Public-Private Partnership and sustainable primary healthcare facilities in Nigeria

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PUBLIC PRIVATE PARTNERSHIP AND SUSTAINABLE PRIMARY HEALTHCARE FACILITIES IN NIGERIA

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ABSTRACT

The Nigerian healthcare system is divided into the primary, secondary and tertiary levels of care, which are under the three tiers of government (local, state and federal) with some overlapping of responsibilities. The Federal Ministry of Health (FMOH) develops policies and physical structures, and supervises the operations of the healthcare system. The Primary Health Care (PHC) level has been identified as the appropriate setting to tackle 90 – 95% of major causes of morbidity and mortality because of its proximity to over 80% of the populace. At the PHC level, the services provided include integrated preventive, promotive and community development activities. However, the implementation of PHC in Nigeria has lacked impact and sustainability, thus leading to the research discussed in this paper which is aimed at proposing an innovative procurement system for sustaining PHC facilities in Nigeria. The proposed system is focussed at developing and encouraging a new market for investment in primary care and community-based facilities and services. It is a form of public-private partnership (PPP) that enjoys national support but with local control. One of the central objectives is the idea of bringing together all the various local stakeholders, interests and users that comprise the local health economy. The arrangement is expected to offer considerable social and economic benefits while satisfying the fundamental philosophy of PHC.

Keywords: Community-based, Primary Healthcare, Procurement, Public-Private Partnership, Sustainable.

INTRODUCTION

With the current estimated population of over 140 million and an annual growth rate of about 2.4%, Nigeria has approximately a quarter of Sub-Saharan Africa’s population (National Planning Commission (NCP), 2004). Available data from the Federal Ministry of Health (FMOH) indicates that as at 1999, there were 18,258 registered Primary Health Care (PHC) facilities, 3,275 secondary facilities and 29 tertiary facilities across the country (National Primary Health Care Development Agency (NPHCDA), 2001). The public sector accounts for 67% of PHC facilities, 25% of secondary facilities and all but one of the tertiary facilities (UNICEF, 2001). In Nigeria, the proportion of households residing within 10 kilometres of a health centre, clinic or hospital is 88% in the southwest, 87% in the southeast, 82% in the north-central, 73% in the northeast and 67% in the northwest regions (NCP, 2004). However, the physical existence of health facilities does not necessarily mean that the facilities are functional as most of them are poorly equipped and lack essential supplies and qualified staff (NPHCDA, 2004).

The PHC level has been identified as the appropriate setting to tackle 90 – 95% of major causes of morbidity and mortality (N-wakoby, 2004) because of its proximity to over 80% of the populace. PHC also has the potential to prevent the development of conditions which can lead to hospitalisation at the secondary level, and these considerations informed the focus of this paper at that level of healthcare provisioning. The UNICEF (2001) report observed that the poor state of Nigeria’s health system is traceable to several factors; organization, stewardship, infrastructure, financing and provision of health services. These have been compounded by other socio-economic and political factors in the environment (NPC, 2004).

However, the NPHCDA as part of its activities to revitalise PHC nationwide introduced the ward’s health system (WHS) in 2001 to replace the old district system (NPHCDA, 2004). To date, 320 WHS model healthcare centres have been approved to be built across the six geopolitical zones. Of these, 200 have been completed and handed over to the communities. According to NPHCDA (2004), the objectives of WHS are to:

1. facilitate provision of integrated PHC services;

1 A ward is a geographical constituency with a population of 20,000 – 30,000 people in groups of villages or urban areas, from which a councillor is elected to represent them at local government level. Each local government area (LGA) has about 10 – 15 wards.
2. provide opportunity for NPHCDA to mobilise political support for PHC; and
3. revitalise the principle of community ownership and co-management.

In the procurement process, a consortium of design consultants are commissioned by the NPHCDA to prepare prototype design and tender documents for use in all the sites, and prospective contractors compete for the projects in open competition on a site-by-site basis so that local conditions and peculiarities are highlighted in each package. The design consultants alongside the representatives of the NPHCDA supervise the successful contractors on all the sites. After completion, each project is equipped with clinical facilities worth ₦5 million, drugs for the value ₦500,000.00 and the sum of ₦1.3 million (in cash) is provided for the implementation of community-based PHC work plan.

Statement of Problem
It is still unclear where and how the WHS model facilities fit into the structure of the Nigeria healthcare system. Other compelling questions arising from the planning and implementation of the WHS include:

(1) what is the relationship between the WHS and other secondary and tertiary facilities? For instance, where does the WHS fit into the existing health sector; does it replace the Village Posts or the Primary Health Centre? This is because while NPHCDA (2004) urged stakeholders to recognise and utilise nationally accepted PHC facilities, it supposedly deliberately omitted primary health centres.

(2) what accountability structure is in place to ensure effective use and management of the facilities and funds provided?

(3) what monitoring and evaluation system is in place to ensure smooth running and control of the facilities?

(4) how does the host community of a WHS assume realistic "ownership"; "co-management" and sustenance of a "system" that it did not actively participate in its planning and/or implementation?

(5) how responsive are the facilities to the peculiar needs of the host communities?

(6) are the WHS facilities cost-effective and sited equitably without political influence and manipulations? This is because it doesn’t seem that emphasis was given to LGAs that had no community health centre (CHC) or had theirs converted to hospitals in the siting of the WHS. The questions raised above indicate the extent and complexity of constraints traceable to the new WHS. Therefore, there is a strong case for a further re-examination of the structure, process and function of the WHS including its overall place in the PHC subsystem.

Aim of the Paper
This paper aims to address the issue of community ownership or co-management of the facilities as envisaged by the NPHCDA under the WHS scheme and as enshrined in the PHC philosophy by proposing a public-private partnership (PPP) that will be responsive to the peculiar needs of the host community and have adequate accountability structure for sustaining PHC facilities in Nigeria.

It is believed that the scheme will facilitate Government desire to resolve the problem of financial constraints in the provision of public facilities by involving private management skills to increase the efficiency, effectiveness and quality of services delivery.

Structure of Healthcare Delivery in Nigeria
The organization of health services in Nigeria is pluralistic and complex. It includes a wide range of providers in both the public and private sectors: private for profit providers, NGOs, community-based organizations, religious and traditional care providers. The Nigerian healthcare system is divided into the primary, secondary and tertiary levels of care, which are under the three tiers of government (local, state and federal), although with some overlapping of responsibilities (NPC, 2001). The lowest is the primary health care level and service delivery is through PHC centres. The state governments provide the secondary level of healthcare and the service delivery is through general hospitals (which also provide some primary care). Finally, the Federal government is responsible for tertiary care through highly specialised services in teaching hospitals, specialist hospitals and federal medical centres. However, some state governments also provide tertiary care through state-owned teaching hospitals. These tertiary institutions also provide some PHC services through their general outpatient departments.

The FMOH is responsible for providing the overall policy environment for the operation of the healthcare system in Nigeria. However, as in other sectors, the federal governance arrangement constrains the leverage that the FMOH has over the State Ministries of Health (SMOH). For instance, the FMOH cannot compel the SMOHs to implement its health policies and programmes. This has widened the gap between policy formulation by the FMOH and implementation by States and local government areas (LGAs), and makes stewardship of the health sector very challenging.

Primary Health Care (PHC)
At the PHC level, preventive, promotive and community development activities are integrated as the core services (Egwu, 2004). According to Nwakooby (2004), the three major pillars of PHC are:

1. Equity – this emphasises that people’s needs rather than social privileges should
drive the distribution of opportunities for healthcare and wellbeing. Social privilege is reflected by differences in socio-economic status, gender, geographic location, age and ethnic/religious considerations. Therefore, equity in health care aims to reduce the available gaps in health status and health services.

2. Community participation – in the planning and implementation of system and services. In Nigeria, this has been encouraged through a variety of local government, district health committees (DHCs) and village health committees (VHCs) (FMOH, 1996). It is, however, important to recognise the need for diversity in the interpretation of community participation since community needs, resources and local practices vary considerably worldwide.

3. Inter-sectoral collaboration – this involves making health goals a high priority in the overall development process. The PHC philosophy recognises that the health of a society is closely related to the overall socio-economic situation and the extent of poverty within it (Nvakoby, 2004). It requires the involvement of relevant health agencies so that they work together with the FMOH to meet all the health-related needs of the communities. For example, the involvement of the Ministry of Education in order to raise literacy and educational levels, spread health knowledge and information.

PROBLEMS OF PRIMARY HEALTH CARE SYSTEM IN NIGERIA

It is commonly acknowledged that the implementation of PHC in Nigeria is inadequate and ineffective (NPHCDA, 2001). The shortcomings and constraints of the past strategies include the following.

1. The strategies were not linked to any target community: - FMOH (1996) observed that the health facilities were built without taking into consideration the needs of the target community and were thus ineffective.

2. Inequality in access to health care services: - A close look at the PHC system in Nigeria shows that access to healthcare services has not been equitable. Only very few health centres provide daily or routine immunisation services (Nvakoby, 2004), and great disparity in access to public health exist between the poor and the rich (Uzochukwu et al., 2003), between the rural and urban areas (Uzochukwu et al., 2004b) and between geographical areas (Nvakoby, 2004). Human resources for health is skewed in favour of urban public health facilities and allocation of resources is skewed in favour of curative services at the expense of preventive services (Nvakoby, 2004).

3. There was no agreed pattern of service delivery: - The past strategies for implementing PHC in Nigeria neither had any well formulated pattern of service delivery nor a system for managing them and ensuring the attainment of the desired quality of service delivery (FMOH, 1996).

4. Lack of involvement of local communities in the planning and implementation: - In Nigeria, despite willingness to participate, communities are rarely involved in health activities due to resistance of the health workers (Uzochukwu et al., 2004a). An important issue in community participation is that of remuneration of the committee members (Uzochukwu et al., 2004a) as well as the Village Health Workers (Nvakoby, 2004). This has implications for the sustainability of community participation within the context of PHC since there are personal costs of time and sometimes income associated with participation.

5. Inequitable and misdistribution of PHC facilities: - NPHCDA (2001) reviewed the national pattern of distribution of PHC facilities and stated that a good number of communities did not have functioning PHC centres, majority of the health workers did not possess the appropriate skills or conceptual understanding of the PHC approach as their training orientation often emphasized clinical as opposed to working within communities, remuneration and conditions of service were considered punitive by the workers.

6. Conversion or non-existence of CHC component: - In recent years, under combined political and administrative pressure, a number of CHCs have been converted to general or cottage hospitals. In other cases, CHC may have been planned for but not implemented. In either case, the structural void created by eliminating the CHC component either due to conversion or non-existence has a number of implications:

   a. weakening or total breakdown of the already fragile health referral network as general hospitals are suppose to serve as first-line of referral to the LGA health sub-system via the CHC and so the conversion or non-existence of a CHC introduces
operational and functional complications; b. ownership problems as LGAs are not supposed to run or own hospitals; c. destruction of the World Health Organisation's concept of comprehensiveness of PHC services (WHO, 1981) as these cannot be provided by a hospital; d. dismantling of the CHC promotes unemployment and wrangling amongst the displaced health workers who may be forced to take positions in other health centres lower than the CHC; and e. reduced utilisation of services, as hospitals will cost more than the CHCs and the economic situation will not permit the desired patronage on need basis.

PROPOSED COMMUNITY-BASED PROCUREMENT SYSTEM
Throughout the world, the limitations of capital resources have forced governments to review how to fund the increasing demand and rising expectations of their citizens. This has consequently led to increased involvement of the private sector in the provision of public services. These initiatives have taken many forms, such as outright privatisation of previously state-owned industries (Ng, 2000), contracting out of services, such as refuse collection (Sindane, 2000) or cleaning to private firms and the use of private finance in the provision of social infrastructure (Tanninen-Ahonen, 2000) such as healthcare and water facilities. This idea of bringing in private finance to fund public sector infrastructure originated with the early occurrences of public-private partnerships (PPP) (The World Bank and the International Finance Corporation, 1992). Carroll and Steane (2000) defined PPPs in broad terms to encompass a very wide diversity of partnerships and the circumstances in which they arise as "agreed, cooperative ventures that involve at least one public and private-sector institution as partners". The rationale of PPP is to combine the resources of public and private sectors, in the quest for more efficient service provision. This proposal fits with Government policy to use private sector, where feasible, to increase healthcare investment (NFC, 2004) and is focussed on developing and encouraging a new market for investment in primary care and community-based facilities and services. One of the key objectives is to bring together the various local stakeholders, interests and users that comprise the local health economy. Nonetheless, the public sector retains responsibility for deciding on the services to be provided, the quality and performance standards of these services, and taking on corrective action if performance falls below targets. Under the scheme, a national joint venture, Health Reform Partnership (HRP), should be established between the FMOH (for the PIC, the FMOH should be represented by NPHCDA) and the Public-Private Partnerships Development Venture (PPPDV). The PPPDV should be established as a PPP between the Federal Government (represented by the National Economic Empowerment and Development Strategy (NEEDS) Department of the National Planning Commission) and the private sector with a shareholding of 49% and 51% respectively. The PPPDV should be responsible for improving the development and delivery of PPPs across the Nigeria public sector. Then at each LGA/ward level, a private sector partner (PSP) - a consortium of diverse specialties - should be identified through competitive procurement and local joint ventures (LJVs) established between the local health bodies (comprising of Local Government Health and Social Services Departments, Medical and Para-medical professionals, Voluntary/Community organisations), HRP and the PSP. Each LJV (Health Development Company - HEDECO) should benefit from a long-term partnering\(^2\) agreement to deliver investment and services in local care facilities over contractual period of between 15 to 20 years. Figure 1 shows the structure and shareholding proposed for each HEDECO.

**Figure 1: Structure of HEDECO**
The HEDECOs should be set-up as public-private partnerships in the form of limited liability companies and each should be run by a management board comprising of directors nominated by the shareholders; the PSP, local health community and HRP. A public sector Strategic Partnering Board\(^3\) (SPB) should be formed between the core statutory bodies in the local healthcare community through a strategic partnering agreement\(^4\) to develop strategic service

\(^2\) Development of sustainable relationships between two or more organisations, to work in cooperation for their mutual benefit in the requisition and delivery of works, goods and/or services over a specified period to achieve continuous performance improvement (ECI, 2003).

\(^3\) Public sector board established by shareholders in a local healthcare community, and responsible for monitoring the performance and identifying the future direction of the HEDECOs.

\(^4\) Standard document which establishes the long-term strategic partnering between HEDECO and other participants relating to the delivery of healthcare services in the area.
development plans, incorporating local primary care service needs. The SPBs should also be responsible for monitoring the performance of the HEDECOs and for identifying their future workloads.

The functions of each HEDECO would include the management and implementation of agreed investments and services, the planning of future estate and services requirements to meet the local health economy’s needs, and the development of opportunities identified by the PSP. It should be noted that whilst the public bodies can offer the existing built facilities and land as equity contribution, the ownership of the health facilities built/refurbished by the HEDECOs would be transferred to or acquired by them, and income will come from rentals charged for leasing space to the users (relevant tier of government, private medical practitioners, dentists, pharmacists and other interested voluntary sector tenants).

All projects under HEDECOs should be assessed to demonstrate the achievement of value for money, partly through the competition in the selection of PSP and partly through the Budget Monitoring and Implementation Unit (BMU)'s endorsement during reimbursement of rentals.

The proposed arrangement has strategic advantages over the conventional forms of procurement as it supports long-term investment projects to be prioritised according to local needs and developed using private sector expertise. It also offers considerable social and economic benefits such as social inclusion through involvement in the planning and decision-making processes and the provision of employment and training opportunities for the community people while encouraging co-location of healthcare professionals. The proposal is akin to the NHS LIFT (Local Improvement Finance Trust) scheme under the British health sector but with recognition of the peculiar needs and the local situation in Nigeria. The NHS LIFT is yielding positive results (National Audit Office, 2005) and it is believed that the scheme can also produce good results in Nigeria too. However, the success of the proposed approach will depend on the effectiveness of the local partnering arrangements, and adherence to the on-going value for money assessment and accountability arrangements proposed.

CONCLUSIONS

Literature has indicated that the implementation of PHC in Nigeria in the past lacked impact and sustainability. This paper attempted to address the issue of community ownership or co-management of the PHC facilities as envisaged by the NPHCDA under the WHS scheme and as endorsed in the PHC philosophy. The paper proposed a public-private partnership (PPP) that will be responsive to the peculiar needs of the host community and have adequate accountability structure for sustaining PHC facilities in Nigeria. The system will enjoy national support but with local control and falls in line with the new strategy adopted for growth; the National Economic Empowerment and Development Strategy (NEEDS), the state-level State Economic Empowerment and Development Strategy (SEEDS) and the health reform agenda of the present government. These strategies have variously emphasized the dilution of the approach to improving healthcare delivery through increased private sector participation, whenever feasible.

The proposed system is focused at developing and encouraging a new market for investment in primary care and community-based facilities and services that will lead to long-term contract arrangements. The proposal aims to deliver a step change in the quality of the primary care estate, remedy some of the deficiencies in the existing arrangements; and contribute to delivery of the investment targets identified within the new health reform agenda. One of the key objectives of the method is the ideal of bringing together the various local stakeholders, interests and users that comprise the local health economy. This way, it is expected that the active community participation will offer considerable social and economic benefits such as social inclusion, employment and training opportunities for the community people in addition to the attainment of the fundamental philosophies of PHC provisioning.

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25


