



# Why Children Under 5 Years of Age Need Free Emergency Healthcare in Nigeria

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## Abstract

Nigeria has very high death rates in children under the age of 5 years. Currently, these statistics are the highest in the world. Policies designed to reduced childhood mortality should be considered by the Nigerian Government.

Most deaths among Nigerian children in this age group are preventable and are largely composed of treatable childhood infections such as lower respiratory tract infections (Pneumonia), diarrhoeal diseases, malaria among others. Many of these deaths occur at home, while others occur in pediatric hospital emergency rooms. Due to considerable Out of Pocket Expenditure (OOPE) for medical services. Many children are not brought to the hospital, while others present critically ill at a late stage, increasing the potentially preventable mortality rates.

The present Nigerian National Health Insurance scheme covers less than 5% of the Nigerian population with low utilization rate among its beneficiaries, so most Nigerian children under the age of 5 years are not covered.

In order to reduce mortality rates, the Nigerian Federal Government should consider free pediatric emergency room healthcare services for all children under the age of 5 years. As a consequence, more families would seek earlier and potentially curative medical care in hospitals. To solve this urgent problem, we propose that free emergency room healthcare should be funded using 1% of oil resources and 1% of VAT in Nigeria.

**Keywords:** Nigeria; Child Mortality Rates; Emergency Healthcare; Free Medical Care

## Abbreviations

OOPE: Out of Pocket Expenditure; NHIS: National Health Insurance Scheme; AED: Automated External Defibrillator; SDGs: Sustainable Development Goals; HICMF: Health Intervention and Cost-Mitigation Fund; VAT: Value Added

Tax; NIMR: Nigerian Institute of Medical Research.

## Introduction

Nigeria had a mortality rate of 107 per 1000 live births in 2020 for children under the age of 5 years, the highest in

the world [1]. According to UNICEF, there were 858,000 deaths in Nigerian children under 5 years in 2019 [2]. These figures are alarming and unacceptable, as the causes of death are largely avoidable and/or preventable. However, the reporting of deaths is primarily hospital-based, meaning that mortality rates are actually underrepresented in reality [2]. Studies show that data gaps remain a serious challenge to child mortality estimation and monitoring, given that 97 low and middle-income countries, including Nigeria, have no reliable mortality data [2]. A major reason for this is that most children under 5 years die in the community without reaching hospital. This has been worsened by the COVID-19 pandemic with non-pharmaceutical prevention practices of social isolation and the fear of hospital utilization that have resulted in increased community-based intervention [3]. Underreporting of community-based deaths through inadequate data collection mechanisms further undermine the national figures quoted in global reports [4-9].

Mortality in children under 5 years of age in Nigeria is largely preventable, including treatable infectious diseases, such as pneumonia, diarrheal diseases, malaria and septicemia [4-7], that have remained consistent since the early 1990s [8]. As children, unlike adults, are less likely to withstand the effect of disease for prolonged periods, they require immediate attention to enable them to have better outcomes and chances of survival. This is especially true when children present with life-threatening features, such as severe respiratory distress, shock, coma, seizures, severe anemia, and/or severe dehydration [9]. Studies have shown that most deaths in children presenting to the emergency room occur within the first 24 hours of presentation and many can be prevented by immediate and effective intervention [10]. Thus, anticipation, adequate preparation, availability and accessibility of medications are key elements to increasing survival rates.

The reasons for early deaths in the pediatric emergency room are not difficult to understand. Most of these children present very late and in critical conditions in a state where medical personnel are unable to intervene effectively. Late presentations are usually due to cost of care, out-of-pocket payments, distance from home and lack of transportation. In the COVID-19 pandemic era, parents for the fear of acquiring COVID-19 in hospitals, preferred to stay at home in line with COVID-19 isolation policies, only for their children to present late in terminally critical states. If they present at all, many parents have little or no money to offset hospital bills, further delaying documentation, physician review, basic investigations, and/or purchase of lifesaving medication. As medical expenses among 70% of Nigeria are mainly out-of-pocket expenditures (OOPE) [11,12], OOPE significantly contribute to poor health-seeking behavior of parents, late and more severe case presentation to the pediatric

emergency room, since caregivers may not have immediate cash or be able to afford medical bills. Therefore, a large majority of these children effectively just “come to die in the emergency room.”

To minimize OOPE, which could be catastrophic in some situations, [13] the Federal Government of Nigeria introduced a national health insurance scheme in 1999 which became operational in 2005 [14]. The national, state, and community health insurance schemes were designed to minimize economic barriers and improve health access for all [13,14]. Currently, the National Health Insurance Scheme (NHIS) is still non-mandatory and mainly caters to Federal Government workers whose premiums are collected at the source, with less than 5% of the population currently covered by the scheme nationwide [15]. NHIS is also underutilized, owing to several bottlenecks in its design and rollout, such as co-payment at the point of access to healthcare services, low coverage across the country, poor quality services by care providers, Health Maintenance Organization bureaucracy, care exclusion, and poor health benefits packages [16-21]. NHIS in Nigeria, therefore, cannot effectively handle emergency care expenses, even among the beneficiaries, much less the underprivileged.

The high unemployment rate in Nigeria, rising inflation, global economic recession, security issues, banditry and insurgencies and corruption among government officeholders have all worsened the economic state in the country, thereby further worsening the purchasing power of the Naira and the ability of average families to meet their basic needs [22,23]. These have continued to delay healthcare access with a resultant increase in mortality rates in children under the age of 5 years in secondary and tertiary hospitals in Nigeria [22,23].

Other factors are the unpreparedness of the emergency rooms to attend to emergencies due to lack of life-saving equipment and personnel, as many pediatric emergency rooms in Nigeria are poorly equipped and unprepared to handle emergencies [4]. In a 2014 survey by Edelu and colleagues to assess the preparedness of pediatric emergency rooms in South-South Nigeria, it was shown that no single tertiary hospital had a functional manual defibrillator or an Automated External Defibrillator (AED), while many lacked the personnel needed to attend to emergencies [4].

With the present trend of events which is likely to continue, Nigeria is far from achieving the Sustainable Development Goals (SDGs) call for an end to preventable deaths of newborns and children under 5 years of age, with a neonatal mortality rate of 12 or fewer deaths per 1,000 live births, and an under 5 years mortality rate of 25 or fewer deaths per 1,000 live births, by 2030 [2].

## Free Healthcare Policy for Under-5 Children in Pediatric Emergency Rooms

The Federal Nigerian Government needs to address this problem urgently. We believe that there should be free emergency healthcare at the point of entry for all children under the age of 5 years across the country. Such a policy would be a life-saving measure and would improve the child health-related health indices of the nation. If a significant proportion of children under the age of 5 years are saved through free treatment in properly-equipped emergency rooms, fewer children would die in the community, as healthcare facility utilization and the healthcare-seeking behavior of families improves. With free treatment for children, economic barriers to healthcare access will be removed, resulting in earlier hospital presentation, better healthcare utilization, and improved health outcomes across the country. When this is coupled with health education to the general public, community health will improve significantly. Also, early presentation and resultant better outcomes will incentivize healthcare workers who naturally get demoralized when they lose children whose lives could otherwise have been saved. Furthermore, motivated staff should minimize the brain drain of Nigerian healthcare workers to Asia, Europe, and North America.

### Funding for the Proposed Free Healthcare Policy

To fund this policy, we propose the creation of a National Health Intervention and Cost-Mitigation Fund (HICMF). The establishment of this will provide the necessary resources needed to properly equip pediatric emergency rooms, upgrade the infrastructure, provide consumables and pay for emergency services within the healthcare system for children under the age of 5 years. We would suggest that the proposed HICMF should be funded using 1% of oil revenue and 1% of Value Added Tax (VAT). Furthermore, this fund should be distributed equitably to the six geopolitical zones of Nigeria and designated primarily for emergency care.

A governing board should be established to manage the proposed HICMF. Members should be drawn from the Pediatrics Association of Nigeria, the Federal Ministry of Health, the National Primary Health Care Development Agency, the National Health Insurance Scheme (NHIS), the private sector, and health economists and laypeople. Following the establishment of HICMF, adequate and proper education of the general population must be undertaken to ensure that the Nigerian public, especially the underprivileged are aware of the availability of this service in primary and secondary health facilities.

### Conclusion

We have outlined the negative impact of OPE on the

health of children under the age of 5 years, the enormous potential benefits of a policy for free medical care for such children presenting to pediatric emergency rooms, and the potential funding source for this policy. We would suggest that the Nigerian Federal Government urgently considers the implementation of this policy.

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