

ENHANCING QUALITY OF HEALTH CARE DELIVERY IN NIGERIA THROUGH PUBLIC-PRIVATE PARTNERSHIP IN HEALTH SECTOR

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Abstract

Despite the investment of public and private sectors in the Nigerian health economy over the years, the performance of the national health systems remains unsatisfactory. The Government, therefore, introduce public-private partnership policy. The question remains: what are the challenges of implementing the National Public-Private Partnership policy in Nigeria, the options and potentials for future partnership? The study reviewed the facilitating and hindering factors of implementation strategies for PPP policy in Nigeria. The study used secondary data, experiences and analysis of stakeholder's meetings. It was found that supplier-driven private sectors will operate parallel to the government sector in a way that serves primarily the financial and professional interests of private providers. The findings also reveal improve conditions of service of the health professionals and other workers in both sectors. This is hoped, will ensure harmonization of opportunities for remunerations, in-service training, security of tenure and advancement in professional status. In spite of the relative success recorded, there were evidence of lack of transparency and politization of the contract process.

Keywords: *Public-Private Partnership, Nigeria, Health Sector, Insurance & Training*

1.0 INTRODUCTION

Despite the investment of public and private sectors in the Nigerian health economy over the years, the performance of the national health systems remains unsatisfactory. The declining resource allocation to health, increasing costs, ever-increasing expectations from the public for better services and the breakdown of equipment at the public health services appears to have worsened the situation. All

these problems plus the desire to expand the choices available to patients prompted the policymakers to search for effective solutions.

One of the key challenges has always been the absence of effective mechanisms to combine different skills, expertise and other resources within an effective policy framework of defined responsibilities, roles, accountability and transparency for a common goal – improvement of the health status of Nigerians.

The National Policy on PPP developed in November 2005 through a nationwide consultative process has been approved by the National Council on Health. The policy was developed with the context of NEEDS, HSRP, MDGs, National Health Policy (2004), National Health Bill (2004), Reviewed National Health Insurance Scheme (2003) and blueprint for Revitalization of the primary health Care (2004). The policy highlights the features that will ensure that both sectors complement each other in achieving national health sector objectives (FMOH 2005). The key principles for effective PPP action in the health sector are that: Governments (Federal, State and Local) share the obligation to ensure an enabling environment for the entire spectrum of (public and private) health provision. This obligation goes side by side with the parallel responsibility for, ensuring that all people are protected from harmful health practices and have rights as consumers of health services. Effective partnerships among private sector institutions, civil society organizations, and governments will allow the fulfillment of their social expectations without compromising core missions. All formal (contractual) partnerships shall be based on written agreements specifying the purpose, duration, and exit arrangements. Partnership agreements shall clearly state the rights and obligations of all stakeholders. Such rights and obligations shall be enforceable. Best practices shall be encouraged /rewarded based on the potential to improve upon the quality of care provided. While for-profit institutions have a right (or an obligation) to make a profit, this has to be balanced against the equally important considerations of ensuring safety quality, and equity. PPP shall be recognized as a process which requires perseverance, regular attention, and maintenance. There shall be ongoing communication/interaction on health issues by all stakeholders in the public and private sectors.

As part of such interactions and consultation, private sector organizations shall have opportunities to contribute towards the planning and implementation of the policy. There shall be decentralization of powers by government and acceptance of the expanded role of the private sector and the community. Part of the wider governmental obligations will include the provision of basic amenities such as water supply, environmental sanitation, and power supply. Other features of the policy include various financing options, provision of care, regulatory framework, human resources for health, roles and responsibility of stakeholders as well as monitoring

and evaluation for effective PPP. The research questions include: What are the pattern and scope of existing collaborations including the size, characteristics, growth and distributions of stakeholders in the health sector? What are the challenges of implementing the National Public-Private Partnership policy for Nigeria? and What are the options and potentials for future partnership?

The main objective of the study is to review the facilitating and hindering factors of implementation strategies for PPP policy in Nigeria. With specific objectives to:

- ✓ Discuss the contracting in the health sector, payment methods, price setting mechanisms and effective monitoring of the contracted service.
- ✓ Identify facilitating factors of Public-Private Partnership
- ✓ Examine the existing characteristics of public-private partnership
- ✓ Discuss the financing options and provision of health services in PPP
- ✓ Identify legal and regulatory interventions for PPP
- ✓ Examine challenges associated with PPP in the health sector

2.0 LITERATURE REVIEW

Public-Private Partnership (PPP) is not a panacea for all the problems in the health sector. There are challenges that need to be overcome in the implementation of PPP. In the absence of effective policy implementation, supplier-driven private sectors will operate parallel to the government sector in a way that serves primarily the financial and professional interests of private providers. As a result, tendencies towards inequity and allocative inefficiencies are likely to be exacerbated as private health sectors expand and greater reliance is placed on them. Hence, the government needs to establish procedures and mechanisms for effective mediation between providers and consumers. This is required to reconcile conflicting interests. The National Health Insurance Scheme NHIS, if effectively implemented, could offer the best chance of playing an effective mediation role. The mediation consists of using financing and payment systems to bring about better integration of the public and private health sectors. Thus, the entire health service delivery system operates on an integrated system. This could also serve to bring these two sectors together so that the comparative advantages of each sector are maximized.

Contracting payment methods of PPP

In contracting, payment methods, price setting mechanisms and effective monitoring of the contracted services are very essential and should complement one another. Similarly, the length or term of the contract is very important. It is essential to ensure that the term or duration of the contract is not too long as government/policymakers may find themselves in the position of buying services, which they no longer want, or

services that are out of the model. But it is equally important to note that PPP ventures have to span sufficient duration for the contract to be worthwhile. What is needed is to ensure that the contract stipulates review processes for relevance. Furthermore, the policy of permitting private practice in public hospitals should also be constantly reviewed to avoid gross abuse. In addition, developing (whether in-house or accessing externally) the necessary expertise for early identification of PPP opportunities and establishing procedures that enable the effective evaluation and delivery of PPP services would be desirable.

Challenges Associated with Contracting

Although the policy has the potential of motivating medical doctors and increase revenues, it stands the risk of generating demand for similar incentives by other categories of health professionals working in the hospital. In Osun State, there is evidence of local government authorities contracting out immunization to the private sector while in Anambra, Benue, Plateau and Nassarawa there are private sector vaccine distributions. Despite the relative success recorded, there was evidence of lack of transparency and politicization of the contract process. For contracting out to be a feasible option, the public sector must have the managerial capacity to handle the contracting process and, equally important, there must be adequate capacity in the private sector to fulfil the contract.

Facilitating Factors of PPP

a. To ensure a robust partnership, adequate considerations should be given to the existing disparities between the health professionals in the two sectors. In this connection, the conditions of service of the health professionals and all workers in both sectors would have to be reviewed to ensure harmonization of opportunities for remunerations, in-service training, the security of tenure and advancement in professional status.

b. The policy implementation strategy should encourage and maximize private sector (as provider) participation in the health sector for efficiency and effectiveness to achieve the national socioeconomic goals. The private sector investments should be protected through appropriate legislation such that it will not be subjected to the manipulation of any government in power. In addition, there might be need to review, amend, repeal as the case may be any existing law that put a restriction on the way of an effective PPP and this should include taxation laws.

c. All the regulatory structures need to be reorganized and strengthened. For example, the Director of Hospital/Medical Services in all States of the Federation has under his control all primary and secondary health care facilities in that State. One of

the responsibilities of the directorate is to periodically inspect and assess all the institutions (public and private) to ensure that standards are continually kept for quality assurance. This is currently not effectively discharged and should be strengthened. It is hoped that the National Health Bill that was passed into law listed condition for the establishment of the National Hospital Services Commission, which is expected to supervise, monitor and evaluate all tertiary health institutions. (Atoyebi 2005)

d. The Nigerian entrepreneur should be encouraged to be socially responsible and to imbibe the culture of corporate governance and best global practices. In this regard, it should be mandatory for all profit-making organizations to donate not less than 0.5% of their profit to the establishment of the Health Trust Fund. This will assist the funding of health services. The fund should be managed by an independent body with membership from private, public, and voluntary organizations (Ogundipe 2005).

e. In addition, certain manufactured commodities such as cigarette, alcohol, wines and other luxury goods with health externalities should attract Health Tax of not more than 5% of their cost price. This will provide ample capital to supplement money generated from other sources to cater to the health needs of all Nigerians.

f. The governments, on their part, should create enabling and competitive environment to facilitate access of Nigerian entrepreneur to SMEIS Funds as well as long-term finance in the financial and capital markets. Like the Bank of Industry and Agricultural and Cooperative Bank, the government may set up Health Care Development Bank (HCDB) for financing health care projects. Governments should provide the take-off grant and provide the enabling environment for its operation. The Private health sector will be able to access HCB and obtain loan at reasonable rate of interest.

Existing Characteristics of Public-Private partnership

Presently, the provision and financing of health services and drugs are through an informal and uncoordinated division of responsibilities between public authorities and private organizations, all undertaking activities in accordance with their mandates or motivations. This division of responsibility constitutes a poorly defined partnership in which the outcomes desired by different parties have never been explicitly negotiated. This kind of arrangement is not responsive to the specific health needs of the urban poor and majority of rural population. For a long time, inequalities in access to health have been recognized as intractable problems that require not just better coordination of roles but also new ways of working together in order to achieve a synergistic combination of the strengths, resources and expertise of the different sectors (Widdus, 2001).

3.0 METHODOLOGY

The study used evidence and information of literature search, review of reports, publications, interview, materials and secondary sources. It also involved information from participatory meetings, maximizing opportunities for different stakeholders to present their experiences and views.

4.0 RESULTS AND DISCUSSION

In this regard, this study examines the features of existing public-private partnerships in Nigeria. The focus is on the partnership between government agencies on the one hand and private for-profit and private-not-for-profit on the other. The category of not-for-profit organizations is diverse, including international organizations, national voluntary associations, religious bodies and other community self-help groups in the financing, provision and regulation of health care services. Non-profit organizations including the faith-based often provide a means to reach the poor and other target populations. This comparative advantage comes from the historical pattern of development, their closeness to communities, and their ability to harness volunteer activity.

Financing and provision of Health Services

Given the mixed systems of health service delivery, financing and provision is a joint responsibility of all the stakeholders in the health sector. However, it is useful to distinguish between the financing and provision of health services in the context of public-private partnership (WHO 1991).

First, health services are publicly financed and provided in Nigeria, similar to countries like Namibia, South Africa, Sri Lanka and Spain. The Federal Government finances public sector tertiary services, state governments finance public sector secondary hospital services, and local governments support public sector primary health care. The federal government with the collaboration of other private-not-for-profit organizations also intervenes at the PHC level through a number of vertical programs and parastatal agencies.

Secondly, health services are also privately financed and provided. There are numerous private health facilities established across the country for consumers who have the ability and willingness to pay. This is the use of various payment mechanisms for private service provision (fee for service, insurance etc). Specifically, it could also take the form of private health care funded by private health insurance, third party employer payment schemes, or Health Maintenance Organization (HMOs) under the National Health Insurance Scheme (NHIS). Private health insurance has been very limited and vulnerable to increasing health care costs.

In 2001, it was reported that only four private health insurance companies were operating in the country, with the largest covering around 18,000 people (Alubo 2001). However, a more stable economic and political climate may have facilitated a rebound in private health insurance as part of employee benefits and catering to higher-income households. The University of Ibadan National Health Account exercise estimated that spending by private health insurance totalled 1,3836 million Naira in 2002, equivalent to around US\$100 million as compared to one-third of this in 1998.

NHIS is a government-sponsored social contract written into law and financed through mandated contributions from wages and salaries of employees in the civil service. This scheme covers employees working in the formal sector and their dependents. This scheme is limited by the small number of people in formal employment. HMOs are comparatively new in Nigeria. In the USA, HMOs have grown rapidly because they offer a health care delivery and payment system alternative to the private indemnity health insurance that has historically dominated the American health marketplace. Members of HMOs agree to pay a monthly or annual subscription rate in return for the right to receive specified benefits directly from the health providers associated with the HMOs. However, there are differences between HMOs operating in the USA and in Nigeria. In particular, those in Nigeria do not have sophisticated statistical procedures used to profile doctor performance because the environment is still at the rudimentary stage of managed care development.

In totality, private health insurance and HMOs cover around 2 per cent of the populations in Nigeria. Although the population coverage of HMOs is growing rapidly in Nigeria, it is doubtful that they would be interested in, or capable of, covering substantial proportions of the population particularly the rural communities. Hence the demand for community financing schemes including community-based health insurance. The private health insurance and HMOs supplement the benefits offered through established NHIS rather than serve as a substitute.

Thirdly, there are examples in Nigeria of the coexistence of private finance with the public provision. As already indicated, health insurance - private or social – is currently being used to purchase private health care as well as public health care. The consideration here is for user charges or fees in the context of the public provision of health care. At all levels of health systems in Nigeria, fees are charged for selected services or certain types of patients. This may include consultation, accommodation, maternity, surgical procedures etc. The objectives of charging patients include raising additional money, improving efficiency and increasing the quality of care.

The reality in Nigeria is that use of fees in tertiary and secondary hospitals cannot by any stretch of the imaginations, be relied on to make a significant contribution to the growth of health services. However, at a lower level of the system, fee income may be a more substantial percentage of expenditure. Though small in aggregate, such money can be vital when retained locally and spent on urgent priorities. In principle, where certain services are expected to be free particularly for children and pregnant mothers, in practice users are increasingly bearing some of the costs of publicly provided services. This is because shortages of supplies and drugs are dealt with by effectively imposing the responsibility for buying these items on the user. Giving a patient a prescription in place of the medicine is, in effect, making the patient responsible for payment in order to receive treatment. Therefore, people have demonstrated a willingness, reflected in the growth of the private sector, to incur charges for better services. Another example of private financing with public provision is the establishment of private wing/wards in Nigerian public hospitals, particularly at the tertiary level. For example, University College Hospital in Ibadan currently operates a private room in each ward and has embarked on the construction of a separate private wing with hotel features using the internally generated revenue. This is targeting consumers who have preference for quality services as well as the ability and willingness to pay. This will also provide access to other healthcare providers outside the public system for the use of the facilities. Other tertiary hospitals in the country are in the process of establishing similar private wing.

Fourthly, a number of public hospitals have introduced the policies of using public finance to purchase private services. In this regard, “contracting out” has been the most commonly tried. This means that government purchases a service from an outside source that provides the service using its own workforce and resource (e.g. University of Ilorin Teaching Hospital, Jos University Teaching Hospital and University of Maiduguri Teaching Hospital). In “Contracting In” government can also hire outside managers to come in and manage an internal workforce or service. The results of these policies have been varied according to the service which has been contracted. The evidence from State consultations on PPP in 2005 shows that the provision of catering, security, cleaning and laundry and mortuary services by private firms appears to be relatively successful. Examples of these are found in some of the tertiary and secondary facilities located in States like Bauchi, Oyo, Borno, Taraba, Yobe, Lagos, FCT, Niger, Imo, Ogun, Gombe and Enugu. Some of these States have also contracted out clinical services in orthopaedic surgery, internal medicine and psychiatry. Another similar scheme that is widespread across public hospitals in the country is the intramural practice. Governments in Nigeria saw the harmonization of income for doctors working in the public and private sectors to be one of the principal challenges in handling the public/private partnership. The governments are now taken steps, on a hospital-by-hospital basis, to encourage public physicians to work privately in government hospitals after normal working hours.

There are numerous legislations in Nigeria, aimed at improving health services. Legal and regulatory policies can affect the costs and availability of inputs needed by private providers, the prices of the services they produce, the quantity and distribution of private services, and the quality of services. The Medical and Dental Practitioner's Act No. 23 of 1988 was also promulgated to establish the Medical and Dental Council of Nigeria for the registration of medical practitioners and dental surgeons and to provide for a disciplinary tribunal for the discipline of members. It also made provision to limit the influx of quackery. The pharmacist Act No. 26 of 1964 also provided for the registration of pharmaceutical chemist, stressing the criteria of good character. The regulation also includes among others, restricting the dispensing of certain pharmaceuticals without a physician's prescription. Regulation in this area is still ineffective because drugs that should be available only with a physician's prescription are often easily obtainable over the counter (Matazu 2005).

The National Drug Law Enforcement Agency Act No. 48 of 1989 provided an appropriate penalty in respect of unwholesome dealing in drugs. The penalties cover offences for engaging in the production, manufacture, extraction, preparation, offering, offering for sale, importation or exportation of any narcotic drug or any psychotropic substance. Another legislative instrument for quality control is the National Agency for Food and Drug Administration Control (NAFDAC) created through the enactment of Decree No. 15 of 1993. This decree controls and regulates the manufacturing, importation, exportation, distribution, advertisement, sale and use of food, drugs, cosmetics, chemical/detergents, medical devices and drinks including pure water.

The scope of this mandate puts the responsibility of safeguarding public health on the Agency. This is similar to the United State Food and Drug Administration. Despite the commendable performance of NAFDAC, drug manufacturing standards are still difficult to completely enforce and monitor as spurious drugs are often widely available. However, between April 2001 and December 2004, NAFDAC destroyed counterfeit products (drugs, medical devices etc) worth 4billion Naira (US\$35 million). Consequently, the Agency efforts have led to renewed confidence and increased patronage of Pharmaceuticals products in Nigeria by other West African countries.

There is also the Standard Organization of Nigeria (SON) which was created through an Act No. 56 of 1971 to undertake an investigation as necessary into the quality of facilities, materials, and products in Nigeria, and establish a quality assurance system, including certification as factories, products and laboratories, etc. Also with the establishment of Consumer Protection Council in Nigeria, legal interventions may also include laws empowering consumers to take actions against providers for malpractice. It is also worth mentioning the campaign being carried out by the

FMOH concerning the dangers of tobacco smoking. Despite this campaign, the rate of cigarette smoking is alarming, hence the need to strengthen collaboration between FMOH, Federal Ministry of Information and the Tobacco industries in Nigeria.

In Nigeria, direct price regulation is not used for health care services by private physicians or hospitals. However, the government should consider regulating private sector prices through price-setting for comparable public-sector services. Where there is effective competition between public and private providers, this can serve to moderate private provider behaviour. This intervention is effective in Malaysia (Berman 1997). Effective regulation requires sufficient government capacity to collect and analyze information, devise sound rules, monitor and enforce compliance. Capacities in these areas are weak in Nigeria. Underpaid civil servants may lack zeal in enforcing regulations. Courts of law may also not be very effective in providing rapid and consistent remedies. With the existing regulatory structure, there are ample opportunities for corrupt practices between the regulators and the regulated.

5.0 CONCLUSION AND RECOMMENDATIONS

The challenge of the coming years will be in finding mechanisms to harness the energies of the private sector to support public sector efforts to promote national health objectives. With the increasing pace of national economic reform, the private health sector is growing in size and complexity. This growth has also been triggered by increasing levels of income, coupled with health insurance and other forms of collective financing arrangements. With this trend, the private sector is likely to overtake the public sector in size and importance in many areas of health service delivery.

It is recommended, therefore, that there is a need for more research and sharing of experiences in terms of growth and effects of private sector participation in the Nigerian health sector. Some of the lessons from other environments that would be useful for consideration for PPP initiatives include developing a strategy for pre-empting public complaint and suspicion and the setting of a framework for dealing with unsolicited bids. Others involve the formation of a partnership with experienced private operators with proven track records and contracting with an emphasis on the transfer of skills.

The public and private sectors would also need to collaborate to improve quality by supporting innovation, improving the information for quality monitoring, enhancing clinical and administrative management capacities, and reviewing national programs and project support. However, it may require new approaches to sharing information, experiences and learning about various options within and outside Nigeria.

To ensure consumer satisfaction, the government should enact appropriate consumer protection laws aimed at protecting consumers from monopolistic and unfair business practices that are direct consequences of market deregulation/privatization. However, governments are not without their failures. Bureaucratic management of diverse and dispersed health care facilities has often resulted in disappointing outcomes. For these reasons, there is a need for governments to strengthen the management of health care delivery at all levels.

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