

Deans Lecture Series

A PATH TO THE HEALTH SERVICE OF OUR DREAM

(In honour of Professor Olu J.Osinowo on his 70th birthday)

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Simply defined, a health service of our dream is one in which any of us will gladly attend to receive healthcare. How can we achieve this? Most of us in this gathering have been working towards this. I have been privileged to know Professor Olu Osinowo for over 20 years. He is an erudite scholar and a teacher par excellence. He is also very innovative and was a member of the pioneering open heart surgery team in Ibadan. Therefore when after several years I met him here in NDU doing the work he knows how to do best- teaching, serving and research – I was excited and grateful that he came to help.

There are a lot of attributes our younger colleagues can emulate from Prof Osinowo. For the older ones, I will say that we complement his good works even though sometimes in different fields; I belong to the latter group. Since my residency training days my areas of interest in healthcare have been the Burden of disease and Quality of Life, Healthcare Financing and Education of Healthcare Professionals. I dare postulate that any society that is able to tackle and conquer these factors will succeed in having a health service of its dream. In this lecture I

intend to narrate how in my own little way tackled those factors.

As an ophthalmologist I studied the burden of disease on society using blindness as a case study. Nearly 28yrs after my training in ophthalmology, cataract is still the main cause of blindness in Nigeria. This is despite the fact that 28years ago we had less than 100 ophthalmologists in Nigeria. Today we have about 500 and the distribution is a lot fairer. Yet most cataract patients are unable to receive treatment.

Perhaps it is easy to appreciate the burden of blindness in a person when he is completely blind-maybe with a vision of light perception in both eyes. But how about a situation where the visual acuity is 6/18 in one eye and 6/24 in the other? Surely, there must be an effect on the person.

I tried to study this burden by using the concept of Quality Adjusted Life years (QALY) lost. Prost and Vaugelade in a study found out that the mortality rate was 4 times higher among the blind than non-blind. The life expectancy of the blind was also 13years shorter than in the non-blind. Quality Adjusted Life Years Lost determines the total number of life years lost because of the disability of poor vision. I conducted a study in a rural community to determine the cost of blindness in terms of Quality Adjusted Life years lost. A total of 1000 persons with varied visual acuities were interviewed to rate the disability (loss of function) that will result in terms of work or occupation if an individual is blind in the both eyes and one eye

only. Nearly all the people interviewed considered loss of an eye as a 50% disability while loss of both eyes as 100% disability. Since as Kessler suggested loss of function should form the basis of a disability decision, a visual acuity of no light perception in one eye was considered as a 50% disability. This amount reduced proportionately from no light perception giving the following disability values:

Table 1

VISUAL ACUITY	%DISABILITY
No Light perception	50
Light perception	45
Count finger	40
6/60	35
6/36	30
6/24	25
6/18	20
6/12	15
6/9	10
6/6	0

The unit disability is the total disability related to the visual acuity expressed in the scale 0-1 is illustrated in the table II. This was obtained from Table I by dividing the percentage disability by 100. Since there is no universally accepted life expectancy table specifically for Nigerians, the figures used in this study were derived from the unpublished data of Ayeni and Olayinka "Evaluation of the Igbo-Ora Statistics registration System". To obtain the quality adjusted life years (QALY) lost due to poor vision, the product of unit disability and the difference between life expectancy and the age at the onset is determined.

For example, if a person had an accident and his visual acuities reduced to OD 6/24 OS 6/36, his total disability is 0.48 (table II). Suppose he is 30 years; then his life

expectancy is 67 years (Table III). The Quality Adjusted Life Years (QALY) he will have if his vision remains unchanged is (67-30) years multiplied by 0.48 which equals 17.76 QALY. This means as he is 30 years old and his life expectancy is 67 years; he is supposed to live for additional 47 years. But because of his visual disability, the 47 years are actually equal to about 18 Quality Adjusted Life Years.

Table 2

Total Disability to visual acuity of individuals eyes on scale 0-1

R/L	6/6	6/9	6/12	6/18	6/24	6/36	6/60	C	L	NL
	F	P	F	P	F	P	F	F	P	P
6/6	0	.1	.15	.20	.25	.30	.35	.4	.4	.50
		0						0	5	
6/9	.1	.1	.24	.28	.33	.37	.42	.4	.5	.55
	0	9						6	0	
6/12	.1	.2	.28	.32	.36	.41	.45	.4	.5	.58
	5	4						9	3	
6/18	.2	.2	.32	.36	.40	.44	.48	.5	.5	.60
	0	8						2	6	
6/24	.2	.3	.36	.40	.44	.48	.51	.5	.5	.63
	5	3						5	9	
6/36	.3	.3	.41	.44	.48	.51	.55	.5	.6	.65
	0	7						8	2	
6/60	.3	.4	.45	.48	.51	.55	.58	.6	.6	.68
	5	2						1	4	
C/F	.4	.4	.49	.52	.55	.58	.61	.6	.6	.70
	0	6						4	7	
LP	.4	.5	.53	.56	.59	.62	.64	.6	.7	.73
	5	0						7	0	
NL	.5	.5	.58	.60	.63	.65	.68	.7	.7	.75
P	0	5						0	3	

Table 3

QUALITY ADJUSTED LIFE YEARS

(QALY)LOST=Life Expectancy- Age of onset X unit of Disability

LIFE	EXPECTANCY	TABLE in YEARS	
AGE	LIFE EXPECTANCY	AGE	LIFE EXPECTANCY
1	56.5	45	70.3
5	57.7	50	71.6
10	63.4	55	72.7
15	64.6	60	74.7
20	65.0	65	75.8
25	65.8	70	77.0
30	67.0	Over 70	80.0
35	67.8	Over 80	90.0
40	67.8		

Blindness, defined as a visual acuity of 3/60 or less in the better eye, causes a great burden in the individual as well as in the society. One may therefore ask why we don't come up with a programme that will significantly treat all cataracts caused blindness since we now have the Eye surgeons and the hospital facilities? There are several factors that prevent such an occurrence but the most important one is finance.

I became interested in healthcare financing when I was the National Treasurer of the Nigerian Medical Association. At that time a group of us (Dr M.A. Atoba, Dr Quadiri etc), who believed that financing of the healthcare should be championed by the medical profession, started the Pan Health Investments Ltd to launch a form of healthcare financing. Unfortunately, it failed because of lack of support.

In later years doctors in the University of Ilorin Teaching Hospital found out that out of the number of patients that are admitted into the hospital only about 10% are able to pay the hospital fees from their pockets. Others obtain the money from relatives, and some sell landed properties. Therefore the problem of inability to pay at the point of healthcare delivery is a major cause of continued morbidity and mortality.

I was able to intervene when as a Commissioner of Health under Governor Alamiyeseigha, we introduced the Bayelsa Health Service Scheme. Three stakeholders were identified in the scheme namely; government, companies and the citizens. Each of the stakeholders made monthly contribution as follows: government N20 million; citizens N200. The scheme provided free healthcare at the point of delivery, free immunization and distribution of bed nets, free treatment at referral centers within the country. The scheme was very successful as shown in the following table.

SUMMARY OF THE BHSS PERFORMANCE STATISTICS MARCH 2001- JUNE 2004

1.	Number BHSS compliant healthcare facilities				24
2.	Number of BHSS subscribers				
	• Civil servants				24, 158
	• Private contributors				<u>77, 410</u>
	Total				<u>101,568</u>
3.	OUTPATIENT CARE				
	• Civil servants and dependents				38,364
	• Private contributors and dependents				<u>31,523</u>
	Total				<u>69,887</u>
4.	INPATIENTS				
	Civil servants and dependents				34,102
	Private contributors and dependents				<u>19,735</u>
	Total				<u>53, 837</u>
5.	SURGERY	MAJOR	SUBMAJOR	MINOR	
	Civil servant and dependents	145	120	518	
	Private Contributors and dependents	<u>140</u>	<u>141</u>	<u>305</u>	
	Total	<u>285</u>	<u>261</u>	<u>823</u>	
	Number of Antenatal care and delivery				14,198
	Number of referral (treated within Nigeria)				53

Surely, there is room for improvement. However, BHSS can form the bedrock of the Healthcare Service of our Dream. People in the urban centers were paying the subscription for their loved ones living in the rural areas. And with just a small additional subscription senior citizens in the rural communities can be cared for by the health visitors, community helpers and even be fed twice a day.

I will like to conclude my talk by dwelling briefly on another factor dear to me. This is the education of the Healthcare Professionals. In 1999 when the civilian government started in Bayelsa state, the number of doctors was

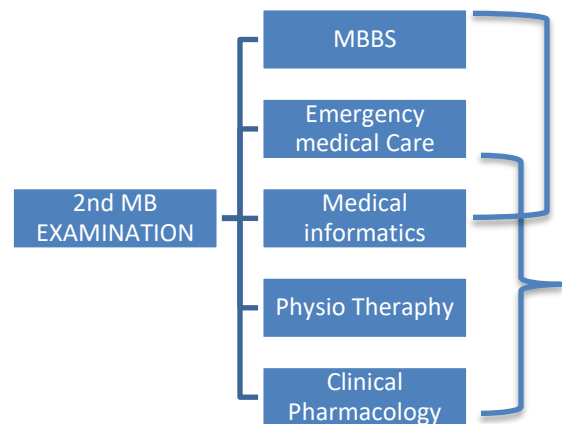
less than 20, number of nurses was equally poor. There were just 3 pharmacists. My team in the Ministry of Health including late Sir Dr Patrick Tekenah, Dr Amaegbe, Mrs Sampou, Pharm Ameri, Dame Dr Okara, Dr Simeni and Dr Kpokiri was determined to start a medical university. It was an innovation and I believe even Professor Osinowo, an innovator himself, will be happy about it. But despite our determination and public advocacy, the opposition was very stiff and we ended up with having the College of Health Sciences. I am happy to mention that the Ondo State government has opened the first Medical University in Nigeria. For their dedication, I will like to thank the pioneer provost, Professor Brambaifa and the college secretary Mr Willabo Apelebiri.

The College of Health Sciences, Niger Delta University is supposed to be highly innovative. It is supposed to value every human life and that is why the motto is “LIFE IS SACRED”. It is not supposed to be just like any other medical school. It is supposed to be a leader in research, innovation and top class service provider. Currently, there are new fields the college can offer leadership in. These include Emergency Medical Care, Medical Engineering, Medical Informatics, Pharmaceuticals and Genomics.

For so long, unknowingly, medical schools have participated in blunting the careers of some of the most intelligent young people in our society. In my days in the medical school, the least WASCE grade in our class was a grade 1(One). Most of us had grade 1(One) distinction. But a lot of students got into the medical school because they were asked or compelled to study medicine. The moment of truth comes after the second MB examinations. Most times those who

fail have their career ruined and yet these are among the best brains. Some finish with BSc Anatomy, Physiology etc.; they have difficulty in securing employment and with the very rigid system of university education, it is tough trying to study another discipline.

Again our dear College of health Sciences Niger Delta University can offer leadership in this area. We must introduce flexibility in the training of healthcare professionals. May I crave your indulgence to suggest the following:



The 2nd MB examination should not be seen as a pruning examination. Rather it should be seen as the stage when the student discovers him or herself. If a student now realizes either through the examination or by self assessment that she would rather be in another profession, such a student should be able to seamlessly transfer to the appropriate discipline and career.

I have fired a shot and I am hoping this will lead to a very healthy debate on how to improve on the training of our healthcare professionals that will lead to the Health Service of our dream.

The stature of Professor Osinowo is such that it is difficult to do justice to his devotion to duty, innovative mind and his passion for academics with a “mere” lecture. Therefore, let me sex it up a bit

by asking you to please rise and give a standing ovation to Professor Olu Osinowo.

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