Mobilizing resources from the private sector for targeted health investments using evidence from costing assessments

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Background: Governments in Nigeria are striving to inject capital into the healthcare sector but the challenges of low revenue generation, tax receipts, and inefficiencies in health expenditure complicate these efforts. It is for this reason that health policymakers now look to innovative public-private partnerships as a way of expanding the fiscal space for Health. In 2017, the Federal Government flagged off a scheme to revitalize 10,000 primary health care centers (PHCs) across Nigeria as part of advancing progress towards Universal Health Coverage (UHC). This revitalization initiative seeks a fully functional PHC in every administrative ward of the country. The Government of Cross River State (CRS) has adopted the initiative and has committed to revitalizing a total of 196 PHCs across 196 political wards.

Methodology: With technical support from USAID, the CRS Government conducted an RMNCH Service Availability and Readiness Assessment (SARA) to identify critical service input gaps at 750 health facilities. Data were aggregated and presented by facility type along the lines of Human resources for Health, Infrastructure, Commodities and Supplies, and Equipment. Furthermore, the infrastructure gaps were costed using the Bills of Quantity (BoQ) methodology to ascertain the financial needs required to close identified gaps through targeted investment. Indices assessed include power supply, water supply, roofing/building/floor/window/door conditions, toilet facilities, and waste management facilities.

Key Findings: Infrastructure in the state’s public health facilities is generally poor. Approximately, half of all facilities visited had a leaking roof, no access to water, electricity or a functional toilet. In 2018, the CRS Primary Health Care Development Agency leadership launched the “Adopt a Health Facility” initiative using evidence from the BoQ assessment to engage the private sector with a view to having them contribute to the renovation of the 196 main PHCs per ward. To date, 40 facilities have had their infrastructures upgraded and an additional 7 PHCs have received basic equipment from well-meaning individuals. This is separate from the PHCs that shall be fully revitalized using public funds through evidence-based priority needs budgeting.

Main Conclusion: In many LMICs, mobilizing resources from Government alone to bridge the huge critical service input gaps for quality RMNCAH + NM services is a big challenge. Financial and non-financial resources from the private sector can significantly contribute to the Government’s efforts by complementing, strengthening, and extending existing resources. However, to engage the private sector effectively; generating evidence of need, establishing robust accountability mechanisms and efficiency improvements will be critical in translating the potential of mobilizing additional resources from this sector into reality.