STRENGTHENING THE COORDINATION OF PUBLIC PRIVATE MIX ACTIVITIES BEYOND DONOR FUNDED PROJECT LIFE SPAN

By

Iorwa Apera

National Coordinator,

National Social Safety Nets Coordinating Office (NASSCO)

Federal Ministry of Humanitarian Affairs Disaster Management and Social Development.

Context

Nigeria's health sector has an annual deficit running into almost US$10 billion (N3.86 trillion) in health infrastructure gap[1], with an increasingly insufficient annual budget to cater for the growing population. This situation naturally creates a niche for the private sector to plays a significant role in the delivery of complementary health services, bringing with it; expertise, technology, infrastructure, and innovations. The programmatic response to the gap is the public private mix for health care delivery[2]. PPM represents a comprehensive approach for systematic involvement of all relevant health care providers to promote the use of International Standards to achieve national and global health care delivery targets.[3] According to the Federal Ministry of Health, the public – private sector mix stood at 73.1% for the public sector and 26.9% for the private sector[4].

[1] Economic and Financial Review, Central Bank of Nigeria, Volume 53, Number 4, December 2015. https://www.cbn.gov.ng/out/2018/rsd/volume%2053%20number%204%20december%202015.pdf

[2] Wells WA, Uplekar M, Pai M (2015) Achieving Systemic and Scalable Private Sector Engagement in Tuberculosis Care and Prevention in Asia. PLoS Med. 12(6):e1001842. 3

[3] Uplekar M (2016) Public-private mix for TB care and prevention: what progress? what prospects? Int J Tuberc Lung Dis. 2016 Nov;20(11):1424-1429.

[4] Nigeria Health Facility Registry, accessed on 13 August 2021; https://hfr.health.gov.ng/

Public-Private Mix (PPM), therefore, represents a comprehensive approach for systematic involvement of all relevant health care providers to promote the delivery of quality health care. PPM encompasses diverse collaborative strategies such as public-private, public-public and private-private mix (e.g. between an NGO or a private hospital and the neighborhood private providers, etc.). This collaborative strategy framework represents a joint partnership approach or a stand-alone niche service. Where the partnership framework is activated, the approach aims to solve development problems through a coordinated and concerted effort between government and nongovernment actors, including companies and civil society, leveraging the resources, expertise, or market efforts to achieve greater impact and sustainability in development outcomes.

While the understanding of the public-private sector health delivery mix is important, it is equally important to appreciate the ability and willingness of the population to pay for services, in order to more appropriately position the services of the private sector. To this extent, I will dwell more on the Nigerian poverty profile, and then come back to the issues of the health delivery challenges from the perspectives of the individual, as well as from an institutional framework.

Nigeria is regarded as one of the resource-rich countries in Africa[5], as well as the poverty capital of the world[6] with about 40.1 % of the population living below the poverty line (equivalent to about 82.9 million Nigerian[7] (NBS/NLSS 2019)), which is the highest number of people living in extreme poverty in any country. A substantial proportion of its population (53.3%) is multidimensionally poor while an additional 17.5 per cent are near multidimensional poverty[8]. Nonetheless, there is conspicuous inequality in the distribution of poverty between the geopolitical regions in the country, with northern states and rural areas, on the average, being the worst hit. The northern states average between 87% – 43% poor per state, while the southern States average between 4.5% - 40%.[9] Public healthcare financing is thus challenged by this poverty profile.

An Overview of the NSR

[5] https://oxfordbusinessgroup.com/overview/emerging-giant-its-rich-history-great-economic-potential-and-abundant-resources-nigeria-looks-future
[6] World Bank, 2014; International Monetary Fund – IMF, 2018;
[7] National Bureau of Statistics (NBS) – Nigeria Living Standard Survey (NLSS) 2019.
[8] OPHI, 2017
[9] NBS, NLSS 2019

The National Social Safety-Nets Coordinating Office (NASSCO) has the mandate to register and document poor and vulnerable Nigerians. This responsibility was codified under two instruments, the National Social Protection Policy, and the National Social Safety-Nets Program (NASSP). Under the NASSP, NASSCO has built the most comprehensive National Social Register (NSR) of poor and vulnerable households in Nigeria. The social register is the main tool used by Nigeria to select poor families for provision of social assistance. It collects details, which can be used by various social programs to lift people out of poverty and to improve human dignity. As of end of July 2021, the NSR has the record of 8,903,637 poor and vulnerable households, equivalent to 37,722,192 individuals across the 36 States of the Federation and the FCT. It has coverage across 714 Local Government Areas, 9,334 wards, and 91,883 communities.

When COVID-19 struck in March, 2020, there were only 2.6 million poor and vulnerable households (PVHHs) registered into the national social register. Since then, NASSCO has added about 5.3 million more PVHHs. The designed approach for the identification and registration of poor and vulnerable households rely on a rigorous and systematic process involving geographic and community-based targeting. This meant that based on the poverty index within each state, the rural areas became prioritised – since there were more poor people in the rural areas. As a result, the data of PVHHs in the NSR is largely made up of people from rural. For this reason, during COVID, NASSCO designed the NASSP scale-up strategy that used innovative technology-based approach to rapidly identify and register urban poor informal workers. This process involved the identification of urban poor clusters based on

scientific validated methods of satellite/remote sensing technology, machine Learning Algorithm and big data from survey and ground truthing to delineate urban and rural wards. Once the urban wards were properly delineated and validated by the States, through the State Operations Coordinating Office (SOCU), USSD codes were transmitted through masts located in such wards targeting dweller in urban slums. The urban poor, would have been sensitized through multiple communication channels, including town criers to respond to the USSD messages. The data, thus, received was structured and validated through home visits to update the additional fields required to assess the eligibility of the respondents. This whole process was christened the Rapid Response Register.

The Rapid Response Register aims to urgently identify and capture excluded groups, made vulnerable by the economic impact arising from the COVID-19 pandemic and to establish a shock responsive framework for reaching vulnerable Nigerians in times of shock. Through this system, the Federal Government has been able to transfer cash to beneficiaries through an end-to-end digital cash transfer to beneficiary accounts. With this process Nigeria has been able to establish the Shock-Responsive Social Protection Framework for future emergencies.

Health Care delivery for the poor

The National social register has 138 variables including age, health status, disability and disaggregated by types of ailment. This database is available for the use of anyone interested in extracting the data as evidence for informed decision making; strategy design, plan and actions directed at lifting people out of poverty or simply providing more appropriate health care promotion, and service delivery.

More recently, through our engagement with the National Health Insurance Scheme, launched in 2005, NASSCO learnt that NHIS covers less than 10% of the Nigerian population leaving the most vulnerable populations at the mercy of health care services that are either not affordable or not available – meaning that the most vulnerable populations in Nigeria are not provided with social and financial risk protection. Poor people constitute about 40.1 % of the Nigerian population (NBS, NLSSS 2019). They lack of access to basic health services, denies the most vulnerable rights to social and financial risk protection. Nonetheless, we learnt that by the provision of allocation under the Basic Healthcare Provision Fund, the NHIS was required to identify and register informal poor workers for support under the State Contributory Health Management Agencies/State Health Insurance Schemes, and to provide social and financial risk protection by reducing the cost of health care and providing equitable access to basic health services.

The most vulnerable populations in Nigeria include children, pregnant women, people living with disabilities, elderly, displaced, unemployed, retirees and the sick. Although these vulnerable groups sometime benefit from free health care services and exemption mechanisms, they largely have to pay for health care services. Free health care services and exemption mechanisms are often politically motivated, poorly implemented, do not become fully operationalized, and sometimes only last a few years. Out of pocket payments for health care services limit the poor from

accessing and utilizing basic health care services, hence, the low coverage of basic health services for the poor.

Reliable access to high-quality medical laboratory services is essential for the successful prevention, diagnosis, and treatment of disease. Lagos State University Teaching Hospital (LUTH) laboratory, is the first hospital with an ISO 15189 accredited laboratory. Despite significant government and donor investments to improve the quality and coverage of diagnostic services in resource-poor settings, many medical laboratories are overwhelmed by high patient volumes, limited capacity, which create bottlenecks in the scale up and decentralization of national health services, especially in remote rural areas. Governments, the public health community, and health service providers themselves have long acknowledged the need to strengthen diagnostic and laboratory monitoring services as an essential component of improving health service delivery for the populace. However, laboratory managers and policymakers are often confronted with limited, expensive, and complicated options for strengthening and expanding laboratory services. In settings where the private health sector offers sufficient human, logistic, or equipment capacities to deliver laboratory services, public-private mix (PPM) mechanisms may be employed at the national or local level to strengthen the provision of laboratory services. Again, this clearly indicates the role of the private sector in complementing the role of government.

Strengthening the Public – Private Sector Mix and Coordination Mechanism

It is government vision to provide ready access to good-quality basic health care for all citizens according to need, regardless of their socioeconomic situation, and specifically to provide mechanisms and provisions to protect the poor, the most vulnerable and the disadvantaged. To do this, there is a need to develop closer coordination and integration between the public sector, private for-profit providers and nongovernmental organizations (NGOs).

It is thus necessary to assess the nature and extent of current private sector involvement in health; institute effective means of promoting private sector partnership; and establish appropriate instruments to facilitate and regulate the private sector in line with existing national laws and regulations. However, only a small amount of official data is available for a small number of registered private health facilities, which are mainly in urban areas. Little is known about the majority

of unregistered and unrecognized facilities, thus making it difficult for the government to formulate appropriate health policies.

Coordination would, therefore, necessarily have to start from the Guild by enforcing government regulatory framework to facilitate the ability of the Guild and Government's Health Management Department to more appropriately document service providers. This goes for all health delivery services.

Challenges

There is no gain saying that the private sector clearly has a niche to fill in health care delivery, and by extension the diagnostic services. Nonetheless, the overall system is challenged by weak and ineffective coordination of the numerous stakeholders in the health sector. More important is the poor use of evidence for planning and policy-making, across board.

It is obvious that the private health sector is also challenged. It is small, undercapitalized, underdeveloped and fragmented in its operations. Where demand for private services exists, ability to pay is often insufficient to cover medically necessary services.

To put it more clearly, there is really a low awareness of the existence of the Social Register that could help potential investors define their clientele and negotiate with government for the provision of services to the vulnerable.

Currently, the private provision is dominated by traditional healers, clinics and drug shops, in that order, spread over all geographical areas. These very small, individually-run private health facilities offer mainly "first aid" services to low-income users in what must be a fairly competitive market.

The multiplicity of providers increases access and choice for patients, and in the case of emergencies a good number of lives are saved. However, the duplication of underfunded facilities has probably decreased the efficiency and standard of services. Most private providers have resorted to treating minor ailments which are common in the area, and sell drugs of the type and in quantities that patients can afford. These practices promote undertreatment and irrational drug use and in many cases, ultimately increase the cost of services to patients.

Funding is a major constraint on the development of the private health sector. The major sources of initial finance for the private sector are personal savings and support from friends and relatives. The lack of access to larger, formal loans considerably limits the expansion of individual facilities. The increasing numbers of patients seeking health services in the private sector nevertheless suggests that well organized investment, which facilitate improvements in efficiency, quality and administration might be money well spent.

To this extent, it calls for a more organized private health sector to deal with primary health care delivery, possibly through organized associations to facilitate supervision and monitoring. The way to go would be to source funding through syndicated loan, and venture capitalist. Government might also provide some finance, and streamline policy and regulations governing the private health sector if approached with a well-defined franchise system. Ultimately, however, investments in this area will only be worthwhile if community incomes improve across many variables including ability and the willingness to pay.

Otherwise, the cycle of poverty in the health sector continues, driven by the purchase ability. Equally, the low incomes of public health workers, which forces them to set up private facilities, the uncertain gains from private practice because of inconsistent demand for services, and the poverty of consumers/patients are essential ingredients of an ill-functioning health care system. Over time, these factors would develop an integrated relationship, of either a virtual or vicious cycle.

Prospects

There remain a number of positive features of the private health sector. Private health facilities are more geographically accessible, and open for long hours. They offer a range of commonly required services – dental, maternity, postnatal, outpatient, inpatient, health education, laboratory and *traditional healing* services. Moreover, problems are said to be solved more quickly in the private health facilities. Although expense is a barrier, many people travel long distances to visit a specific, highly desired private provider.

The Federal Government's health policy under the Economic Recovery & Growth Plan 2017-2020, provides a niche for negotiation. As with the private sector objectives, the ERGP aims to improve the availability, accessibility, affordability and quality of health services by increasing access to primary health care services, expanding health coverage and improving the quality of the services provided. This can only be achieved with the collaboration of a better organized private sector.

Conclusion

To conclude, information outlined in the Nigerian Economic Recovery & Growth Plan 2017-2020, Nigeria's healthcare system still does not provide the level of service required to meet the needs of its population. The Economic Recovery & Growth Plan 2017-2020 summarizes several reasons for the poor performance of the country's healthcare services. These include insufficient financing, inadequate and inequitable access, weak supply chain management, limited human resource capacities and insufficient coordination, cohesion and accountability.

For the private sector, and despite its shortcomings, the private sector relieves government of the burden of providing everything for the population. As such, the private health sector is a service rather than a business venture. Though the government openly recognizes and appreciates the private sector's contribution to the health system, it interacts with private health-sector operations purely as a business venture. Government's main concerns thus surround issues of taxation, drug supply and licensing. The limited explicit government support for the private health sector has significant policy implications.

The way to go in achieving the long-term vision of government and the private providers therefore is to aggregate and partner with government by meeting the minimum organizational standards needed to collaborate effectively.

Notes

1. Nigerian Medical Association and the PPP Lullaby (Anyanwu, Ebere)
2. The Sorry State of Nigerian Health Sector and the Agitation for a 21st Century Comprehensive Healthcare
3. Delivery System in Nigeria. (Benjamin Ogbebulu).
4. Ufuoma John. E. Accelerated reforms in Healthcare Financing; the need to scalp up Private Sector Participation in Nigeria, International Journal of Health Policy and Management. PMCID:3937949.
5. The Future of Healthcare in Africa , A report from the Economist Intelligence Unit sponsored by Janssen, EIUjanssen
6. –Healthcare Africa-Report-web. Accessed 12: 23:12:15.
7. Philippe Burger, Ian. H, National Policy on Public Private Partnership for Health in Nigeria, Federal Ministry of Health Secretariat. November 2005.
8. Peter A. Berman, "Rethinking Health Care Systems: Private Health Care Provision in India." *World*
9. *Development* 26:1463-1479 (1998). Public Private Partnership- the answer to Nigeria infrastructure problem? www.howemadeitnafrica.com/public-private-partnerships-the- answer- to-Nigeria's infrastructure –problems/, accessed 06:18:12:15.
10. John T. Dunlop, Public Private Partnership: Problem and Opportunities, National center for Biotechnology information, www.ncbi.nim.nih.gov/.
11. Buse, K. and G. Walt, Global Public-Private Partnerships: Part II –What are the Health Issues for Global Governance? (Bulletin of the World Health Organization, 2000, vol. 78, no. 5.
12. Buse, K., and G. Walt, Global Public-Private Partnerships: Part I – A New Development in Health*?* (Bulleting of the World Health Organization, 2000, vol. 78, no. 4,
13. Birdsall Nancy, and Estelle James, "Health, Government, and the Poor: The Case for the Private Sector" World Bank Policy Research Paper, (1992).
14. https://amity.edu/UserFiles/admaa/70a2bPaper%203.
15. https://core.ac.uk/download/pdf/234657515.
16. https://socialprotection.org/discover/blog/health-care-nigeria-challenges-and-recommendations.