 | 34 | 39 | 0 | 4 | 28 | 14 | 39 | 69 |
| Emzor | 24 | 20 | 33 | 38 | 19 | 23 | 47 | 24 | 16 | 8 | 10 | 6 |
| Evans | 20 | 11 | 14 | 16 | 16 | 10 | 32 | 13 | 9 | 4 | 27 | 12 |
| May & Baker | 18 | 11 | 27 | 15 | 12 | 11 | 15 | 9 | 19 | 1 | 16 | 17 |
| GSK/Glaxo Wellcome/Bechams | 19 | 7 | 23 | 13 | 17 | 4 | 21 | 9 | 6 | 0 | 20 | 10 |
| Pfizer | 15 | 5 | 11 | 9 | 22 | 9 | 9 | 2 | 6 | 1 | 18 | 4 |
| New Health Pharmacy | 10 | 8 | 6 | 9 | 26 | 25 | 4 | 4 | 0 | 0 | 5 | 1 |
| Niemeth | 10 | 3 | 28 | 4 | 2 | 6 | 9 | 4 | 9 | 3 | 2 | 0 |
| Tinna Pharmaceutical Chemist | 3 | 6 | 0 | 3 | 0 | 0 | 2 | 0 | 34 | 26 | 0 | 0 |
| Jawa | 5 | 4 | 1 | 0 | 1 | 1 | 36 | 17 | 0 | 2 | 2 | 1 |
| Fidson | 5 | 2 | 14 | 10 | 0 | 0 | 9 | 1 | 6 | 0 | 0 | 0 |
| Horse Power | 1 | 4 | 0 | 0 | 0 | 0 | 6 | 16 | 0 | 4 | 0 | 0 |
| Mopson | 2 | 3 | 4 | 4 | 0 | 3 | 9 | 8 | 0 | 1 | 0 | 0 |
| Dan Asabe Medicine Store | 1 | 4 | 2 | 0 | 0 | 0 | 0 | 0 | 9 | 18 | 0 | 0 |
| Drugfield | 3 | 2 | 5 | 4 | 0 | 0 | 9 | 0 | 9 | 4 | 0 | 0 |
| Orange Drugs | 2 | 2 | 3 | 1 | 1 | 1 | 6 | 5 | 0 | 4 | 1 | 1 |
| Yankari Pharmacy | 0 | 3 | 0 | 0 | 0 | 0 | 0 | 0 | 3 | 16 | 0 | 0 |
| Dana Drugs | 2 | 2 | 2 | 1 | 1 | 0 | 6 | 7 | 0 | 0 | 1 | 0 |
| Pal Pharmaceutical Kano | 0 | 2 | 1 | 7 | 0 | 0 | 0 | 1 | 0 | 4 | 0 | 0 |
| Farmex | 1 | 1 | 2 | 4 | 2 | 1 | 0 | 0 | 0 | 1 | 1 | 0 |
| Others | 1 | 1 | 3 | 2 | 2 | 2 | 0 | 1 | 0 | 0 | 0 | 0 |
| Jama Pat | 0 | 1 | 1 | 3 | 0 | 0 | 0 | 1 | 0 | 3 | 0 | 1 |
| Dr Meyer | 1 | 1 | 2 | 2 | 0 | 0 | 0 | 0 | 0 | 2 | 2 | 1 |
| Vinna Pharmaceutical Kano | 1 | 1 | 2 | 1 | 0 | 0 | 0 | 0 | 9 | 2 | 0 | 0 |

*Question allowed for multiple responses.

## 4.9.2 FACTORS INFLUENCING CHOICE OF DISTRIBUTORS AND WHOLESALERS BY PHARMACISTS AND PMVS

Price, service, and reputation are the major factors that influence the choice of purchasing drugs from distributors and wholesalers (Table 26). Pharmacists, except those in Nasarawa and Bauchi, considered reputation to be the most important consideration of whom to purchase drugs from, while price was the most important factor in all states except Nasarawa and Kano for PMVs. Service may be a problem in Nasarawa, as both pharmacists and PMVs indicated that it was the most important consideration in that state. In addition, location and availability of credit were important considerations for pharmacists in Lagos and Abuja (and credit for PMVs in Abuja).

### TABLE 26: FACTORS INFLUENCING CHOICE OF DISTRIBUTORS AND WHOLESALERS BY PHARMACISTS AND PMVS BY STATE

| PHM=pharmacy | All | | Lagos | | Abuja | | Nasarawa | | Bauchi | | Kano | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | PHM | PMV | PHM | PMV | PHM | PMV | PHM | PMV | PHM | PMV | PHM | PMV |
| Total number of providers | 400 | 553 | 109 | 112 | 109 | 108 | 47 | 110 | 32 | 114 | 103 | 109 |
| | % | % | % | % | % | % | % | % | % | % | % | % |
| Price | 77 | 78 | 75 | 80 | 84 | 90 | 53 | 57 | 97 | 83 | 77 | 82 |
| Service | 78 | 72 | 79 | 74 | 80 | 83 | 77 | 68 | 72 | 61 | 79 | 75 |
| Reputation | 81 | 70 | 90 | 70 | 88 | 81 | 55 | 52 | 69 | 61 | 81 | 87 |
| Location | 46 | 49 | 60 | 64 | 58 | 61 | 23 | 25 | 28 | 49 | 34 | 47 |
| Available credit | 54 | 43 | 60 | 34 | 61 | 65 | 40 | 22 | 38 | 39 | 52 | 56 |
| Other (specify) | 7 | 5 | 6 | 4 | 6 | 2 | 0 | 4 | 19 | 13 | 7 | 4 |
| High-quality products | 4 | 4 | 1 | 3 | 1 | 1 | 0 | 2 | 16 | 12 | 7 | 4 |
| Others | 2 | 1 | 4 | 0 | 3 | 1 | 0 | 2 | 3 | 1 | 0 | 0 |
| Availability | 1 | 0 | 2 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Popularity | 1 | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

*Question allowed for multiple responses.

## 4.9.3 FREQUENCY OF DRUG PURCHASES BY PHARMACISTS AND PMVS BY STATE

Slightly more than half of the pharmacists and PMVs buy their drugs at least once a week, although 35 percent of pharmacists in Lagos buy drugs every few days.

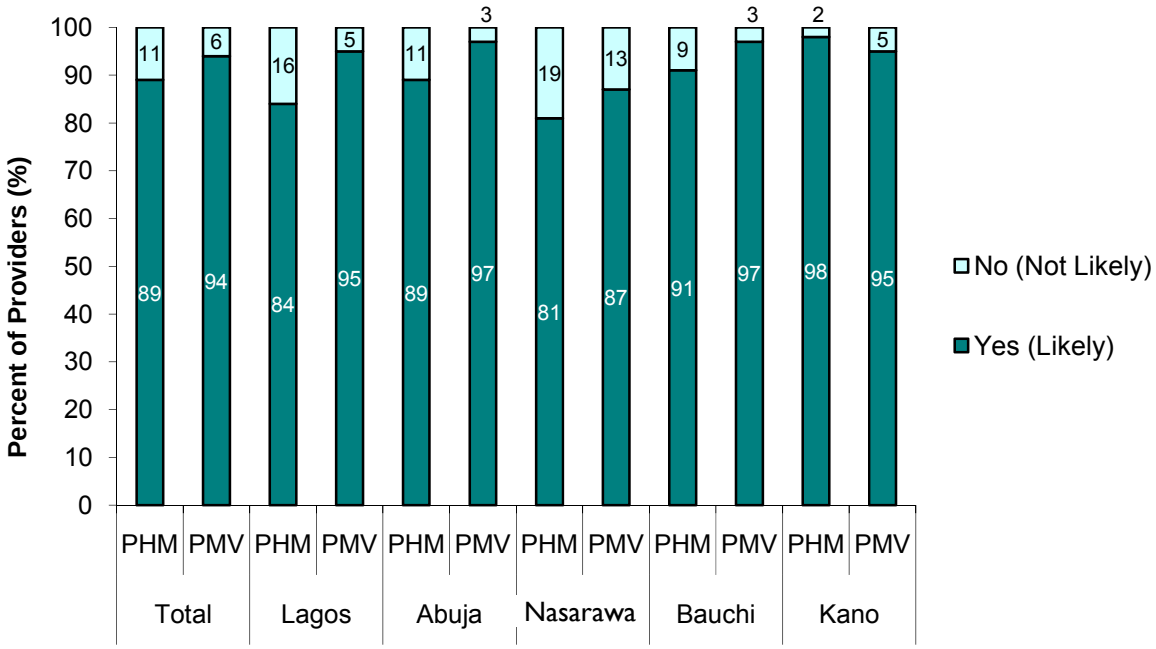
### TABLE 27: FREQUENCY OF DRUG PURCHASES BY PHARMACISTS AND PMVS BY STATE

| PHM=pharmacy | All | | Lagos | | Abuja | | Nasarawa | | Bauchi | | Kano | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | PHM | PMV | PHM | PMV | PHM | PMV | PHM | PMV | PHM | PMV | PHM | PMV |
| Total number of providers | 400 | 553 | 109 | 112 | 109 | 108 | 47 | 110 | 32 | 114 | 103 | 109 |
| | % | % | % | % | % | % | % | % | % | % | % | % |
| Every day | 12 | 8 | 21 | 7 | 14 | 3 | 6 | 14 | 0 | 12 | 8 | 6 |
| Every few days | 20 | 19 | 35 | 26 | 18 | 22 | 13 | 9 | 9 | 16 | 17 | 24 |
| Once per week | 20 | 30 | 15 | 39 | 17 | 29 | 19 | 25 | 31 | 21 | 27 | 33 |
| Every two weeks | 16 | 16 | 8 | 13 | 11 | 10 | 21 | 20 | 34 | 25 | 19 | 12 |
| Once per month | 8 | 11 | 3 | 4 | 6 | 10 | 17 | 12 | 13 | 18 | 9 | 9 |
| Depends on the product | 20 | 15 | 17 | 11 | 24 | 25 | 24 | 20 | 13 | 8 | 17 | 14 |
| Not sure | 4 | 1 | 1 | 0 | 10 | 1 | 0 | 0 | 0 | 0 | 3 | 2 |

### 4.9.4 PROPORTION OF PHARMACISTS AND PMVS REPORTING LIKELIHOOD OF PURCHASING DRUGS MORE FREQUENTLY IF THEY HAD MONEY

If funding were available, almost all pharmacists and PMVs would be likely to buy drugs more frequently (Figure 23).

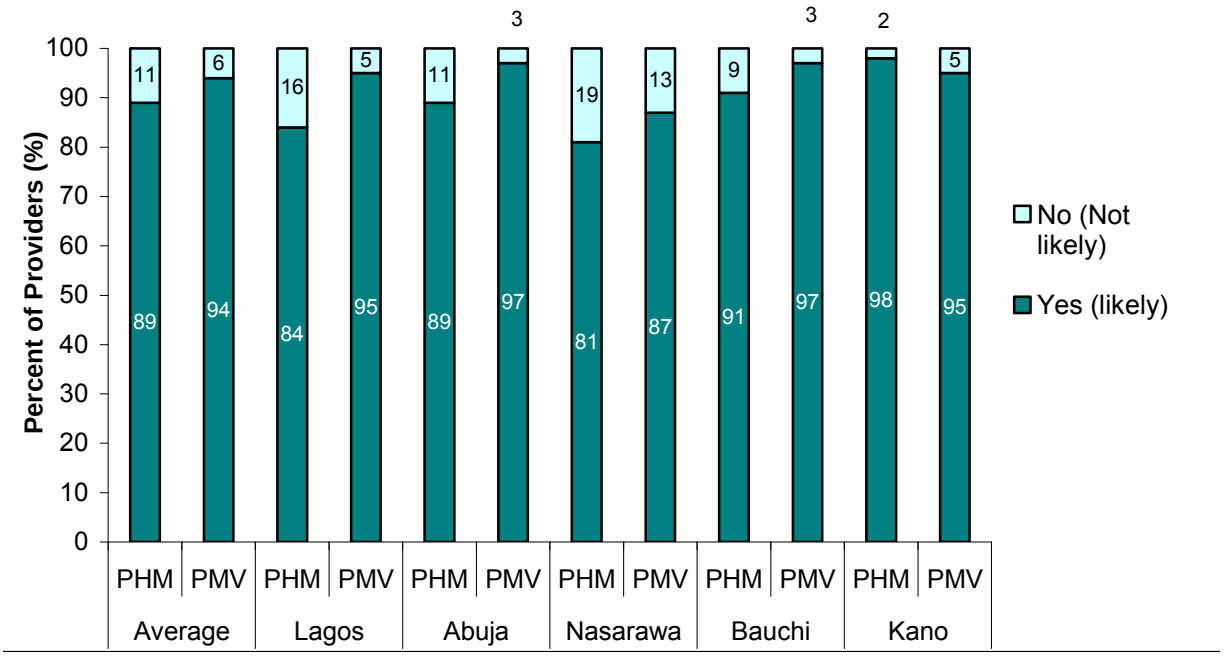
**FIGURE 23: PROPORTION OF PHARMACISTS AND PMVS REPORTING LIKELIHOOD OF PURCHASING DRUGS MORE FREQUENTLY IF THEY HAD MONEY BY STATE**




Almost 90 percent of pharmacists and 94 percent of PMVs stated certain products are unobtainable (Figure 24). Availability of certain drugs is especially a problem in Nasarawa and Bauchi, as a majority of both pharmacists and PMVs in those states indicated that there are drugs they cannot obtain. The products that providers reported as unattainable are listed in Table 28. It is significant that 41 percent of pharmacists in Nasarawa cannot obtain ARVs.

### 4.9.5 PROPORTION OF PHARMACISTS AND PMVS REPORTING THAT THERE ARE PRODUCTS THEY CANNOT OBTAIN BY STATE

**FIGURE 24: PROPORTION OF PHARMACISTS AND PMVS REPORTING THAT THERE ARE PRODUCTS THEY CANNOT OBTAIN BY STATE**




### 4.9.6 PRODUCTS PHARMACISTS AND PMVS CANNOT OBTAIN

**TABLE 28: PRODUCTS PHARMACISTS AND PMVS CANNOT OBTAIN BY STATE**

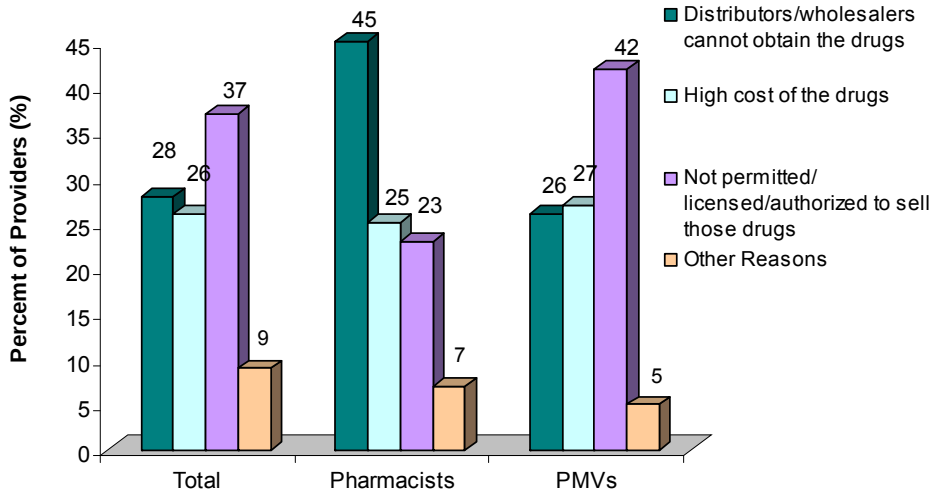
| PHM=pharmacists | Total | | Lagos | | Abuja | | Nasarawa | | Bauchi | | Kano | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| PMV=patent medicine vendor | PHM | PMV | PHM | PMV | PHM | PMV | PHM | PMV | PHM | PMV | PHM | PMV |
| Total | 141 | 337 | 29 | 65 | 35 | 49 | 27 | 82 | 17 | 79 | 33 | 62 |
| | % | % | % | % | % | % | % | % | % | % | % | % |
| Products not registered by NAFDAC | 20 | 11 | 17 | 22 | 26 | 18 | 7 | 5 | 6 | 3 | 33 | 13 |
| Injectable contraceptive and injections | 11 | 17 | 14 | 22 | 0 | 16 | 22 | 33 | 12 | 4 | 9 | 8 |
| Valium 5 | 6 | 15 | 0 | 2 | 0 | 0 | 0 | 15 | 18 | 29 | 18 | 24 |
| Antiretroviral vaccine and ARVs | 12 | 9 | 7 | 3 | 11 | 0 | 41 | 26 | 0 | 6 | 0 | 2 |
| Ampiclox | 4 | 6 | 3 | 0 | 0 | 0 | 0 | 7 | 24 | 19 | 0 | 0 |
| Banned products | 7 | 4 | 7 | 3 | 17 | 6 | 0 | 1 | 6 | 3 | 3 | 6 |
| Over-the-counter drugs | 6 | 4 | 3 | 2 | 0 | 4 | 4 | 1 | 24 | 11 | 6 | 0 |
| Controlled drugs | 4 | 3 | 10 | 2 | 3 | 6 | 4 | 1 | 0 | 1 | 0 | 6 |
| Ethical products | 4 | 3 | 3 | 5 | 11 | 6 | 0 | 4 | 0 | 0 | 0 | 3 |
| Analgin | 4 | 3 | 0 | 0 | 0 | 0 | 4 | 2 | 29 | 9 | 0 | 0 |
| Diazepam | 1 | 4 | 0 | 0 | 0 | 0 | 0 | 5 | 6 | 13 | 0 | 0 |
| Blood tonic | 1 | 5 | 0 | 0 | 0 | 2 | 0 | 7 | 12 | 13 | 0 | 0 |

| PHM=pharmacists | Total | | Lagos | | Abuja | | Nasarawa | | Bauchi | | Kano | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| PMV=patent medicine vendor | PHM | PMV | PHM | PMV | PHM | PMV | PHM | PMV | PHM | PMV | PHM | PMV |
| Total | 141 | 337 | 29 | 65 | 35 | 49 | 27 | 82 | 17 | 79 | 33 | 62 |
| | % | % | % | % | % | % | % | % | % | % | % | % |
| Antibiotics (not defined) | 4 | 14 | 14 | 35 | 0 | 18 | 4 | 15 | 0 | 3 | 0 | 2 |
| Glucometer | 2 | 1 | 0 | 0 | 6 | 0 | 0 | 0 | 0 | 1 | 3 | 5 |
| Sleeping drugs | 1 | 2 | 3 | 5 | 0 | 2 | 4 | 2 | 0 | 0 | 0 | 0 |
| Lagation tablet | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 6 | 3 | 3 | 2 |
| All Pakistan-produced drugs | 4 | 0 | 0 | 0 | 3 | 0 | 15 | 1 | 6 | 0 | 0 | 0 |
| Human insulin | 1 | 1 | 3 | 0 | 3 | 4 | 0 | 0 | 0 | 1 | 0 | 0 |
| Cancer drugs | 1 | 0 | 3 | 0 | 3 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Artesunate | 1 | 1 | 0 | 0 | 0 | 2 | 4 | 0 | 0 | 1 | 0 | 0 |
| Malaria drugs | 1 | 1 | 0 | 0 | 0 | 2 | 0 | 1 | 6 | 1 | 0 | 0 |
| Biotic product | 1 | 0 | 0 | 0 | 0 | 0 | 4 | 1 | 0 | 0 | 0 | 0 |
| Betadine cream | 1 | 1 | 0 | 0 | 3 | 0 | 0 | 1 | 0 | 1 | 0 | 0 |
| Restricted drugs | 0 | 4 | 0 | 2 | 0 | 8 | 0 | 4 | 0 | 4 | 0 | 3 |
| Libron codeine | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 3 |
| D5 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 10 | 0 | 0 |
| Pfizer Tramazine | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 |
| Nestatine | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 |

### 4.9.7 WHY DRUGS ARE NOT AVAILABLE TO PHARMACISTS AND PMVS

The major reason pharmacists cannot obtain certain drugs is that distributors and wholesalers cannot get the drugs themselves (Figure 25). PMVs most commonly reported that they cannot obtain certain drugs because they are not permitted or licensed to sell those drugs.

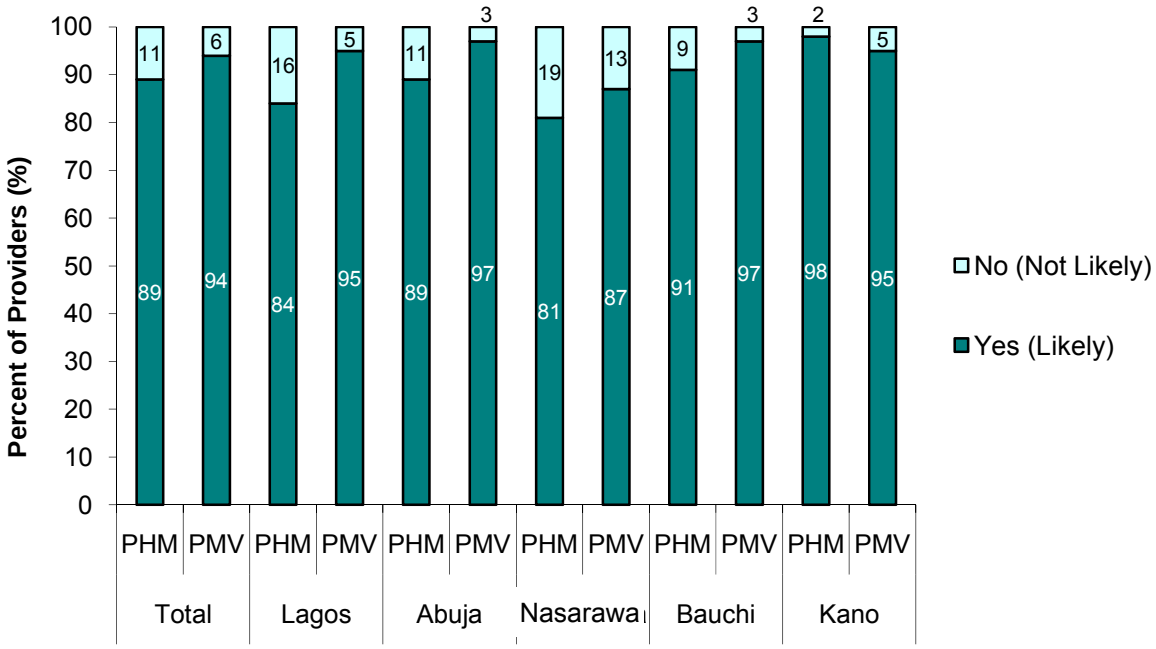
**FIGURE 25: WHY DRUGS ARE NOT AVAILABLE TO PHARMACISTS AND PMVS**



### 4.9.8 PROPORTION OF PHARMACISTS AND PMVS EXPERIENCING STOCKOUTS DURING THE MONTH

Over eighty five percent of the pharmacists and PMVs experience stockouts during the month in all five survey states. (Figure 26). The majority of pharmacists and PMVs in all five states surveyed experience a stockout once or twice a month (Table 29). The frequency and pervasiveness of stockouts has major implications for access and quality of care.

**FIGURE 26: PROPORTION OF PHARMACISTS AND PMVS EXPERIENCING STOCKOUTS DURING THE MONTH BY STATE**




### 4.9.9 FREQUENCY OF STOCKOUTS FOR PHARMACISTS AND PMVS

**TABLE 29: FREQUENCY OF STOCKOUTS FOR PHARMACISTS AND PMVS BY STATE**

| PHM=pharmacist | Total | | Lagos | | Abuja | | Nasarawa | | Bauchi | | Kano | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | PHM | PMV | PHM | PMV | PHM | PMV | PHM | PMV | PHM | PMV | PHM | PMV |
| Base number | 216 | 313 | 77 | 64 | 58 | 62 | 26 | 66 | 20 | 80 | 35 | 41 |
| **Stockout frequency per month** | % | % | % | % | % | % | % | % | % | % | % | % |
| None | 5 | 2 | 5 | 2 | 5 | 1 | 0 | 0 | 5 | 8 | 1 | 5 |
| Once | 45 | 34 | 55 | 48 | 38 | 29 | 53 | 34 | 46 | 33 | 31 | 20 |
| Twice | 26 | 27 | 25 | 27 | 28 | 27 | 19 | 24 | 30 | 25 | 31 | 34 |
| Three times | 9 | 15 | 8 | 9 | 10 | 24 | 12 | 11 | 10 | 14 | 6 | 20 |
| Four times | 7 | 12 | 5 | 8 | 9 | 13 | 8 | 21 | 5 | 10 | 11 | 7 |
| Five times | 4 | 4 | 1 | 3 | 3 | 2 | 0 | 5 | 0 | 5 | 14 | 2 |
| Six times | 2 | 2 | 0 | 0 | 2 | 0 | 8 | 2 | 5 | 3 | 3 | 5 |
| Seven times | 1 | 1 | 1 | 0 | 3 | 2 | 0 | 0 | 0 | 1 | 0 | 0 |
| Eight times | 0 | 1 | 0 | 0 | 0 | 2 | 0 | 2 | 0 | 0 | 0 | 0 |
| Ten times | 1 | 2 | 0 | 3 | 2 | 0 | 0 | 0 | 0 | 1 | 3 | 7 |

### 4.9.10 REASONS FOR PHARMACIST AND PMV STOCKOUTS

The major cause of stockouts for all provider types and in all five states is distributors' failure to supply drugs on time (Table 30). Reasons why the drugs are late, however, are unclear. Forty-five percent of pharmacists in Abuja indicated that the distributor cannot obtain certain drugs. And the cost of drugs is a problem for a substantial number of pharmacists and PMVs in all five states.

**TABLE 30: REASONS FOR PHARMACIST AND PMV STOCKOUTS BY STATE***

| PHM=pharmacist | Total | | Lagos | | Abuja | | Nasarawa | | Bauchi | | Kano | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | PHM | PMV | PHM | PMV | PHM | PMV | PHM | PMV | PHM | PMV | PHM | PMV |
| Base number | 216 | 313 | 77 | 64 | 58 | 62 | 26 | 66 | 20 | 80 | 35 | 41 |
| | % | % | % | % | % | % | % | % | % | % | % | % |
| Distributor fails to deliver drugs on time | 56 | 45 | 48 | 31 | 50 | 50 | 69 | 50 | 60 | 38 | 71 | 66 |
| Drugs are too expensive to maintain a sufficient quantity | 27 | 31 | 30 | 33 | 28 | 26 | 23 | 33 | 30 | 33 | 20 | 27 |
| Distributor cannot obtain drugs | 31 | 16 | 25 | 17 | 45 | 31 | 15 | 5 | 25 | 13 | 37 | 17 |
| Lack of funding or financial problems | 3 | 11 | 3 | 8 | 3 | 3 | 0 | 9 | 15 | 28 | 0 | 0 |
| High demands from customer or exhausted stock | 3 | 4 | 9 | 14 | 0 | 2 | 0 | 3 | 0 | 0 | 0 | 0 |
| Other reasons (not specified) | 2 | 1 | 0 | 0 | 7 | 2 | 0 | 3 | 0 | 0 | 0 | 0 |
| Scarcity of drugs | 0 | 2 | 0 | 0 | 0 | 2 | 0 | 3 | 0 | 0 | 0 | 5 |

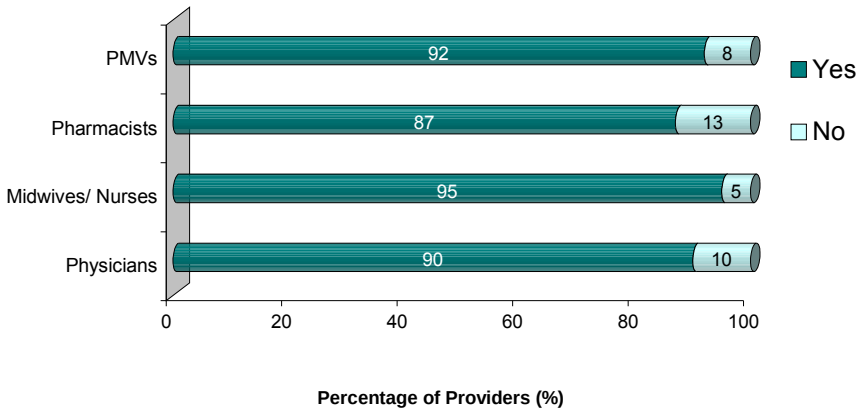
*Question allowed for multiple responses

## 4.10 TRAINING NEEDS ASSESSMENT

### 4.10.1 INTEREST OF PRIVATE PROVIDERS IN BUSINESS MANAGEMENT TRAINING

Respondents are interested in training that improves the management of their business. All provider groups indicated a strong interest in business-management training (87 percent of pharmacists, 92 percent of PMVs, 90 percent of physicians, and 95 percent of nurses and midwives) (Figure 27).

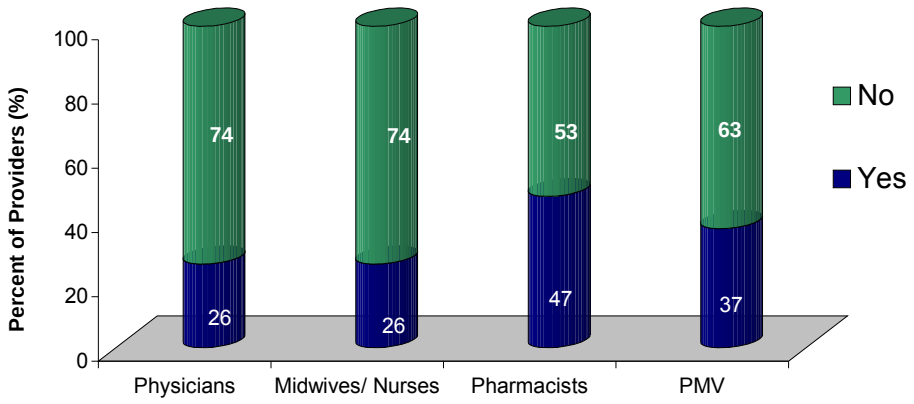
**FIGURE 27: INTEREST OF PRIVATE PROVIDERS IN TRAINING FOR IMPROVED MANAGEMENT OF MEDICAL BUSINESS BY PROVIDER TYPE**



## 4.10.2 PREVIOUS TRAINING IN ACCOUNTING AND FINANCIAL RECORDS

A majority of physicians, nurses, midwives, and PMVs had no training in accounting or financial records in the past five years, while almost half of pharmacists did receive some training in accounting and financial records during this time period (Figure 28).

**FIGURE 28: PREVIOUS TRAINING IN ACCOUNTING AND FINANCIAL RECORDS IN THE PAST FIVE YEARS BY PROVIDER TYPE**




## 4.10.3 TYPES OF TRAINING DESIRED BY PROVIDERS

Respondents showed interest in different training subjects, particularly those related to accessing finance and clinical training (Table 31). Many of the pharmacists and PMVs also are interested in training regarding marketing and stock control. A large number of the PMVs, nurses, and midwives are interested in a training covering government regulations on private health practices.

**TABLE 31: TYPES OF TRAINING DESIRED BY PROVIDER TYPE***

| | Physicians | Nurses and midwives | Pharmacists | PMVs |
|---|---|---|---|---|
| Base number | 350 | 358 | 355 | 515 |
| **Percent** | % | % | % | % |
| Clinical training | 59 | 61 | 61 | 68 |
| Accessing financing | 76 | 76 | 61 | 68 |
| Marketing | 40 | 40 | 55 | 58 |
| Stock control | 39 | 41 | 56 | 51 |
| Obtaining payment from patients | 35 | 40 | 35 | 42 |
| Understanding government regulations on private health practices | 41 | 53 | 47 | 68 |
| Bookkeeping | 35 | 32 | 44 | 36 |
| Finding medical suppliers | 25 | 30 | 23 | 38 |
| Finding drug suppliers | 22 | 26 | 25 | 38 |

*Question allowed for multiple responses.

### 4.10.4 SERVICES PROVIDED BY AND EXPECTED FROM PROFESSIONAL ASSOCIATIONS

Almost all of the physicians, nurses, midwives, and pharmacists belong to a professional association compared to just 74 percent of PMVs (Table 32). From 47 percent (physicians) to 64 percent (pharmacists) of providers reported that their professional associations offer training in business management, but a greater proportion of respondents (76 percent to 83 percent) in all private provider groups indicated that they expect business-management services from their professional association.

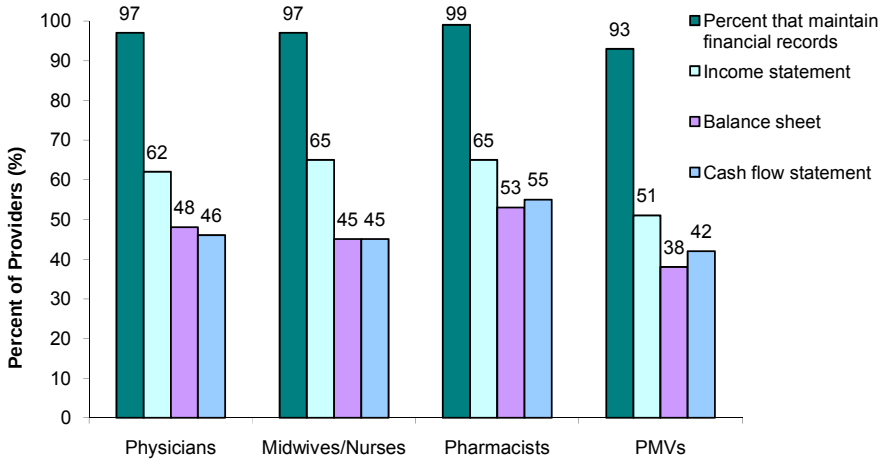
**TABLE 32: SERVICES PROVIDED BY AND EXPECTED FROM PROFESSIONAL ASSOCIATIONS BY PROVIDER TYPE**

| | Physicians | | Nurses and midwives | | Pharmacists | | PMV | |
|---|---|---|---|---|---|---|---|---|
| Base number | 388 | | 408 | | 400 | | 553 | |
| Percent belonging to a professional health association | 95 | | 95 | | 97 | | 74 | |
| **Percent** | % | | % | | % | | % | |
| **Services provided by association** | **Currently provided** | **Expected** | **Currently provided** | **Expected** | **Currently provided** | **Expected** | **Currently provided** | **Expected** |
| Is a national advocate on issues that affect health professionals | 88 | 95 | 89 | 94 | 89 | 92 | 83 | 80 |
| Provides information relevant to medical or pharmacy training | 95 | 96 | 94 | 98 | 94 | 96 | 89 | 87 |
| Provides medical or pharmacy training | 76 | 87 | 74 | 88 | 87 | 90 | 77 | 82 |
| Provides business-management training | 47 | 82 | 48 | 79 | 64 | 83 | 57 | 76 |

### 4.10.5 TYPES OF FINANCIAL RECORDS PREPARED BY PRIVATE PROVIDERS

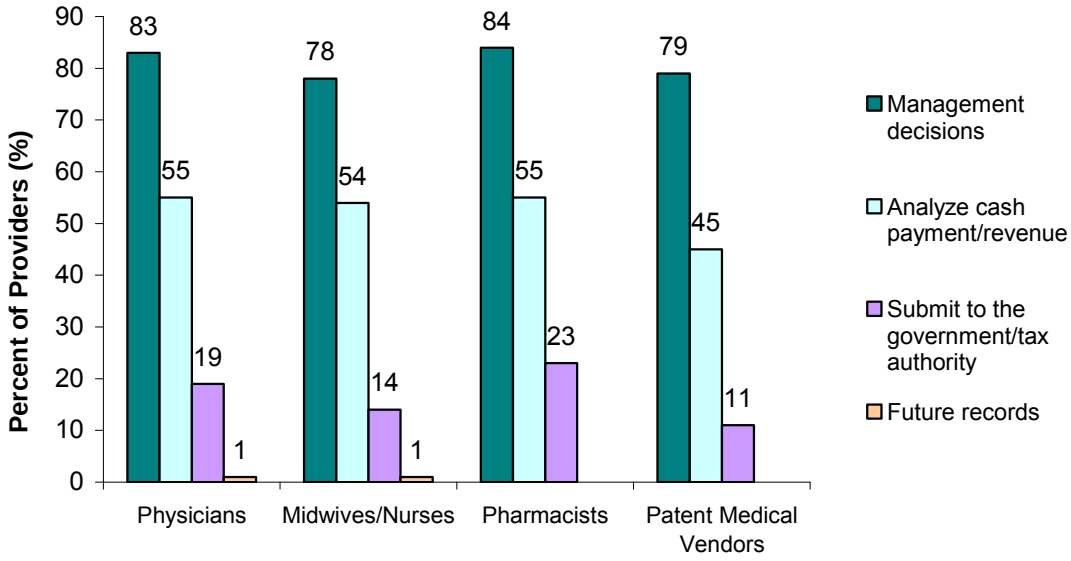
Almost all of the private providers indicate that they maintain financial records, with a majority in all provider groups reportedly maintaining income statements (Figure 29). Financial institutions in Nigeria, however, indicated that few small businesses maintain financial statements. Most often the owner of the medical practice, particularly among PMVs, maintains the financial records for the business. Many private physicians, nurses, midwives, and pharmacists, however, delegate financial recordkeeping to an employee.

## FIGURE 29: TYPES OF FINANCIAL RECORDS PREPARED BY PRIVATE PROVIDERS




Survey respondents indicated that financial records are most commonly used for management decisions and cash analysis (Figure 30).

## FIGURE 30: HOW FINANCIAL RECORDS ARE USED




*Question allowed for multiple responses.

# 5. CONCLUSIONS

This research focused on the business characteristics, financing, and training needs of private medical providers in Nigeria. These needs are directly linked to the provision of sustainable, quality health care as credit is linked directly to small firms' growth, including those in the medical sector. Most of these private medical businesses need additional investment to improve their practices by purchasing equipment, expanding stock, renovating facilities, and adding services.

Private providers have a role to play in contributing to positive public-health outcomes, and the government and donors can strengthen this function. Private providers in Nigeria already offer a number of priority public-health services, including some related to reproductive health, family planning, and HIV/AIDS. If the government and donors are looking to expand access and reduce the burden on public facilities, the private sector can help achieve those results. Partnering with and promoting the development of the private sector is an important strategy that must be considered. A growing private sector can provide health workers with an alternative to leaving the country and help reduce the demand on public-sector facilities.

## 5.1 AS MOST PRIVATE PROVIDERS IN NIGERIA OPERATE AS SINGLE PROPRIETORS, IT IS IMPORTANT TO MAKE SURE THAT BUSINESSMANAGEMENT TRAINING IS EMPHASIZED

Private providers also need to understand the cost advantages of operating group practices, as they reduce overhead expenses. Businessmanagement training should be approved for the CME requirement for license renewal. For physicians participating in the NHIS, a primary expected result from business-management training would be keeping costs down and staying profitable under capitation.

## 5.2 GREATER COVERAGE OF FAMILY PLANNING AND HIV/AIDS SERVICES WITHIN NHIS SHOULD BE CONSIDERED

As a substantial percent of private providers offer services related to family planning and HIV/AIDS, encouraging private providers to offer these services should reduce the pressure on public-sector facilities. The MoH projects a need to have 1.2 million Nigerians on ARVs by 2009. Lack of capacity in the public sector means that ARV management must be pushed outward and downward to additional providers to meet the growing need. Integration of HIV/AIDS treatment with other primary care is likely to be desirable if providers have training and drug supplies are available.

## 5.3 EXTEND EXISTING PUBLIC-SECTOR PROGRAMS TO THE PRIVATE SECTOR

Surveyed providers indicated that they want additional clinical training. Private providers should be brought systematically into training activities that support their ability to provide high-quality services. Survey respondents expect their professional medical associations to provide these services, and HMOs accredited under NHIS can provide the same function. Additionally the survey indicated training that clarifies government regulations pertaining to private medical practices is needed for PMVs, nurses, and midwives.

## 5.4 ACCESS TO FINANCE IS NEEDED TO GROW THE SECTOR

A range of 64 to 81 percent of survey respondents indicated that access to financing was a major constraint to the profitability of private practices. At the same time, 46 to 61 percent of providers have little interest in applying for loans because of high interest rates. In most countries where access to finance is the major constraint, the private health sector is characterized by a large number of small clinics that never are able to access funds to grow and achieve scale. As the survey results indicated, this situation is the case in Nigeria given the predominance of sole-proprietor medical facilities.

## 5.5 EXPANDING ACCESS TO FINANCE WILL HELP EXISTING PRIVATE PROVIDERS TO GROW AND WILL BE IMPORTANT FOR NEW ENTRANTS

The survey revealed that few private providers applied for financing from a financial institution in the previous three years but that 39 percent (physicians) to 63 percent (PMVs) of private providers planned to apply for a medical business loan in the next year to grow and improve their businesses. Furthermore, given the substantial size of the private sector in Nigeria, the sector represents a major market opportunity for financial institutions. Private providers often have medical businesses that are well established. Banks will need to emphasize cash flow and business experience rather than collateral in evaluating loan proposals from private medical providers, although survey respondents indicated that they often have collateral. Furthermore, a USAID Development Credit Authority guarantee would help encourage financial institutions to lend to a sector that they view as especially risky.

## 5.6 ENCOURAGE THE CONTINUED DEVELOPMENT OF SPECIFIC LOAN FACILITIES FOR PRIVATE SECTOR MEDICAL GROUPS

PSP-*One* linked Fidelity Bank with the Association of Community Pharmacists of Nigeria, and by defining the financial needs of the pharmacists, Fidelity Bank developed a loan facility specifically structured for local associations of the Association of Community Pharmacists of Nigeria. As the survey demonstrated, many pharmacists and PMVs start their businesses with savings and family support and lack of access to credit for working capital is an ongoing constraint to maintaining sufficient stocks, meeting demand, and staying profitable. Integrated Microfinance Bank, one of the largest MFIs, also developed a loan facility specifically for nurses.

Almost 90 percent of pharmacists and 94 percent of PMVs would purchase more drugs if they had more funding. PSP-*One* should continue to encourage financial institutions to develop loan facilities specifically for pharmacists and PMVs as well as other private medical provider groups. This work is especially important given that loan terms often do not meet longer-term financing needs of private providers, such as for buying medical equipment.

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