Performance-Based Financing as a Tool for Reforming Primary Health Care in Nigeria

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Abstract

Primary health care is the bedrock of any viable health system, hence, attention must be paid to its functionality and sustainability. This paper analyses primary health care (PHC) in Nigeria and showcases performance-based financing as a tool for health system reform. This study adopted content analysis methodology involving review of peer-reviewed and grey literature to analyse Nigeria's PHC system thematically using the World Health Organization's health system building blocks framework. The study shows that PHC in Nigeria is underperforming in all the six building blocks while performance-based financing is an approach to health system reform with capacity to strengthen each building block of the health system. With strong institutional arrangement, performance-based financing may be adopted as a national policy to reform PHC system in Nigeria for improvement in access, utilization and quality of healthcare in Nigeria.

Keywords: Primary health care; Health system; Reform; Strengthening; Building blocks; Performance based financing; World Health Organization; Nigeria

Introduction

Health systems comprise of all functional units working in concert in the health sector with the goal of promoting, restoring and maintaining health [1-4]. According to World Health Organization (WHO), health systems have six building blocks, *viz*, leadership and governance, health financing, health workforce, medical products and technologies, health information and service delivery [1-3]. The Nigerian health system is organized into primary, secondary and tertiary levels managed by the local government authority (LGA), state government and federal government respectively, but it has been plagued by underperformance and poor health indicators [5-7].

Primary Health Care (PHC) in Nigeria was adopted in the National Health Policy of 1988 following Alma Ata declaration of health for all in 1978 [4,6]. National Primary Health Care Development Agency (NPHCDA) was established through a military decree in 1992 to implement government policies on PHC [8-10]. NPHCDA is the institution saddled with the role of regulation, support and coordination of the Nigerian PHC system [11]. The Nigerian health system is fragmented and in a deplorable and shambolic state [5,12,13]. Several evidences point to poor health indicators and inability to meet set targets [12-16]. The establishment of PHC was done to bring healthcare closer to the people especially those in rural communities [17]. The objective of this article is to analyse the Nigerian Primary Health Care system using the WHO health system building blocks and showcase performance-based financing as a tool to reform PHC in Nigeria.

Methodology

Methodology adopted for this study involved content analysis of secondary data retrieved from peer-reviewed articles and grey literature. Literature search was performed on Google Scholar, PubMed and Science direct databases on primary health care in Nigeria and performance-based financing. In order to identify relevant literature, a search strategy involving the use of key words and phrases such as primary health care, health system building blocks, health system strengthening, health system reform, performance based financing etc. was initiated. Data was collected and analysed thematically using WHO health system building blocks, namely; service delivery, health workforce, health information systems, access to essential medicines, health financing and leadership & governance [18].

Results and Discussion

Analysis of Nigeria's PHC system

Service delivery: In terms of geographic access to PHC, Nigeria has a relatively high PHC density of about 18 PHCs per 100,000 people and number of PHC centres (PHCCs) in wards across the nation is more than recommended level [9]. Studies show that majority of people in rural areas are within 30 minutes from a PHCC [9,19], however, the productivity and provider competence of Nigerian PHC system is low [9]. These evidences cast doubt on the effectiveness and quality of service delivered at PHCCs [9,10,13]. Reports have shown that there are issues of absenteeism and poor professional practice among health workers, thereby hampering service delivery at PHCCs [9]. Even though there exists geographic access to PHC, paying for healthcare could pose a challenge as user fee ranges from as low as 2.30 US Dollars (USD) to as high as 8 USD [9,19]. Furthermore, there is a general perception of low quality of healthcare at PHCCs leading to non-use or low patronage [10,17,20]. PHC in Nigeria is in deplorable state owing largely to infrastructural deficits and lack of medical equipment [13,17]. Service delivery at PHCCs has also been hampered by unavailability of vehicles and other logistical supports to conduct outreaches to neighboring villages and communities [17].

Health workforce: The attributes of an effective health workforce are responsiveness, fairness, efficiency and productivity [1]. Even though Nigeria has one of the largest pools of health workforce in Africa, its health workforce density (1.95 per 1,000) is low [21]. Nigeria's health workforce density is below Africa's average (2.3 per 1,000) [22]. Consequently, inadequate manpower is one of the major challenges facing PHC in Nigeria [10,17]. While many health workers lack requisite training, others lack required equipment to perform their duties [10,17,23]. Misdistribution and defective deployment of health workers in Nigerian PHC system has led to some PHCCs having less than required number of staff while others are overstaffed, thereby contributing to absenteeism, redundancy and ineffectiveness within the system [9,10,13,17,24]. The non-use of performance framework and other productivity enhancement mechanisms is the bane of underperformance in the Nigerian PHC system [9]. On the other hand, weak incentive structure, especially for health workers in rural areas, inadequate supportive supervision, poor planning, lack of job description and inter-cadre conflicts are also contributors to health workers' ineffectiveness [9-10].

Health information systems: The role of health information system (HIS) entails collection, storage, analysis, presentation and utilization of health data from health facilities [1,17,25]. HIS comprises of HIS resources, indicators, data sources, data management, information products and information use [16]. Owing to the importance of quality data in decision-making, HIS is a critical component of the health system [16,20]. The National Health Management Information System (NHMIS) was established to bridge the gap between evidence and decision-making by policy makers but it has over the years fallen short of expectations and desired results [16,20,25]. Weak NHMIS, which has trickled down to PHC, has led to spurious policies and unreliable health reforms [13,25].

Access to essential medicines: Provision of quality drugs, vaccines and other commodities remains an important component of the health system [1]. Nigerian PHCCs are bedeviled with issues related to shortage of drugs, poor maintenance culture, pilfering of commodities and other fraudulent activities, thus significantly weakening the capacity of PHCCs to implement interventions [9,10,13,20]. In many PHCCs, medical equipment are either

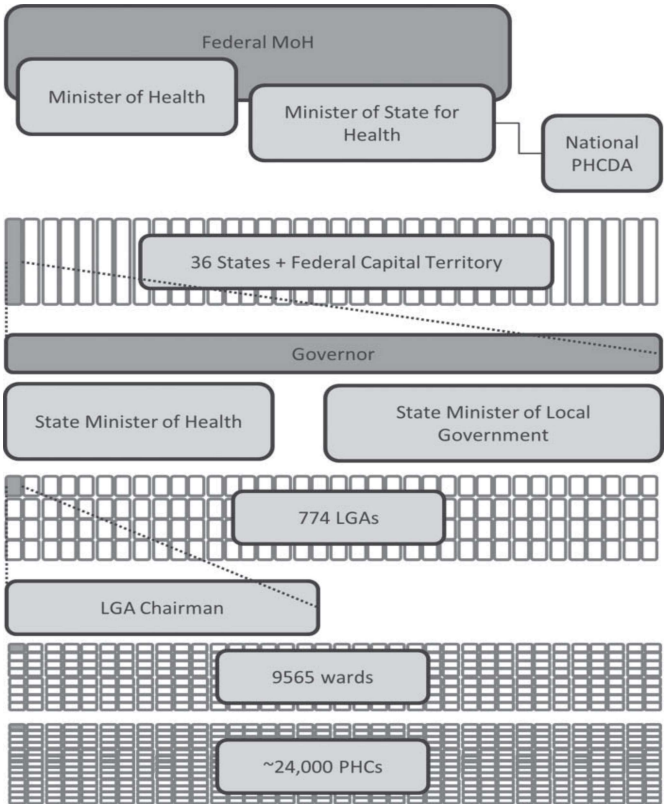

Figure 1: Governance Structure of the Nigerian Health System [9].

unavailable, spoilt or obsolete [12]. Issues related to supply chain and preponderance of adulterated drugs are still issues yet to be resolved in Nigeria's PHC system [9,20].

Health financing: PHC is managed by LGA through funds it receives from the state government, most of which are used to pay health workers' salaries and little or nothing is left for the procurement of drugs, programmes and other operational costs [9,10,13]. Nigeria's PHC system is generally poorly funded and its viability is usually dependent on the disposition of LGA chairman to public health and the level of commitment of the state government to healthcare [9-10]. Access to PHC services is basically through out-of-pocket spending, which is a major barrier especially for poor people in rural communities [9,13,20]. As a result of dismal funding of PHC by LGA and state government, PHC relies on cost recovery and user fees [9].

Leadership and governance: Generally, Nigeria runs a deeply fragmented health system [9]. Figure 1 is a pictorial representation of the fragmentation that exists in the Nigerian health system. The federal government through the Federal Ministry of Health provides policy direction for the health sector, the state government through state ministries of health implement government health policies at the state level while the LGA through LGA PHC Department coordinates the activities of PHC [9,12]. In the same vein, the federal government is responsible for the management of tertiary hospitals, state government runs secondary hospitals while LGA is responsible for PHC administration [10,17]. The PHC Department is headed politically by the Supervisory Councilor for Health and administratively by PHC Coordinator. The PHC Coordinator reports to the Supervisory Councilor for Health, who in turn reports to the LGA Chairman [17].

The major problem in the governance structure of the PHC system is that the lowest and weakest tier of government, the LGA, is saddled with the management of the most important level of healthcare, the PHC [6,9,10]. This weak and fragmented governance arrangement has oftentimes been linked to corrupt and fraudulent activities involving PHC [10,17].

Performance-based financing as health system reform

Health system reform refers to a government-led shift in policy direction, institutional framework and operationalization of the components of the building blocks with the goal of improving access to equitable, affordable, effective and quality healthcare and enhancing public health [13,26,27,28]. Health strategies, policies and reforms are not in short supply in Nigeria [4,7,10,20]. The challenge has always been abysmal, partial or defective implementation, leading to low performance and poor sustainability [4,20].

Performance-based financing (PBF) is a health system reform approach [23,29-32]. Based on the health system building blocks, PBF targets health financing [2,23,29], but also has capacity to strengthen other building blocks of the health system [29]. Reports show that PBF has been implemented in many countries including Nigeria, Cameroon, Burundi, Afghanistan, India, Haiti, Rwanda, Bangladesh, Cambodia and others [15,30-35]. Evidences from countries implementing PBF show that PBF presents an opportunity for improved service delivery at health facilities, effective management of health facilities through autonomy and improvement in health system performance [15,23,29-36].

Several studies indicate that PBF strengthened service delivery and health workforce in Rwanda [23,31,37-39]. In a study on PBF pilot in Yobe State, it was reported that PBF increased the utilization of antenatal care and skilled delivery [15]. Another study conducted in Wamba LGA of Nasarawa State revealed that PBF has the capacity to motivate health workers towards effective service delivery [40].

Conclusion

This study analysed the Nigerian Primary Health Care system using the WHO health system building blocks and showcased performance-based financing as a tool to reform PHC in Nigeria. The analysis of PHC in Nigeria reveals that it is underperforming in all the six building blocks of the health system and therefore requires holistic strengthening through evidence-based health system reform. PBF is an approach to health system reform and studies have shown that it has capacity to strengthen the six building blocks of the health system. Evidences from the Nigerian PBF model indicate that it has capacity to improve utilization of health services and motivate health workers. The adoption and implementation of PBF as a national policy could reform PHC in Nigeria, thereby improving access and utilization of health services and strengthen the delivery of quality healthcare. However, for PBF to yield desired results, its design and implementation will require strong institutional arrangements [4,8,10]. This study also lends credence to the need for rigorous impact evaluation and other evidence gathering initiatives on the Nigerian PBF model to ascertain its effectiveness, viability and sustainability.

Conflict of Interest Disclosure

Author declares that there are no competing interests in relation to this study.

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