Original Article

Constraints, Challenges and Prospects of Public-Private Partnership in Health-Care Delivery in a Developing Economy

Anyaehie USB[1,2], Nwakoby BAN[2], Chikwendu C[2], Dim CC[1,3], Uguru N[4], Oluka CPI[5], Ogugua C[6]

[1]Departments of Physiology, [2]Community Medicine, [3]Obstetrics and Gynecology and [4]Health Management, College of Medicine, University of Nigeria, Enugu Campus, Enugu State, Nigeria, [5]Enugu State Health Board, Enugu State, Nigeria [6]Department of Medicine, Medway Maritime Hospital, Gillingham, Kent, UK

Address for correspondence:
Dr. Ugochukwu S Bond Anyaehie, Department of Physiology, College of Medicine, University of Nigeria, Enugu Campus, Enugu State, Nigeria.
E-mail: bond.anyaehie@unn.edu.ng

Abstract

Background: In Nigeria, concerns on the quality and financing of health-care delivery especially in the public sector have initiated reforms including support for public-private partnerships (PPP) at the Federal Ministry of Health. Likewise, Enugu State has developed a draft policy on PPP since 2005. However, non-validation and non-implementation of this policy might have led to loss of interest in the partnership. **Aim:** The aim of this study was to provide evidence for planning the implementation of PPP in Enugu State health system via a multi-sectoral identification of challenges, constraints and prospects. **Subjects and Methods:** Pre-tested questionnaires were administered to 466 respondents (251 health workers and 215 community members), selected by multi-stage sampling method from nine Local Government Areas of Enugu State, Nigeria, over a study period of April 2011 to September 2011. Data from the questionnaires were collated manually and quantitative data analyzed using SPSS version 15 (Chicago, IL, USA). **Results:** Only 159 (34.1%, 159/466) of all respondents actually understood the meaning of PPP though 251 (53.9%) of them had claimed knowledge of the concept. This actual understanding was higher among health workers (57.8%, 145/251) when compared with the community members (6.5%, 14/215) ($P < 0.001$). Post-PPP enlightenment reviews showed a more desire for PPP implementation among private health-care workers (89.4%, 101/113) and community leaders/members (55.4%, 119/215). **Conclusion:** PPP in health-care delivery in Enugu State is feasible with massive awareness, elaborate stakeholder's engagements and well-structured policy before implementation. A critical challenge will be to convince the public sector workers who are the anticipated partners to accept and support private sector participation.

Keywords: Enugu, Government, Health-care, Public-private partnership, Reform

Introduction

It will be difficult for Africa to come close to reaching the millennium development goals (MDGs) if it continues "business-as-usual" in the health-care sector.[1] Likewise, Nigeria is currently facing several challenges in meeting its health related MDGs.[2] Most African countries structure the delivery of government provided health services as a hierarchy – from small peripheral units to larger clinics and a referral chain is expected to link the facilities. In theory this should provide an optimal mix of service provision but in practice this rarely works out, partly because organizations and people do not behave the way planners expect them to and the hierarchy provides no clear roles for privately owned institutions that handle a significant proportion of the population. It has thus been deduced that one of the key factors responsible for the unsatisfactory national health status is weak and ineffective coordination of the numerous stakeholders and active participants in the health sector.[3] Another important challenge in Nigeria's health-care system is the lack of use of evidence for planning and policy making.[4] Evidence shows that a lot of the services in many African countries are provided

Access this article online

Quick Response Code:

Website: www.amhsr.org

DOI: 10.4103/2141-9248.126615

by the private sector.[1] Though the private sector does not provide many of the services that the public sector offers,[1] but the critical question remains thus: Does government commit adequate resources to the running and functioning of these health facilities? (HF) Other key questions are: Does government has enough political will and commitment to ensure optimal health service provision for the citizenry? And to what extent does the government interface with the private sector including Civil Society Organizations and faith-based organizations in health service provision? These questions expose the crucial gaps in the current system, which the public-private partnership (PPP) seeks to bridge.

PPP refers to the establishment of on-going relationship between public and private actors; so far, evidence supports such interventions in all aspects of the economy and it has been shown to have a positive impact on health-care delivery in areas where it is practiced.[1,5] Already the private sector plays a significant role in delivery of health services in Nigeria, serving both urban/rural as well as the rich and poor.[3] Though there is no conclusive evidence that private sector offer significant price variation,[1] they are preferred because of responsiveness to consumer preferences and accessibility. Interestingly, some PPP initiatives domiciled in public health institutions are already thriving at the Lagos State University Teaching Hospital and National Orthopedic Hospital, Igbobi, both in Lagos, Nigeria.[6]

In Nigeria, achieving the objectives of good health outcome, equity, patients and providers' satisfaction is very challenging.[4] As part of efforts toward promoting partnerships in health-care as a strategy for improving health service delivery in Enugu State, Partnership for Transforming Health Systems-1 (PATHS-1) project piloted a PPP project for the provision of emergency obstetric care plus + in the state in 2005 between the government and an FB Health Institution in Emene, Enugu.[7] This was a test project, which had a reasonable degree of success. PATHS-1 also supported the state to develop a draft PPP policy.[8] In furtherance to that the new PATHS-2 program has sensitized the Enugu State Ministry of Health (SMoH) adequately on PPP and facilitated the establishment of a PPP unit in the SMoH, including a technical working group to support it.[9] Non-validation of the policy and implementation of PPP may have led to loss of interest and may have been a consequence of not appreciating the challenges and constraints initially. Challenges and constraints with reforms usually differ from place to place and the shortcoming in many reforms in Nigeria is not being specifically designed to meet with indigenous challenges. Based on the belief that the prevailing issues of poor access and quality of health-care in Enugu State could be improved through the adoption and implementation of PPP, this study aimed at a multi-sectoral identification of challenges, constraints and desirability of implementing PPP in Enugu State health-care delivery system. The study hopes to present evidence for planning and policy making for PPP in the state, which is expected to improve the scope and quality of services, improve the government's capacity to meet other developmental needs as well as serve as a model for PPP implementation in other States of Nigeria and sectors of the economy.

Subjects and Methods

The study was a questionnaire based cross-sectional study of health workers and community members selected from Enugu State of Nigeria by multi-stage sampling technique. The study period was from April 2011 to September 2011. In the first stage, 9 (53.0) Local Government Areas (LGAs) (3 urban and 6 rural) were selected from the 17 LGAs in Enugu State by stratified random sampling based on the rural – urban population distribution in the state. In the second stage, a sampling frame was developed for each category of HF (primary health-care centers [PHCs], private health-care centers and FB HF) for each selected LGA. Afterward, a quarter of HF was selected from each frame by simple random sampling. In the third stage, two sampling frames were developed for each facility (one for medical practitioners and the other auxiliary staff (nurse/midwives/community health extension worker [CHEW]). For each HF, one-half of the study population on the frame for medical practitioners and a quarter of that of other staff were selected by simple random sampling. In this sampling stage also, a quarter of all members of Facility Health Committees (FHCs) for each selected PHCs was selected by simple random sampling and a union leader of each town in which each selected PHC was located was recruited. Furthermore, included in the sample population were Directors of Ministry of Health and members of Health Board of the State. In all, pre-tested questionnaires were administered to the following three pre-defined categories of respondents.

Public health-care workers

Directors of the SMoH, members of State Health Board and staff of the PHCs in selected LGAs.

Private health-care workers

Medical doctors and auxiliary health workers from FB and privately owned health institutions in selected LGAs.

Community leaders/members

Members of FHCs of selected PHCs and leaders of town union.

Data obtained from respondents included their demographic characteristics (age, gender, occupation, educational attainment, etc.), preferred health-care service points with reasons, understanding of PPP, identification of challenges and constraints after enlightenment on PPP, identification of the role and willingness to support PPP in the state.

Data from the questionnaires were collated manually and quantitative data analyzed using SPSS version 15 (Chicago I1, USA). Results were presented as simple frequencies and percentages. Test of significance between variables was done using Chi-square test with significance set at $P < 0.05$.

No ethical issue was identified and the study was an approved Master of Public Health degree project of the College of Medicine, University of Nigeria Enugu Campus.

Results

Table 1 shows that most of the respondents were community members/leaders (46.2%, 215/466), males (63.1%, 294/466) and had educational attainment above primary education (90.3%, 421/466). Furthermore, a significant proportion of health workers had tertiary education compared to only 5.6% (12/215) of community leaders.

Table 2 shows that only 80 (17.2%) respondents would prefer to utilize a government hospital while a majority of respondents (41.9%, 195/466) chose FB HF as their most preferred point of service. In all, 298 (64.0%) respondents would prefer either a private or FB HF as a point of health service. A significant proportion (34.9%, 75/215) of community members/leaders demonstrated confidence on either patent medicine dealers (PMDs) or herbalists.

Table 3 shows that a significant firm understanding of PPP was demonstrated by public health workers and private health workers compared with community leaders/members ($P < 0.001$). In all, only 159 (34.1%) of respondents actually understood the meaning of PPP though 251 (53.9%) respondents had claimed understanding of the concept.

Table 4 shows that most respondents (61.4%, 286/466) would desire PPP implementation in Enugu health system and a significant proportion of these were private health workers. On the other hand, only 19.5% (91/499) were against its implementation and a significant proportion of these (71.4%, 65/91) were public health-care workers. Furthermore, after enlightenment on PPP, many (37.2%, 80/215) of community leaders/members remained un-sure of their desire.

Table 5 shows that all groups of respondents felt PPP would improve service delivery.

Table 6 shows the concerns of different groups of respondents with respect to implementation of PPP in the health system of the state. Community members felt that PPP might lead to abandonment of public institutions as well as loss of jobs by public servants.

Table 7 shows a fair understanding of roles of the different groups of respondents in the effective implementation of PPP in the state.

Table 1: Some demographic characteristics of respondent

Categories of respondents (*n*=466)	Age		Sex (%)		Highest educational attainment (%)			Percentage of respondents' categories
	Range	Mean (SD)	Male	Female	Primary	Secondary	Tertiary	
Public health workers (*n*=138)	29-58	37.3 (2.1)	69 (53.6)	64 (46.4)	12 (8.7)	72 (52.2)	56 (40.6)	29.6
Private health workers (*n*=113)	26-62	40.1 (2.0)	81 (71.7)	32 (28.3)	1 (0.8)	32 (28.3)	80 (70.1)[x]	24.2
Community members/ leaders (*n*=215)	31-66	41.2 (2.6)	139 (64.6)	76 (35.4)	34 (15.8)	169 (78.6)	12 (5.6)	46.2
All (*n*=466)	29-66	38.2 (1.9)	294 (63.1)	172 (26.9)	47 (10.1)	273 (58.6)	148 (31.8)	100

[x]Significant at *P*=0.05, compared to other categories of respondents. SD: Standard deviation

Table 2: Health service delivery points of preferences for self

Categories of respondents	Public health workers (*n*=138) (%)	Private health workers (*n*=113) (%)	Community members/ leaders (*n*=215) (%)	All (*n*=466) (%)
Private clinics	31 (21.7)	44 (38.9)	28 (13.0)	103 (22.1)
FB hospitals/clinic	48 (34.7)	60 (53.1)	87 (40.5)	195 (41.9)
Government hospitals	49 (35.5)	6 (5.3)	25 (11.6)	80 (17.2)
Others, e.g. PMDs, herbalists	10 (7.1)	2 (1.7)	75 (34.9)[x]	87 (18.7)

[x]Significant at *P*=0.05, compared to other categories of respondents. PMDs: Patent medicine dealers, FB: Faith-based

Table 3: Assessment of understanding of PPP of respondents

Responses	Public health workers (*n*=138) (%)	Private health workers (*n*=113) (%)	Community members/leaders (*n*=215) (%)	All (*n*=466) (%)
Yes	98 (71.0)	104 (92.0)	49 (22.8)	251 (53.9)
No	12 (8.6)	8 (7.1)	86 (40)	106 (22.7)
Not sure	28 (20.3)	1 (0.9)	80 (37.2)	109 (23.4)
Actual	67 (48.6)[x]	78 (69.0)[x]	14 (6.5)[x]	159 (34.1)[x]

[x]Significant at *P*=0.05, compared to yes values. PPP: Public-private partnerships

Table 4: Assessment of post-enlightenment desire of implementation of PPP

Responses	Public health workers (*n*=138) (%)	Private health workers (*n*=113) (%)	Community members/leaders (*n*=215) (%)	All (*n*=466) (%)
Yes	66 (47.8)	101 (89.4)	119 (55.4)	286 (61.4)
No	65 (47.1)	10 (8.8)	16 (7.4)	91 (19.5)
Not sure	7 (5.1)	2 (1.8)	80 (37.2)[x]	89 (19.1)

[x]Significant at *P*=0.05, compared to other categories of respondents. PPP: Public-private partnerships

Table 5: Identified likely advantages of PPP implementation in Enugu state

Public health-care workers (*n*=138)	Private health workers (*n*=113)	Community members/ leaders (*n*=215)
More choices for patients	Improved service delivery	Increase choices
Reduced cost to government	Improved capacity utilization	Improved service delivery
Possible improvement in service delivery	Better health indices	More jobs in the private sector

PPP: Public-private partnerships

Table 6: Identified likely problems with PPP implementation in Enugu state

Public health workers (*n*=138)	Private health workers (*n*=113)	Community members/ leaders (*n*=215)
Job losses in public sector	Un-cooperative civil servants	Cost
Abuse	Cost to public	Abandonment of public institutions by government
Poor monitoring	Government policy inconsistency	Loss of jobs in public sector
Cost to public		

PPP: Public-private partnerships

Table 7: Identified role of the different segments toward effective PPP implementation in Enugu state

Public health workers (*n*=138)	Private health-careworkers (*n*=113)	Community members/ leaders (*n*=215)
Cooperating with private participants	Offering services	Service utilization
Ensuring compliance with any rules		Prompt payment for services
Monitoring		

PPP: Public-private partnerships

Discussion

This study showed that most of the respondents completed secondary education indicating a fairly educated study population. There was no significant difference between the age ranges of the different categories of respondents, though males constituted a significantly higher population except among the public health-care workers. This may be due to predominant preference of females for auxiliary health workers profession and CHEWs who in most cases are the most senior personnel in the PHCs in the state.[10] Conversely, more males are involved in the private health practice and are predominant in the FHCs from where many respondents were selected from private health-care workers and community members respectively.

Many of the respondents would prefer to use either the faith-based (FB) centers or private facilities, instead of government owned centers [Table 2]. This supports the reported lack of confidence for public health institutions despite the availability of more trained personnel in many places. The few that preferred public institutions may be due to reasons including a wider range of services, assumed lower cost and availability of trained personnel at some government centers. This assumption suggests that a good percentage of the citizenry will benefit from any step that can improve the quality of staff and reduced the cost of service at either the private or FB HF. This reported goodwill enjoyed by the private health sector needs harnessing with a view to improving health-care delivery. A PPP arrangement may also support capacity availability at the private clinics and may overtime reduce the cost of health-care if the clientele population increases. This study also showed that a significant proportion of community members/leaders preferred other service points to public health institutions. Though the lower education level of this cohort may be contributory, the use of traditional birth attendants and PMDs is reportedly common among community members both in the rural and urban areas of Nigeria.[11,12] It is worrisome that over 60% of respondents from the public health-care facilities preferred other service points especially the FB centers, rather than government-owned facilities [Table 2]. This demonstrates the un-acceptable level of services available in public health-care facilities and is a good prospective index for the implementation of PPP in the state. Even among private health workers, the confidence in FB institutions is remarkable and these centers may be used to pioneer PPP roll-out in the state.

A misconception of PPP was common in the state as there was a significant difference between actual understandings and assumed initial understanding of the concept. The least understanding of PPP, both before and after enlightenment, was noted among community members/leaders, which is understandable considering their educational attainments and non-inclination to health delivery systems. In general, many private health-care workers demonstrated an understanding of PPP and this suggests that with adequate enlightenment, majority will appreciate PPP [Table 3]. Interestingly, a significant proportion of respondents were desirous of PPP implementation in Enugu [Table 4]. Though this finding was

after enlightenment, it is also a prospective indicator for PPP in health-care in the state. However, noteworthy is the finding that 47% of public health-care workers were not in support of the PPP implementation in Enugu State, Nigeria; when this proportion is added to the 7% that were not yet convinced, it may imply over 50% of public health-care worker may be willing to frustrate PPP implementation in the state. Though, this finding may constitute an important challenge to PPP implementation in the health system of Enugu State; it is however, not surprising because it has been noted that government health officials did not appear willing to promote the PPP interventions.[13] Indeed, health officials may actually perceive PPP as an indictment for failure, may also fear giving up control with attendant less power and prestige related to procurement, recruitment, postings and transfers of health workers.[14,15]

It is obvious from this study that Private Health workers and community members have limited awareness for PPP however, having been educated on the advantages of the partnership a large proportion advocated for it. This may conform with the observation that communities' care less about who is delivering services other than efficient services that are available at an affordable cost.[16]

Health sector reform is an integral part of ongoing reforms in Enugu State[17] and there is a need to re-strategize on already existing policies that support such partnerships.[18] Extensive enlightenment of the public, community engagements, well-structured agreements, a joint committee that would monitor and evaluate progress made in any project involving both sector could ensure better implementation.[19-24] The strength of this study is that its findings will assist health policy makers in the state with field evidence on possible challenges of the partnership. A larger sample size for each category of the sample population would have given adequate power for a multivariate analysis. It is hoped that future studies will address that.

Conclusions

This study has identified poor awareness of PPP in Enugu State despite current efforts by the state government and its partners that resulted d to the development of a PPP policy. Despite the enlightenment of respondents on PPP, a high proportion of public health-care workers did not express a desire for PPP implementation in the state. Loss of jobs and increased cost of health-care were the most recurrent problems, which respondents felt may be associated with implementation of PPP in the state.

Recommendations

PPP in health-care delivery in Enugu State has good prospects. The state should re-strategize on its current effort by engaging on extensive mass enlightenment and other measures to build the Private sectors confidence in government policies and also win the support of the public health workers.

References

1. Marek T, O'Farrel C, Yamamoto C, Zable I. Trends and Opportunities in Public-Private Partnerships to Improve Health Service Delivery in Africa. African Region Human Development Working Paper Series No. 93. Washington, DC: The World Bank; 2005.
2. Nigeria Federal Ministry of Health (FMoH). National Health Sector Reform. Abuja: FMOH; 2008.
3. Nigeria FMoH. National Policy on Public Private Partnership in Health. Abuja: FMOH; 2007.
4. Olakunde BO. Public health care financing in Nigeria: Which way forward? Ann Niger Med 2012;6:4-10.
5. International Finance Corporation. The business of health in Africa: Partnering with the private sector to improve people's lives, 2008. Available from: http://www.ifc.org/ifcext/healthinafrica.nsf/Content/[Last accessed on 2011 Dec 10].
6. Business day. Private partnership critical in revamping nation's health sector. Available from: http://www.businessdayonline.com/NG/index.php/component/content/article/126-health/27411-private- partnership-critical-in-revamping-nations- health- sector. [Last accessed on 2012 Sep 14].
7. Enugu State of Nigeria Ministry of Health (MoH). Strategy for health 2008-2013. Enugu: Ministry of Health Enugu State; 2008.
8. Enugu State of Nigeria MoH. Enugu State Health Sector Development Plan (ENSHDP)- 2010-2015 Enugu: Ministry of Health Enugu State; 2010.
9. Anyaehie UB. Constraints Challenges and prospects of Public Private Partnership in healthcare delivery in Enugu State, Nigeria. MPH Project College of Medicine University of Nigeria, 2011.
10. Uzochukwu BSC, Onwujekwu OE, Soludo E, Nkoli E, Uguru P. The District Health System in Enugu State, Nigeria: An Analysis of policy development and implementation. May 2009. Available from: http://www.crehs.lshtm.ac.uk/downloads/publications/District_health_system_in_Enugu_state.pdf. [Last accessed on 2012 Sep 14].
11. Umeora OU, Egwuatu VE. The role of unorthodox and traditional birth care in maternal mortality. Trop Doct 2010;40:13-7.
12. Uzochukwu BS, Onwujekwe OE. Socio-economic differences and health seeking behaviour for the diagnosis and treatment of malaria: A case study of four local government areas operating the Bamako initiative programme in south-east Nigeria. Int J Equity Health 2004;3:6.
13. Marek T, Eichler R, Schnabi P. Resource allocation and purchasing in Africa: What is effective in improving the health of the poor?. Africa Region Human Development Working Paper Series. The World Bank; 2004.
14. Uneke CJ, Ogbonna A, Ezeoha A, Oyibo PG, Onwe F, Ngwu BAF. Health System Research and Policy Development in Nigeria: The Challenges and Way Forward. Internet Journal of World Health and Societal Politics. 2009; 6: 2.
15. WHO 2006 World Report; working together for health. Available from: http://www.who.int/whr/2006/en/.[Last accessed on 2011 Dec 10].
16. Onwujekwe O, Hanson K, Uzochukwu B. Do poor people use poor quality providers? Evidence from the treatment of presumptive malaria in Nigeria. Trop Med Int Health 2011;16:1087-98.

17. Enugu State of Nigeria. Poverty Reduction Strategy/ State Economic Empowerment and Development Strategy (SEED). Enugu: Ministry of Human Developments and Poverty and Reduction, Enugu State: 2004.
18. Benneth SK, Hanson K, Kadama P, Montago D. Working with the non-state sector to achieve public health goals. Making Systems Working Paper No. 2. Geneva: World Health Organization; 2005. www.who.int/entity/management/working_paper_2_en_opt.pdf. [Last accessed on 2013 Aug 14].
19. Marek T, O'Farrell C, Yamamoto C, Zable I. Trends and Opportunities in Public-private Partnerships to Improve Health Service Delivery in Africa: Africa Region Human Development Working Paper Series No. 33636. The World Bank Africa Region; 2005. Available from: http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2005/09/28/000090341_20050928145352/Rendered/PDF/336460AFR0HDwp931health1service.pdf [Last accessed on 2011 Dec 10].
20. van Kammen J, de Savigny D, Sewankambo N. Using Knowledge Brokering to Promote Evidence-Based Policy-Making: The Need for Support Structures. Bull World Health Organ. 2006; 84: 608–12.
21. Ravenholt B, Feeley R, Averbug D, O'Hanlon B. Navigating Uncharted Waters: A Guide to the Legal and Regulatory Environment for Family Planning Services in the Private Sector. Bethesda, MD: Private Sector Partnerships-One Project, ABT Associates Inc.; 2006.
22. Federal Republic of Nigeria. Infrastructural Concession Regulatory commission (ICRC) Act, 2005. Available from: http://www.icrc.gov.ng/docs/doc-Infrastructure%20Concession%20Regulatory%20Commission%20Act.pdf. Last accessed on 2009 Dec 5].
23. McPake B, Mills A. What can we learn from international comparisons of health systems and health system reform? Bull World Health Organ 2000;78:811-20.
24. Brugha R, Zwi A. Improving the quality of private sector delivery of public health services: Challenges and strategies. Health Policy Plan 1998;13:107-20.

How to cite this article: Anyaehie U, Nwakoby B, Chikwendu C, Dim CC, Uguru N, Oluka C, Ogugua C. Constraints, challenges and prospects of public-private partnership in health-care delivery in a developing economy. Ann Med Health Sci Res 2014;4:61-6.

Source of Support: Nil. **Conflict of Interest:** None declared.