The Nigerian PBF Approach to Contracting Using State Actors

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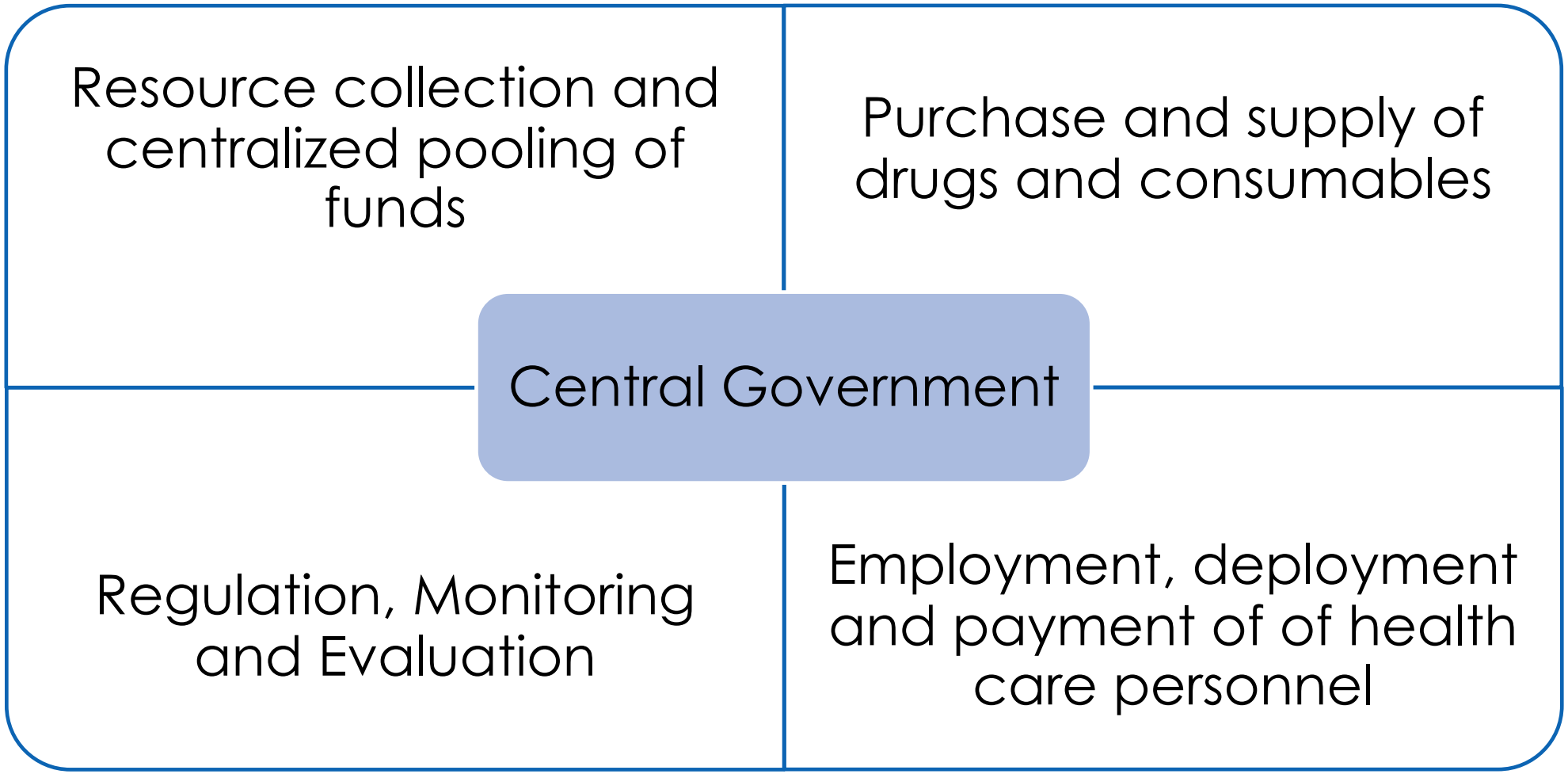
Governance of the Nigerian Health System

- Decentralized into three tier structure with responsibilities at the Federal, State and Local Government

- All three are involved in major health systems functions – leadership & governance, financing and service provision

  - Federal – Policy and technical support to the overall health system and provision of health services through tertiary and teaching hospitals
  - State – regulation and technical support to PHC. Provision of services through secondary hospitals
  - LGA – Primary Health Care

Nigerian Health Care System



Traditional Centralized Input Financing

NIGERIA'S HEALTH INDICES

Indicator	2003	2008	2013	2015 MDG target
Infant mortality rate (per 1,000 live births)	100	75	69	30
Under-5 mortality rate (per 1,000 live births)	201	157	128	60
Maternal mortality ratio (per 100,000 live births)	800	545	576	260
Births attended by skilled health personnel	36%	42%	38.1%	100%

- Health indices in Nigeria have missed the 2015 MDG targets
- Especially MNCH indicators

PHC REFORMS AND POLICIES

National Strategic Health Development Plan (2009 -2015)

- An explicit objective of Nigeria's health sector reform - Broaden financing options to expand and improve access to affordable and adequate healthcare to a majority of Nigerians
- PHC system is almost moribund, mostly due to poor funding and challenges with human resources
- Most common health problems could be tackled through a well functioning and funded PHC system
- Re-energising the Primary healthcare (PHC) system and financing reforms are major planks of the National Strategic Health Development Plan (NSHDP)

PRIMARY HEALTH CARE UNDER ONCE ROOF (PHCUOR)

- Thus, in 2011, the National Council on Health adopted the "Bringing PHC Under One Roof" (PHCUOR) guidelines for the integrated management of PHC level services to advance PHC reforms as stipulated in the Health Policy of 2004.
- The Nigeria National Health Policy of 2004—as revised in 2011—prescribed the establishment of SPHCDBs, primarily saddled with the responsibility "for the coordination of planning, budgeting, provision and monitoring of all PHC services that affect residents of the state."
- The proposed PHCUOR policy was designed to ensure a unified structure across states and a coordinated management of PHC systems and services within states.

RESULTS-BASED FINANCING THROUGH THE NIGERIA STATE HEALTH INVESTMENT PROJECT

OVERVIEW OF NSHIP

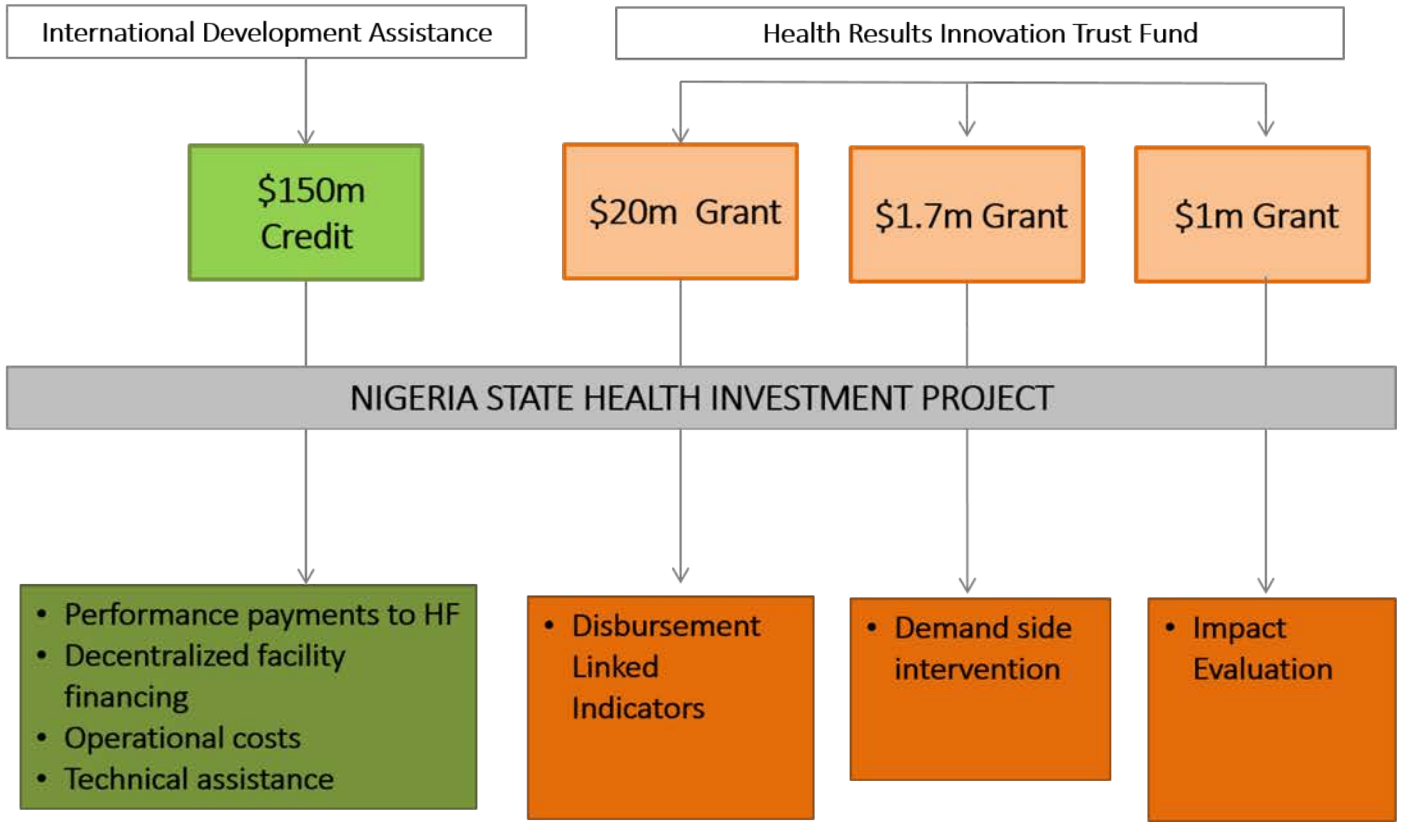
NSHIP seeks to provide managerial autonomy to health facilities whilst strengthening accountability mechanisms at the LGA Primary Healthcare Authority and State Primary Healthcare Development Agencies through a collective package of institutional and operational level results based financing approaches.

Project Development Objective:

To increase the delivery and use of high impact maternal and child health interventions and to improve the quality of care at selected health facilities in participating states.

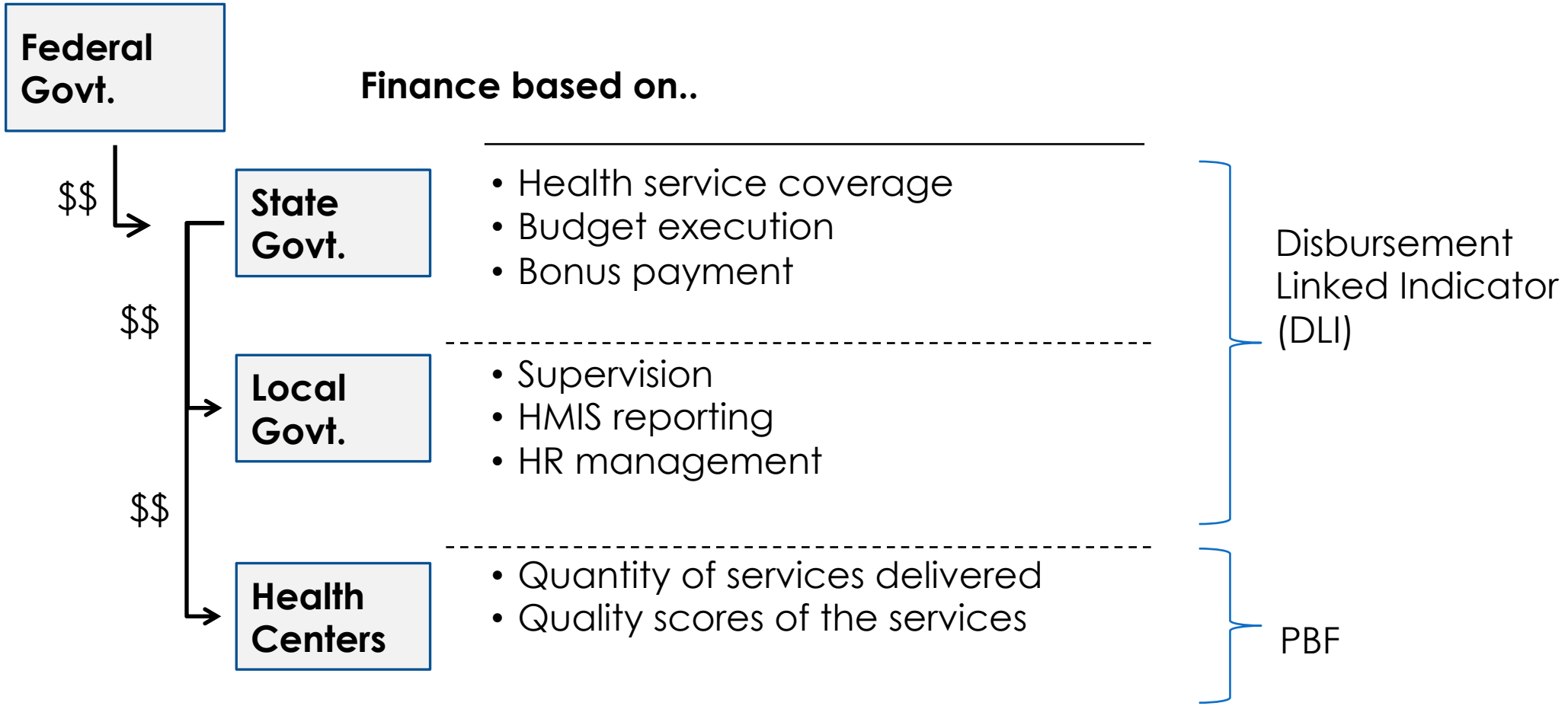
NSHIP FUNDING SOURCES

NSHIP is funded from two different entities of the World Bank Group (WBG)



The government pays for results at multiple levels supported with rigorous internal and external monitoring

Results Based Financing approach in Nigeria:



Implementing States

World bank supported MNCH project on PBF in partnership with the Nigerian Government

In 2011, NSHIP began in three Pilot States in Nigeria which were selected based on:

- Health needs
- Willingness of their State governments to test out results-based approaches
- They serve as representatives of their geopolitical zones with significantly different levels of performance in health indicators

The three pilot States are:

1. **Adamawa State in the North-Eastern zone**
2. **Nasarawa State in the North-Central zone**
3. **Ondo State in the South-Eastern zone**

GoN has adopted a 'Contracting-In' model for Performance Based Financing to health facilities

Performance Based Financing Models

'Contracting-in'

- **Internal market** created for government to purchase services from its own, non-profit and for-profit facilities
- Contracted non-state actors or co-opted CSO to **strengthen Government services – Technical Assistance**
- **Technical and financial support** from development partners

Examples:
- Nigeria
- Democratic Republic of Congo
- Rwanda
- Burundi

'Contracting-out'

- **Non-state actors contracted** to provide certain services
- **Contractors have full responsibility** for the delivery of services, employment of staff, management
- By-passes publicly financed healthcare system

Examples:
- Afghanistan
- Senegal
- Haiti

How PBF works: the 11 best practices

Separate the functions	of regulation, provision, fund disbursement, contract development & verification and community empowerment;
Stimulate competition	for contracts among facilities and other stakeholders;
Promote public-private partnerships	with equal treatment of public, religious and private providers;
The roles of the regulator	at national, regional and district level are to define output, quality and equity indicators. The regulator also costs out public budget with equity bonuses for vulnerable regions, facilities and individuals.
Providers are autonomous	to hire and fire, set user fees and respond to government defined packages and patient or consumer demand

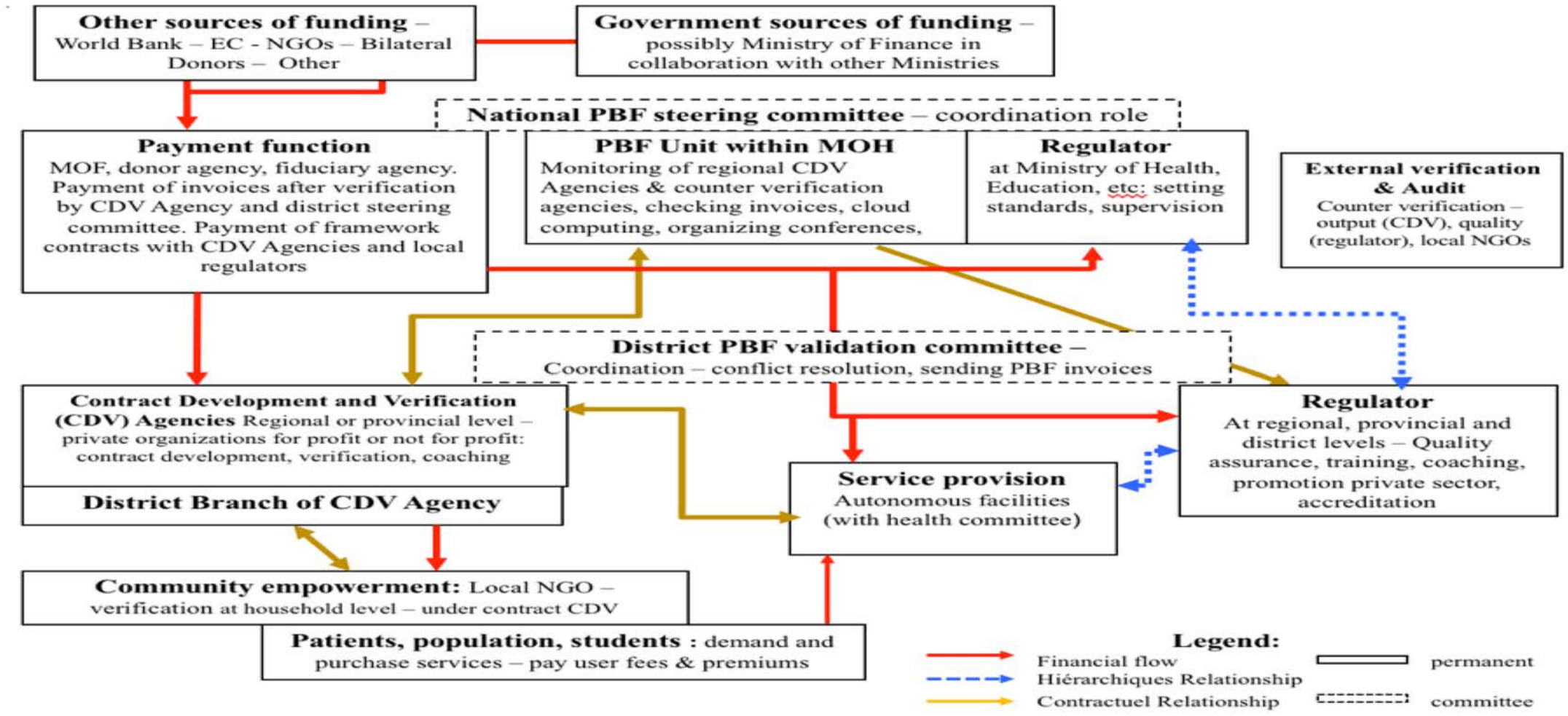
Adapted from SINA Health Manual 2018

How PBF works: the 11 best practices

Revenues and expenditures are balanced	while providing quality and equitable services with motivated staff at the risk of non-renewal of contract and bankruptcy;
Contract development & verification (CDV)	negotiate contracts, verify results and coach managers to use business plans and indices instruments;
enhance patient interests	Local community groups enhance patient interests and health facilities conduct social marketing;;
Promote efficiency and cost containment by CDV agencies and government	Cash rather than inputs paid to health facilities. Facilities must have the free choice to purchase their inputs from independent distributors operating in competition;
Economic Multiplier effect	
Extend the PBF system	• towards other sectors than health.

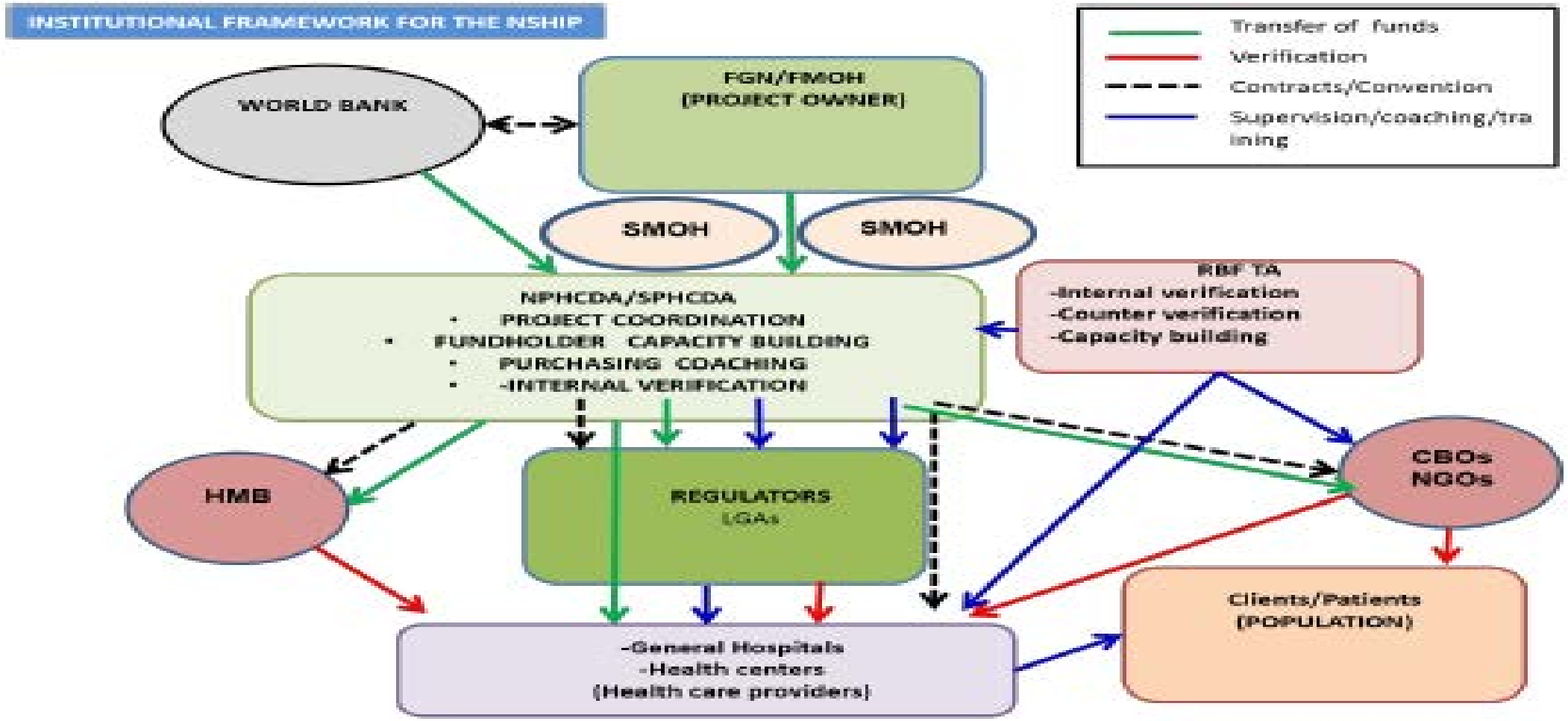
Adapted from SINA Health Manual 2018

A Prototype Institutional Design of PBF Systems



Sina Health manual 2018

NSHIP Institutional Framework



Measuring NSHIPs Implementation Fidelity

Conceptual Framework

- Our study was based on the implementation fidelity analysis framework of Carroll et al. (2007)

- Implementation fidelity is "the degree to which . . . programs are implemented . . . as intended by the program developers"

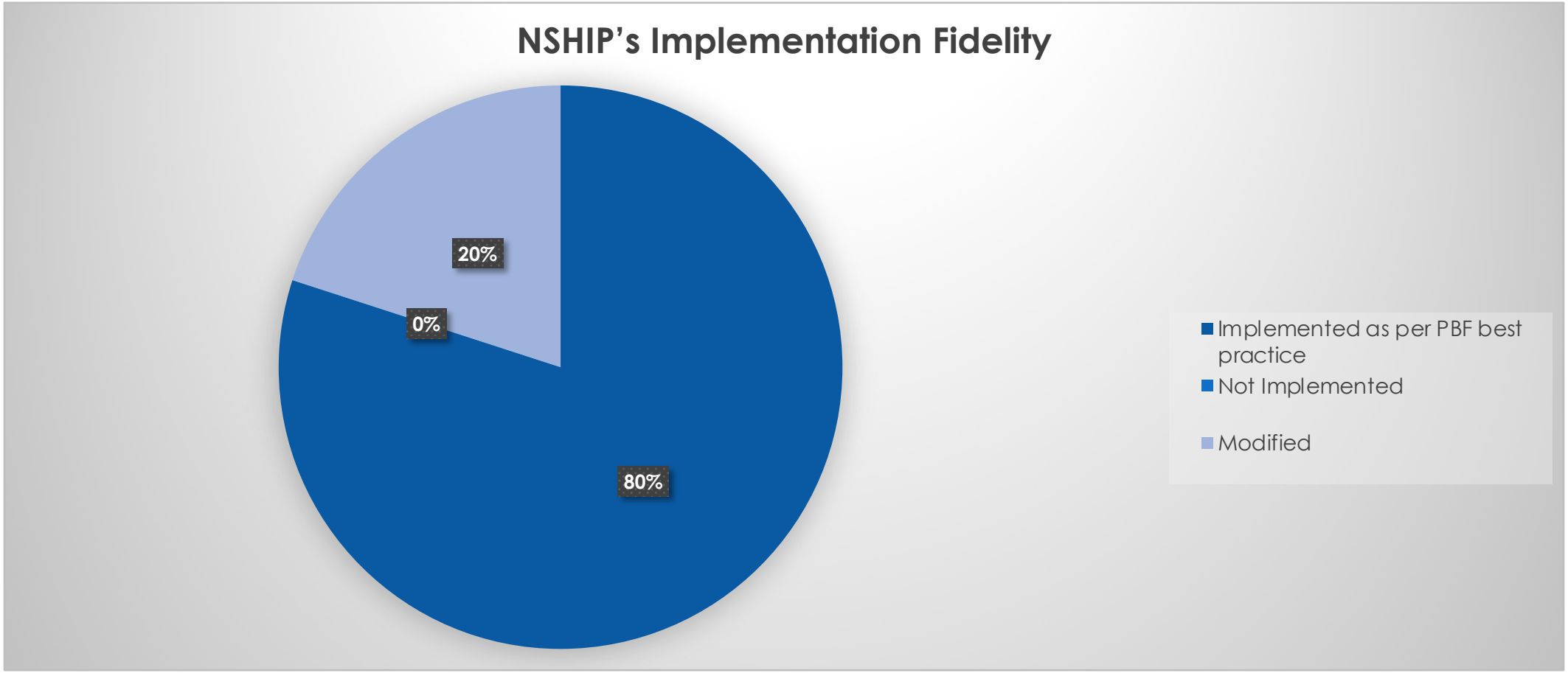
Measuring NSHIPs Implementation Fidelity

- Using Design and Implementation Characteristics fundamental to good governance in PBF through separation of functions
- Measured around the 5 key distinct functions and key players

Measuring NSHIPs Implementation Fidelity

The Distinct Stakeholder Functions of PBF Key Players			Content Fidelity		
Function	Best practice recommended Institutions	NSHIP	Implemented as per PBF best practice	Not Implemented	Modified
Provision	HFs (Primary and Secondary)	HFs (Primary and Secondary)	✓	x	x
Regulation	MoH	MoH	✓	x	x
Purchasing	CMVA/CDA	SPHCDA/B	x	x	✓
Fund holding	MoF	MoF	✓	x	x
Community Voice	CBOs	CBOs	✓	x	x

Results


NSHIP's Implementation Fidelity
20%
0%
80%
Implemented as per PBF best practice
Not Implemented
Modified

The Nigerian Advantage to Using State Actors

- There was a strong project ownership by the FGN which implemented the project to suit country policies.
  - The first was lodging the PBF project in the National and State institutions. The agencies were pre-existing entities in at National and Regional level, and in States where they weren't, they were mandated by law to.
- Alignment with and adaptation to, the specific, local institutional context
- This is a strong advantage seen through the Nigerian model to build local capacity and strengthen the existing institutions (Odutolu et al. 2017).
- Autonomy at every level of the health system allowed institutions, all the way down to the PHC facilities, to take managerial decisions, including how to allocate funds, thus avoiding the inefficiencies of central bureaucracy

Governance Challenges

- Overlapping roles and conflict of interest – no clear separation of functions
- A major difficulty with the contracting in approach is bureaucracies in the system. The PIU were not independent and every activity could not go through without official administrative authorization from hierarchy.
- Weak capacity especially at district levels

Lessons learnt

- The need for appropriate design and implementation vital for obtaining good results in PBF programs Institutionalization
- Implementation of the NSHIP reinforced the emergence of PHC accountability in Nigeria, as envisioned in the PHCUOR policy
- In the three implementing States, there's been an increased accountability link between State agencies (SPHCDBs) and National (NPHCDA) levels. This also facilitated NPHCDA's role in providing regular technical assistance to the SPHCDB

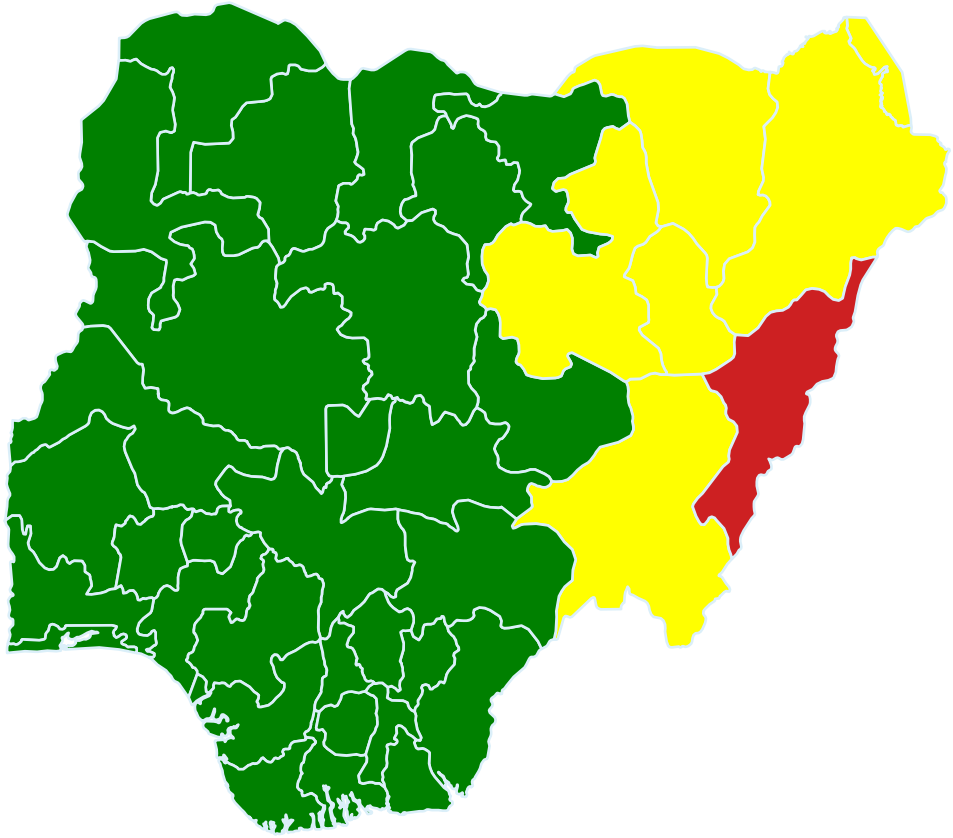
Where are we now?

- Through the support of the NSHIP project, all three states have developed a strategic plan for health (2016) that looks at building on the experiences of implementing a PBF system alongside other key programs and leveraging them in the long term for better sector results.

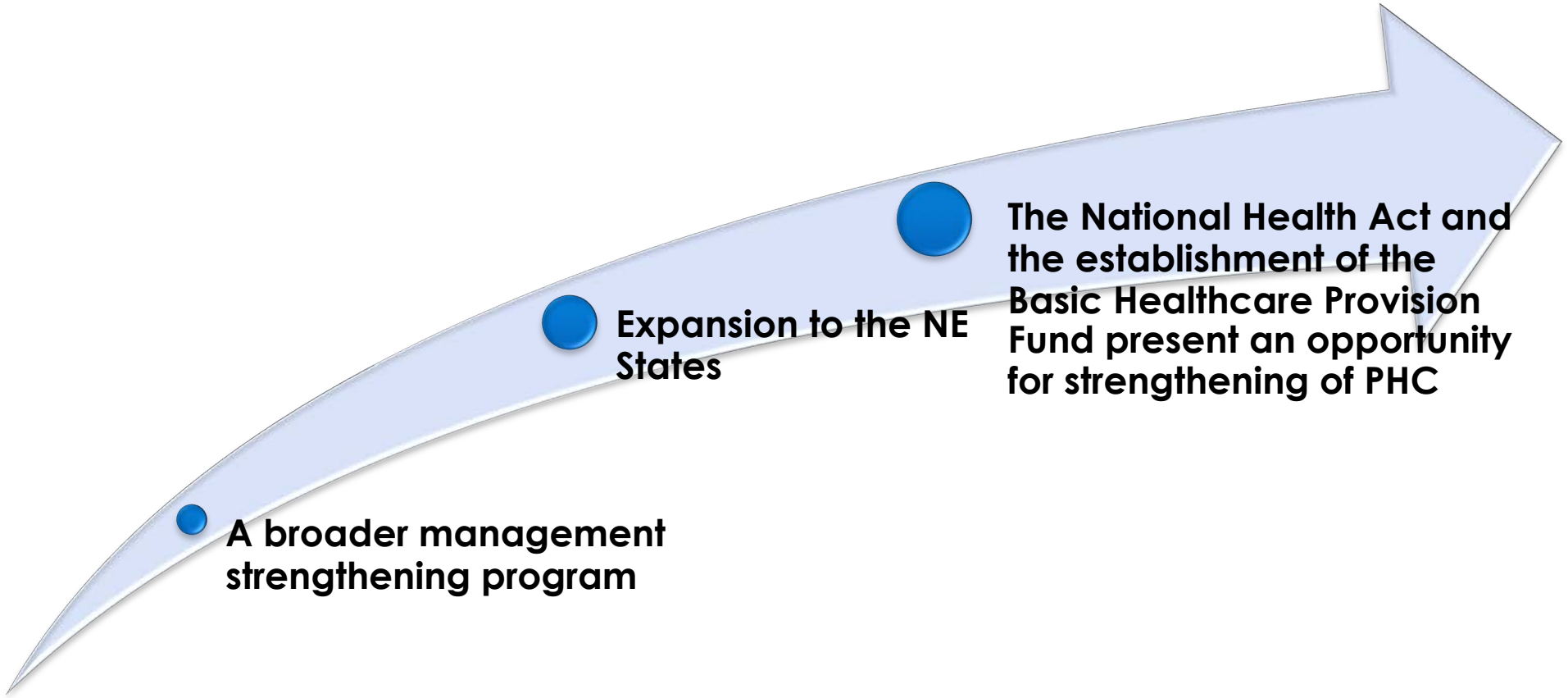
- Sustainability.. including it to government policies such as the BHCPF, State Budget as seen in Nasarawa

Next Steps – Expanding PBF To The Nigerian North East

- AF NSHIP
- Separation of Functions
- Use of indigenous firms
- Use of Higher Institutions for Counter verification



THE FUTURE OF PBF IN NIGERIA



Thank You

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