

ENTREPRENEURIAL BUSINESS MODEL: PREREQUISITE FOR INCLUSIVENESS IN HEALTH CARE DELIVERY SYSTEM IN NIGERIA

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Abstract

The dynamics of sociocultural influences on access to public health has moved current thinking beyond the behavioural, biological, environmental, and physical causes of diseases to embrace the relationships between health and social contexts. This with a view to proffer direct and specific solutions to the pervasive predominant problems of healthcare accessibility that matches each context. Thus, this study examined the effects of deployment of innovative business model on the performance indicators of healthcare delivery system in the frontier countries, like Nigeria. Specifically, the study examines effects of entrepreneurial business model on availability, affordability and accessibility of quality healthcare services to all including the poor and vulnerable citizens. Primary data collected through the instrumentality of structured questionnaire administered on twenty-five (25) senior staff and twenty-five (25) patients of purposively selected five (5) hospitals operating in the southwestern Nigeria, and personal interview on five (5) CEOs also purposively selected were analysed with the aids of descriptive statistics to determine the contribution of each identified variables. Findings revealed that, any appropriate business model that will foster inclusiveness in health care delivery system in Nigeria must earn the trust of the vulnerable, must be relatively affordable and geographically accessible. The paper concludes that stakeholders, policymakers, and hospital management must consider the peculiarities of the subpopulation's sociocultural factors in designing their health care value propositions.

Keywords: Business model, healthcare services, accessibility, affordability, availability

Introduction

Health and human well-being constitute the most important elements in Human Development Index. Thus, the United Nations, prompted by the closeness between healthy living and economic wellbeing, describes its Human Development Index as a composite index that reflects life-expectancy, educational achievement, and real per capita income (UNDP, 2019). These constitute the three most essential elements required by people to enjoy a long and healthy life. And as posited by the World Health Organisation (WHO, 2018), the health and well-being of people around the world critically depend on the performance of the healthcare system that serves them. It is therefore not surprising that quite several government and non-governmental organisations focus attention on this important area of human livelihood.

The World Health Report (2000) predicated the health care system assessment of nations on five basic indicators: overall level of population health; health inequalities within the population; overall level of health system responsiveness; distribution of responsiveness within the population; and the distribution of the health systems financial burden within the population. A closer look at these five indicators suggest that they are designed to examine the disparities in attention giving to people's well-

being, level of people's satisfaction with healthcare services and the costs implications of these services on the citizenry. And this is particularly to the general people, irrespective of social status, gender, level of education, etc. to ensure healthcare system that is available, affordable and freely accessible to all and sundry.

Further, the Health Care Index can be described as a measure of the overall quality of the health care system, its cost implications, health care professionals, doctors, nurses, staff, equipment, and all paraphernalia necessary to engender the well-being of a nations' citizenry. And as asserted by Ileana et al. (2015), it is an organisation of people, institutions, and resources needed to deliver health care services to meet the health needs of a target population. The Bloomberg (2019), in its Bloomberg Healthiest Country Index, considering variables like life expectancy, environmental factors of access to clean water and sanitation, ranked Spain as the best country with an excellent healthcare system as at 2019. Italy, Iceland and Japan were ranked 2nd, 3rd, and 4th respectively. The Bloomberg study conducted their ranking using data from WHO, World Bank and the UN Population Division which also include a guaranteed universal healthcare system, the healthy dietary habits, as well as a conducive healthy

environment (Tapia, 2019). Other criteria, as applicable to all other countries are the number of healthcare professionals (including Doctors, Nurses, etc.); number of bed spaces, quantity and quality of facilities and equipment, etc.

It should however be noted that most countries with the lowest rankings are the developing countries of Asia and sub-Saharan Africa with the attendant low life expectancies, prevalence of ill-health resulting from malnutrition, unhygienic environment, lack of access to clean water and sanitation, HIV and AIDS epidemics etc. The peculiarities of health environment of the less-developed countries, as opined by Angeli and Jaiswal (2016) is characterised by poor living conditions, unhealthy dietary habits, dangerous exposure to diseases, and limited access to healthcare services. These coupled with the predominantly low literacy level, low incomes, high unemployment and official corruption has ensured a large proportion of the population lives in abject poverty resulting in a depleted quality of life that contribute to reduced life expectancy. Corroborating this assertion, The World Health Report (2000) affirms that the impact of health systems failures is most severe on the poor who have no financial protection against ill-health but must buy health from their own pockets which drives them deeper into poverty. Also alluding to this position Angeli and Jaiswal (2016); George, et al. (2015); Kim, et al. (2013) posited that the major cause of health systems failure in less-developed countries is the under-optimal access to health care services.

Thus, the need for a paradigm shift in the way healthcare is provided has necessitated the call for different approaches to ameliorate the deplorable nature and arrest the decay in the healthcare systems in these climes. Consensus in literature suggests that patients, like customers are demanding more value for their monies, and that healthcare providers must strive to render quality services, better care, and at lower costs (Berwick et al., 2008; Porter and Teiberg, 2006; Smith et al., 2009). In the less-developed nations' context, traditional methods that have been successful in developed nations have proved ineffective, no thanks to the peculiarities that are markedly different between them. And as posited by (Hubley, 1986; Marmoth, 2000) much of the knowledge available on health determinants and disparities emanate from research efforts on the interactions between socioeconomic variables and health in developed countries, which may not necessarily be relevant to situations in the less-developed countries. Also, the resulting interventions might not be sufficiently suitable for other contexts. Hence, extant literature is replete with the need to fashion out new business models in these climes to

improve access to healthcare and at the same time increase returns to providers (Angeli and Jaiswal, 2016; George *et al.*, 2015; Kim *et al.*, 2013; Simanis *et al.*, 2008).

While business model explains the underlying economic logic that describes how a producer can deliver value to customers at an appropriate cost. It is designed to identify customer needs, appreciate his/her cherished value, and strive to meet those needs while generating appreciable returns on investment. An appropriate business model that will deliver health care services to all, including the less privileged must necessarily describes the rationale of how the service provider creates, delivers, and captures the peculiarities of all and sundry, taking cognisance of sociocultural and economic contexts. It is on this premise this study examined the effects of deployment of innovative business model on the performance indicators of healthcare delivery system in the frontier countries, like Nigeria. Specifically, the study examines effects of entrepreneurial business model on availability, affordability and accessibility of quality healthcare services to all Nigerians including the poor and vulnerable citizens.

The Sociocultural Health Environment of Frontier Countries

The effects culture exerts on health of a people can be very vast and encompassing. Culture can be described as a pattern of ideas, customs, believes, norms and behaviours shared by a group of people or a society. Culture shapes the perceptions of health, illness and death. It greatly influences believes about the causes of diseases, it defines how illness and pains are experienced and expressed, how and where to seek medical attention. Thus, cultural bias often results in very different health-related preferences and perceptions to the extent that both patients and care givers are greatly influenced by their respective cultures and which determines the overall success of a health system. As posited by Marmot et al. (2008), the idiosyncratic believes, traditions, norms and institutional isolation do frustrate the very process of health need recognition, as patients rely on their networks, local communities to identify their ailments (albeit wrongfully), to determine when and which type of medical care to seek. It has been observed that healthcare services are characterised by high information asymmetry between patients and care providers across contexts (Lako and Rosenau, 2009; Marmot et al., 2008; George et al., 2015). The strong influence of sociocultural believes, tradition and norms often ensure that the first point of consultation, in most less-developed countries, is the unqualified, uncertified traditional healers or even quacks that pervades chemists and mushroom drug stores within the neighbourhood. Regular healthcare

facilities are resulted to only when the ailment becomes critical and the cost of treatment must have risen. The environmental health of any nation, as opined by Abolade (2018) must include, among others: access to clean water, food hygiene, housing sanitation, health education, school health services, air pollution control, prevention and control of communicable diseases, care of the dead and so on.

The Nigerian healthcare system operates a three-tiered governance structure where the primary facilities (maternal, child, family, and dispensaries) is by the local authorities; secondary healthcare falls within the jurisdiction of State governments, while tertiary healthcare responsibilities are under the purview of both the States and Federal government. However, with an estimated total health facility of 23,640 as at 2010, the WHO's Global Healthcare Index 1990 - 2015 ranked the country 187th out of 195 member states on health-related issues. The WHO/UNICEF Health Development Index (2018) statistics indicated that with an estimated population of 200 million, the patient-to-doctor ratio stood at 2500:1, as against WHO's recommended 600:1, average life expectancy at birth of 52 years, infant mortality per 1000 of 77.8, all compounded by a healthcare financing of 8.17% of annual GDP (WHO, 2018). It should however be noted that about 70% of healthcare services in Nigeria is provided by private health vendors, including NGOs (Welcome, 2011), hence, the inadequacy of the healthcare delivery system resulting in only about 43.3% of the population having access to healthcare (WHO, 2018).

The dysfunctional healthcare system is further compounded by the fact that more than 50% of Nigerians live below poverty line of less than \$1 a day, hence could hardly afford the costs of healthcare. And as posited by Akande (2004) the poor managerial functions of the healthcare delivery system as manifested in the very poor referral system between the various tiers, coupled with the fact that some 70% of drugs dispensed are alleged to be fake or substandard further complicates Nigerian health system. Notable challenges to healthcare delivery system in Nigeria, as observed by the WHO (2018) Oxford Business Group (2019) and reported by Medic West Africa (2019) includes: inadequate government funding; rising incidence of infant and maternal mortality; heavy reliance on out-of-pocket finance of health by private individuals; and with noticeable decline in health workforce migration, the major challenge remains inadequate production and equitable distribution (Medic West Africa, 2019).

Access to Healthcare Service Delivery in Frontier Countries

Every individual craves for a better quality of life and a better functional capacity derivable from the ability to command appropriate healthcare resources. Having timely use of personal health services with a view to achieving long and healthy living is the utmost desire of man. Access to healthcare describes the ability of every individual to seek and benefit from effective healthcare services as at when needed. In their study on "Access to Primary Healthcare in Brazil", Boch, et al. (2016) describe access to healthcare as a combination of fast availability of quality care, affordable services and easy geographical access to healthcare facilities. Thus, for any healthcare system to function effectively good quality healthcare services must be available in large quantity, at lower costs to the people and must be inclusive to all and sundry. However, extant literature affirms that a higher proportion of the population of frontier countries do without healthcare from which they could benefit (OBG, 2019; O'Donnell, 2007; WHO, 2018). From the supply side, good quality, effective healthcare services, can only be induced by an effective high-level of demand, this may not be attractive to the poor masses. On the demand side, many individuals, from the frontier countries, may not be willing to patronise good quality health facilities due to a range of factors, chiefly poverty and illiteracy.

The complex and idiosyncratic characteristics foisted on the masses by the prevailing sociocultural factors that manifested in poor level of awareness and reluctance to accept public health facilities has ensured a poor health-seeking behaviour. Confirming this assertion, Angeli and Jaiswal (2016), posited that awareness and acceptability remain critical factors in these climes due to the challenges posed by patient's limited health literacy and exposure to traditional dissemination channels devoted to publicising socio-culturally acceptable (but substandard) solutions. Thus, even where good quality health care facilities are available, patronising them becomes socially and culturally a taboo. Preference is rather given to traditional healers and unqualified chemists whenever it becomes expedient to seek medical helps. And where allopathic health care services are sought, it is usually when the ailment has become dangerously bad. Thus, access to healthcare services in the form of fast availability, appointment with a medical doctor, diagnosis, and treatment, as described by Boch et al. (2016), becomes elusive as a result of some reinforcing sociocultural characteristics of the people.

In his exploratory classic paper, Arrow (1963) explain the specific differential of medical care as the object of normative economics in which its specific problems are explained as adaptations to the existence of uncertainty in the incidence of disease and in the efficacy of treatment. While uncertainty and information asymmetry always exist in markets across contexts, the willingness and preference for consumer products and services provide just enough information and certainty for consumers to make purchase decisions. In a consumer market, value for money is the driver of competition, innovation, and product/service quality (Arrow, 1963). Every producer must therefore strive to beat the competition by seeking to always identify customer needs to ensure improved value creation at the lowest cost possible. Not so in the healthcare sector, since customer needs, expectations and preferences are not necessary to design value propositions. And as posited by Castano, (2014), value created in healthcare is not so obvious to patients, as only doctors and healthcare professionals are traditional designers of solutions to patients which gives them the privilege to create the structures and processes that are expected to result in the possible best outcomes. It is based on this premise that Arrow (1963) predicated the healthcare industry's inability to create value for money. He proposed that uncertainty in the diagnosis and treatment of disease makes it difficult for doctors to achieve predictable outcomes. Furthermore, that recovery from diseases is as unpredictable as its incidence due to the complications in medical knowledge where the doctor possesses more information on the consequences of the treatment than the patient. Advancement in technology notwithstanding, costs of medical care is always on the increase as novel medical technologies generates negligible benefits at increasing costs as against happenings in other industries (Berwick et al., 2008; Castano, 2014; Smith et al., 2009).

Fundamentally, healthcare affordability critically depends on patient's income, propensity to spend on unforeseen contingencies, and personal/societal judgements about the value of health facilities available. As posited by Weiner and Glickman (2018), it is a sentiment, involving a qualitative ability and willingness to pay. Unlike most economic measures, health care spending is usually skewed with customer needs and demand largely varying from one individual to the other, and that with time health status of individual changes. Factors affecting health care affordability have been classified into three by the American Hospital Association to include: societal, systematic, and operational (Bathija, 2019). Social determinants of health with respect to variables like education, housing, transportation,

employment, and other non-medical factors of population possess huge impact on preventing serious illness among vulnerable populations which is capable to drive health costs. The systemic factors include the coverage rates, disparities in coverage and quality among vulnerable populations, and safety all with implications on preventive health and evidence-based practices. The operational factors revolve around existing and projected workforce shortages, rising prescription drug prices, rapid technology adoption, as well as the burden of regulatory compliance. In less-developed environment, consideration must be given to the vulnerable poor whose out-of-pocket expenses is driving them deeper into abject poverty.

Provision of adequate geographic access to health care facilities is one of the defining characteristics of a functioning health system (Evans and Stoddart 1990). And as opined by Lawal and Anyim (2019), to measure geographic access, consideration should be given distance to facilities, ease of transportation, travel time and costs. In less-developed countries, it is the inequalities in geographic access to health care that constituted greater challenges in achieving the third Sustainable Development Goal set by the United Nations (UN, 2015). For regions with huge population and population density, as obtained in most less-developed countries, the pattern of access, both within the rural and urban areas, are usually inadequate. This was said to be responsible for the outbreak and easy spread of Ebola as an infected individual possesses the capacity to transmit the disease to hundreds of people within short period because of the proximity and inadequate access to health facilities (Alexander et al., 2015; Heymann et al., 2015). Thus, in a good and efficient health care system every individual should have easy access to appropriate quality health care in a timely, acceptable and affordable manner (Lawal and Anyim, 2019).

Finding Appropriate Business Model for Health Care Delivery in the Frontier Countries

The theory of disruptive innovation, as propounded by Christensen (1997), is a process by which a new entrant into an established industry directs its efforts towards satisfying the needs of neglected, resource-constrained, bottom of the pyramids customers. The new entrant gains traction through quality but low-cost offerings and moving up market by offering attractive solutions to the most profitable segment of the target market. The process continues until when the new entrant efforts gather enough momentum to dislodge market leaders with its new innovations (novel products and services). Uber, Bolt, Airtel, MTN, to mention but a few, have succeeded in revolutionising transport and telecommunication industries for example. Having established the fact

that traditional business models that have been successful in the advanced countries have been grossly ineffective in these climes (Angeli and Jaiswal, 2016; George et al., 2015; Hubley, 1986; Kim et al., 2013; Marmot, 2000), appropriate business models must be cognisance of the identified peculiarities of the resource-constrained populations.

That a large proportion of the population in rural Nigeria have very limited health literacy and do find it very difficult to identify their health problems or that they may not be able to describe them properly is a major challenge. The World Health Report of 2014 estimated that, world-wide, some 2.5 billion people do not have access to basic sanitations, which results in loss of some 600,000 lives through bacteria-induced diarrheal infections annually. In most rural and urban slums, the report confirm that dwellers are not favourably disposed to the idea of using toilets, especially the ones under the same roof where they eat and sleep. This is because they lack the understanding that from their open defecation practices come contaminations from human wastes which is dangerous to their health. In the same vein, the OBG (2019), while commenting on the 2017 National Health Policy, as amended, describe the Nigerian health care services as fraught with inequities that manifests greatly in socioeconomic and geographic lines. To the extent that only 11% of births to illiterate women occur in certified health facilities as against 91% of educated mothers, and some 86% of women in urban cities receive prenatal care compared with 48% in the rural areas. Similarly, the World Health Statistics reported an estimated 63 million Nigerians lack access to potable water while one-third of rural and 12% of urban population still practise open defecation (WHO, 2018). It is on this basis we conclude that a business model that will describe the resources, processes and cost assumptions capable of leading to an appropriate value propositions in this clime must first and foremost ensure that patients are aware of their health needs, especially practices that are injurious to their health, and believe in the efficacy of the proposed solutions. Thus, we formulated the first proposition that:

A dynamic interaction between patients and healthcare providers that engender trusts is associated with appropriate business model.

Persistence high costs of health care delivery across contexts, as affirmed by Christensen *et al.* (2000), is usually explained away in the ever-increasing personnel costs (especially in the area of specialised knowledge required in most phases of care and treatment). And in the rural areas, this is further compounded by the costs of medical equipment that

must be imported coupled with the unattractiveness of the rural and urban slums to qualified health professionals. The scarcity of qualified medical doctors in Nigeria stems from the limited number produced yearly from Nigerian universities. The WHO Study on Medical Doctors in each country by every 1000 people revealed that Nigeria produces 370 doctors in every 10,000 (Motolani, 2019). With as little as less than 80,000 population to serve about 200 million people. Nigerian doctors are leaving its shores in droves, to seek greener pastures, same as their Nurses, Mid-wives, and other counterparts from the medical field (Medic West Africa, 2019). An appropriate business model must necessarily try to overcome these menaces, either by leveraging on medical professionals' intrinsic motivations, as suggested by Christensen et al. (2000). This can be done by invoking the spirit of volunteerism (encouraging well-placed medics to be socially responsible), patriotism (by offering them opportunity to contribute or give back to the community from where they grow up). Most Non-Governmental Hospitals in Nigeria are currently benefiting from volunteers, as posited by Adele (2014), Pathfinders International, Amen Healthcare Foundation, Breast Cancer Association of Nigeria, Association for Reproductive and Family Health, to mention but few.

To address the scarcity of qualified medics, Niezen and Mathisjssen (2014), suggested the use of task reallocation practices. This involves organising training for young people, with flair for medical practices to handle simple tasks, as support staff and nurses. They assist in routine activities of preparing a patient for major operations and effect management of post-operations. Thus, doctors spent very little time per patient, to perform just the critical operation. In which case allowing the doctor to attend to as many patients as possible. Example is the assembly line operational model adopted by Aravind Eye Hospital in India. As reported by Rosenberg (2013), by devoting their time to only the core surgical operation, an ophthalmologist performs an average of 2000 cataracts operation annually with little defect precision, and at very lower costs.

Furthermore, efforts must be made to ensure the deployment of appropriate, locally sourced sophisticated medical equipment that are not as expensive to increase costs of health. For instance, an incubator is a very expensive medical equipment usually employed to maintain environmental conditions for a neonate, not many hospitals can afford it, especially in the less-developed world.

It is on these pretexts, as reported by Dana (2008), a group of students, rising from a class in Engineering for Extreme affordability at Stanford University

devised a little sleeping bag attached with a space-aged wax technology inserted in the back pouch. Once heated over boiling water, it can keep the baby at proper temperature for four (4) hours. This locally produced sleeping bag is at a cost of \$25 instead of \$2500 for a standard incubator (Dana, 2008). In the same vein, as reported by Express Healthcare (2008), the popular medical equipment manufacturer, GE – with India markets in view, rolled out series of low-costs, battery-powered, easy to use devices like Tejas XR 6000, an X-Ray machine that provides high resolution digital images at half the cost of its imported counterpart. The MAC 400, lightweight with rechargeable lithium-ion battery, an ECG machine that produces ECG Reports at less than \$1, and with capacity to produce more than 100 reports on a single battery charge. It was manufactured by GE at a cost of less than one-fifth of the conventional machines (Express Healthcare, 2008). Thus, we formulated the second proposition that:

Leveraging medical professionals' intrinsic motivations while deploying low-cost but appropriate technology are prelude to fostering appropriate business model

Globally, the health care facilities distribution usually follows the rich-poor line divide that tends toward a negative relationship. Thus, as observed by Hart (1971), health facilities are likely to cluster in the high-income neighbourhood where health needs are low and car ownership is high to the detriment of the low-income areas. While the spatial dimension of access to healthcare includes accessibility and affordability of health care services, geographic accessibility, as posited by Delamater et al. (2012) is a measure of the friction of distance or burden of travel between potential users' residents and hospital facilities. Access to health care becomes complex and multifaceted as a result of the complexities in the characteristics of the population in need of health services as well as the health care delivery mechanism that serves them. And as opined by Delamater et al. (2012), the inequalities in geographic access to health care is a function of the population distribution, configuration of facilities and the available transportation infrastructure within a community. The closeness of health care services to the people, irrespective of their personal circumstance, is bound to improve healthy living and this implies adequacy and timely reach to health services when necessary in order to improve physical and mental wellbeing. In Nigeria, lots of efforts on improving health care by policy makers, health experts and administrators are usually focused on financing, increasing human resources and other interventions at the expense of attention to spatial access. These often results in abandoned, unused, or

redundant facilities as a result of non-consideration of spatial access at the planning stage (Otu, 2018). A large proportion of subscribers to the NHIS are presently unable to access it due to geographic distance. Most of the facilities are in urban centres that are difficult for rural dwellers to access in time of needs.

However, advancement in technology and easily available spatial data have reduced the burden of travel as well as the friction of distance to the extent networking, partnership and telemedicine has ensure delivering quality medical services by experts irrespective of location. A good business model must leverage partnership, networking and collaborate with appropriate resource owners with a view to simplify the delivery of quality care. With a mission to provide cardiac care to all and sundry in India, Dr. Shetty, as reported by Madhavan (2014), established Narayana Hrudalaya Hospital (NHH) in Bangalore in 2001. To circumvent delivery hurdles, he established small Cardiac Care Camps (CCC) across rural settlements and with the aids of networking, partnership, and video conferencing he linked them up to the main hospital. Each CCC was equipped with medical supplies, facilities and ECG machines that were operated by locally trained medical staff. And on the account of Suresh (2012), through these camps, NHH was able to analyse some 144000 ECG outputs as well as 33000 angiograms, being the largest telemedicine platform as at 2008. The feat by Dr. Shetty was made more outstanding when consideration is given to the achievement of zero-defect precision as against 8 – 40% post-surgery bed sore world-wide (Madhavan, 2014). Furthermore, Dr. Shetty's NH Hospital forged strategic partnerships with the Indian Space Research Organisation (ISRO) to leverage on its internet connectivity for the extensive telemedicine across the CCCs, and the Indira Gandhi Open University, providing training grounds for first Diploma in cardiac care (Angeli and Jaizwal, 2016). Thus, with the aids of medical technology innovation, networking, strategic partnerships, and collaboration, inequalities in geographic access to health care can be reduced to the barest minimum. Thus, we formulated the third proposition that:

A good business model must leverage technology, strategic partnership, and networking to circumvent inequality in geographic access to health care

Methodology

The study was conducted on five (5) purposively selected hospitals operating in the southwestern part of Nigeria. Simple random sampling technique was employed to select 25 senior officials from each

hospital (including Professionals, Doctors, Nurses, Administrative staffs) to give equal representation to each segment of the hospital management.

Primary data for the study were gathered through the instrumentality of structured questionnaire administered on 25 senior officials and 25 patients from the selected hospitals with a set of multiple items reflecting a 5-point Likert-scale to measure each identified variable, and personal interviews conducted on the Chief Medical Director of each hospital. Of the 250 questionnaires administered, a total of 234, representing 93.6% response rate were retrieved and utilised for data analysis after screening and evaluation. Data obtained were analysed with the aids of descriptive statistical tools to describe the necessary attributes of a business model suitable for inclusive healthcare delivery, most especially in the frontier countries.

Results

This study examined the effects of deploying innovative business model in healthcare delivery system as a prelude to achieving all important inclusiveness on the part of the general populace with a view to ensure healthy living for all and sundry. This is an attempt to identify attributes of a business model

that ensure good quality healthcare is made generally available to the people at very affordable rate and at their easily accessible convenience. Three propositions were formulated to identify the study variables, and which form the kernel upon which our structured questionnaire and personal interviews were based. The results of descriptive statistical tools deployed to analyse data obtained through administered questionnaire, on both hospital officials and their patients, and the qualitative data gathered from personal interviews were compared for the purposes of literal and analytical generalisation.

Results obtained, as shown in Table 1. indicated that most sampled hospital official respondents (74.45%) agreed that they render fast and convenient healthcare services to their patients irrespective of status, and that their structure is such that affords a patient to see a doctor, get examined and undergo diagnostics, if required, on the first visit to the hospital. Corroborating this view as obtained from the Table 2, most sampled patients (69.5%) agreed that the hospital services are fast and convenient. These opinions were also corroborated by the analysis of the data from the interviewees, as the textual descriptions from three of the participants summarised their responses as presented:

Table 1: Responses of Sampled Hospital Officials on Accessibility, Affordability and Geographic access to health care delivery Services (%)

Particulars	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
We render convenient and fast health care services	3.25	15.05	7.25	34.40	40.05
Our facility can offer medical exams and diagnostics to patient on the first day	5.25	7.05	10.20	37.00	40.50
We have speed in arranging medical appointment and doctor consultation	11.35	12.25	14.40	28.02	33.98
We offer high quality healthcare services at very affordable prices	6.75	10.20	12.25	30.40	40.40
Some of our partners sometimes offset medical bills of low-income patients	7.30	7.65	15.70	29.30	40.05
We get supply of drugs mostly directly from our partners - pharmaceutical firms that produce them	10.00	12.30	18.15	29.05	30.50
Our hospitals are strategically located close to the people	4.55	6.75	11.10	35.2	44.4
We consider areas easily accessible to public transport in citing our facilities	3.35	5.05	12.20	35.0	44.4
We network other medical facilities to bring our services closer to the people	11.15	8.35	14.65	30.05	35.80

Source: field survey, 2019

Table 2: Responses of Sampled Hospital Patients on Accessibility, Affordability and Geographic access to health care delivery Services (%)

Particulars	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
This hospital renders convenient and fast health care services	10.05	7.20	13.25	30.30	39.20
This facility can offer medical exams and diagnostics to patient on the first day	12.25	8.10	15.75	30.40	33.50
Patient do seek appointment and meet a doctor same day	12.80	10.00	15.65	28.05	9.60
The hospital offers high quality services at affordable prices	32.85	30.05	14.45	13.05	9.60
The hospital sometimes renders free medical services	22.00	25.50	15.20	18.85	13.45
Prescription drugs from the hospital are usually of good standard and cheaper	32.50	44.50	10.00	7.85	5.15
Hospital facilities appear to be carefully located closer to the people	40.05	36.80	11.25	6.35	5.55
Hospital facilities are easily accessible through public transport	30.50	33.05	14.25	12.75	9.45
The hospital has arrangements with other medical facilities to bring services closer to their patients	28.30	40.00	22.35	5.35	4.00

Source: field survey, 2019

Participant 1:

This is a strategy to give assurance that we have solutions to their health challenges, and it is psychological. Our facility is designed to provide quality care through speed in arranging medical appointment with patients and for them to see a doctor on their first visit to our facility.

Participant 2:

We understand that access is the most convenient and fast possibility to provide healthcare, hence, we always ensure our patients see a Doctor for examination, receive the diagnostics results on their first day in our facility.

Participant 3:

Access is very important, and to us it means speed in attending to each patient. The outpatient unit is well structured to ensure dignified examinations are conducted with high quality and agility, and that gives assurance to patients that they are in good hands and that psychologically the solution to their ill-health is near, and, with us.

This agrees with the WHO (2018) report that the health and wellness of people around the world depend on the healthcare system that serves them. And that psychological solution to ill-health is obtainable by the nature of attention a patient receives on the first visit to a hospital.

Results obtained from Table 1, also revealed that most sampled hospital official respondents (70.8%)

agreed that they offer high quality healthcare services at very affordable prices. However, Table 2, indicated a high proportion of sampled hospital patients (62.90%) disagreed that their hospital services are relatively cheap and affordable, while some (22.65%) agreed to the hospital services affordability. This is expected as the question of affordability is very subjective and relative, while healthcare providers believe they are fair enough in their charges most low-income patients may not agree to their claims. As expected, the analysis of data from the interviewees corroborated the position of sampled hospital officials, and that the textual descriptions from three participants summarised their responses as presented:

Participant 1:

To us in this hospital, we believe in offering good quality services, with respect, dignity, and affection. Our clients do acknowledge our services and that we offer all these at affordable prices to the satisfaction of a large proportion of our patients.

Participant 4:

Our strategy is simple, with good quality services offered at our clients convenience, we have endeared ourselves to a crop of donors, including big pharmaceutical industries who supply us standard drugs and equipment, most times for free, hence, we are able to reduce costs of treatment and drugs to our clients.

Participant 5:

Here, we believe in aligning quality and excellent healthcare services with financial availability. Our innovation differential is to provide quality services at very affordable prices, even to those without access to health insurance.

This result is in consonance with the position of Castano (2014), that costs of medical services is always on the increase as advancement in technology which usually reduces costs in other industries does not apply, as novel medical technologies bring negligible improvement at higher costs. It also corroborates the report of Weiner and Glickman (2018) that expresses healthcare affordability as a sentiment involving patients' qualitative ability and willingness to pay. Thus, to hospital patient's healthcare affordability is a question of relativity, to the high-income people the prices are generally affordable, not so to the low-income earners and the poor.

To the question whether health facilities are geographically accessible to the general people, Table 1. Revealed that a large proportion of sampled hospital official respondents (77.6%) agreed that their hospital complex is strategically located very close to the general people. This is to reduce the burden and stress of distance; it is one marketing strategy that management need to adopt to ensure robust patronage. However, a large proportion of sampled hospital patients (63.55%) disagreed that hospital facilities are easily accessible through public transport. Most rural dwellers who must seek medical attention are not finding it easy to visit the hospital complexes located in the urban centres. The analysis of the data of interviewees also agrees with the sampled hospital officials view as the textual descriptions from three participants summarised their responses as presented:

Participant 2:

To buttress our philosophy of guaranteeing good quality healthcare to the general people, our facility is located in areas easily accessible through public transport. This is a marketing strategy to ensure good patronage from all and sundry.

Participant 3:

Yes, our facility must be easily accessible to our clients, we are opened to serve the people, so we consider location very important. As you can see, we are really in the centre of the city.

Participant 5:

As a public health facility, we have a robust relationship with several primary healthcare centres in our rural areas and with superb referral system. We

even make good arrangement to always give them rapid attention as the case demands, including ambulance services where required.

The result is in tandem with the submission of Hart (1971) that health facilities, as a marketing strategy, are likely to cluster in the high-income neighbourhood where car ownership is high and the health needs of the people are relatively low at the detriment of the low-income areas. The result also agrees with the opinion of Delamater et al. (2012), that the inequalities in geographic access to healthcare facilities is a function of the population distribution characteristics, configuration of facilities and the availability of transportation infrastructure within a community. The facility location as a marketing strategy can only favour high-income communities, where patronages of the rich is assured, not the other way around.

Conclusion

Human desire, irrespective of status, is to enjoy better quality of life and better functional capacity to command appropriate healthcare resources, juxtaposed with the philosophy of care giver with respect to accessibility, affordability and geographical access have been examined in this study.

The study employed qualitative approach to compare perceptions of both the care givers and their patients vis-à-vis the business model of the care givers as it currently captures the yearnings and aspirations of the general people from the identified variables in the Nigerian context.

The study results revealed a wide gap between the aspirations, yearnings and expectations of a large proportion of hospital patients and what the hospital managements are offering them as services. While a high proportion of sampled officials and their patients acknowledged fast availability of most hospital services in the manner of prompt doctor attention, diagnostics and sometimes obtaining medical results on first day at the hospital, there appear wide disparities in their responses to questions on other variables.

Findings revealed that healthcare affordability portends the greatest point of disagreement between sampled health officials and their patients. While health management officials-based pricing of their services on the quality of their offerings, thereby believing they are very reasonable in their pricing, the fact that healthcare is a must for all and sundry irrespective of income status make the pricing system of the hospitals exclusive. To the extent not many poor people and low-income earners can comfortably afford their services. Perhaps this explains why a large number of the disadvantaged,

low-income, and marginalised still patronise the unqualified, uncertified quack doctors, mushroom chemists or traditional healers that further endanger their lives.

Findings also revealed that both sampled hospital officials and their patients are diagrammatically opposed in their perception of spatial access to hospital facilities. While the sampled officials based their facility location primarily on marketing strategy, for those that can afford it. This is manifested in their presence predominantly in the urban centres at the detriment of the rural dwellers. A large proportion of sampled patients however disagreed that the hospital facilities are easily accessible, this as a result of their difficulty in transporting themselves from the rural communities.

For an inclusive healthcare delivery system, the study recommends the employment of innovative business models for hospital managements that consider the yearnings and aspirations of the general population irrespective of social and economic status. A business model that considers the socio-cultural characteristics of the people; the idiosyncratic beliefs, norms, culture, as well as their tradition to involve them in determining their health needs and that educate them on which is the best medical care to seek. To the extent their involvement in the process arouses their sense of belonging – in determining their health needs. A business model that involves the deployment of appropriate, locally sourced sophisticated medical staff and equipment, and that makes it very attractive to qualified medics to work in the remote/rural areas of the country, these with a view to reduce costs of health to the barest minimum. And a business model that considers distance to health facilities, ease of transportation, travel time and costs to simplify access to healthcare. It must be capable of leveraging partnership, networks, and collaborate with appropriate resource owners to reduce distance and costs to quality care for all and sundry.

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