

MANAGING AND FINANCING HEALTH CARE FACILITIES IN KOGI STATE, NIGERIA

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Abstract

This study gives an overview of managing and financing primary health care facilities in Nigeria, explaining the existing state of the facilities. It highlights the problems of health care facilities in Nigeria, using the Kogi diagnostic hospital as case study. It presents the various models of public private partnerships from literature, such as neoliberalism and complexity of governance, prevailing public private partnership management models. The selected model as appropriate is to be implemented through action planning. This involves the unbundling of the health facilities ripe for privatization. It attempts to find the most suitable private public partnership for the study area. It was finally concluded that no one method is mutually exclusive, more than one method of governance could be applied at the same time depending on the existing situation.

Key words: Primary Health Care Facilities; Public Private Partnership; Nigeria.

1.0 Introduction

1.1 Background of study

The concept of Primary Health Care (PHC) first came about on 12th September 1978 when 134 countries met at the Alma Ata conference in Russia, organized under the aigees of the World Health organization. The programme was jointly funded by the world health organization (WHO) and the United Nations Children's Fund (UNICEF). Here, it was reiterated that the importance of primary health care as an, "essential, scientifically, sound and socially acceptable methods and technology, universally accessible to individuals and families in the community, through their full participation at a cost which the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination" (WHO, 2006). The goal of primary

health care (PHC) in Nigeria is to provide accessible health for all by the year 2000 and beyond. However these have not been achievable to this day. This could still remain unrealistic if certain measures are not taken. The PHC centers were established in both rural and urban areas in Nigeria with the intention of equity and easy access, however the rural populations are still seriously underserved when compared with their urban counterparts. Since it is recorded that about two-thirds of Nigerians reside in rural areas Primary health care being the bedrock of the country's health care policy, is currently catering for less than 20% of its potential patients (Gupta et al, 2004).

Akintoye et al (1999) explained that Primary Health Care form an integral part of the Nigerian social and economic development. It is seen as the first level contact of the individual and

community in the national health system, it was to therefore make health care more accessible to the people as much as to where they live and work and it is also to contribute as the first element of a continuing health care process,

The Primary Health Care is so crucial that the Federal Republic of Nigeria In the 1999 constitution put health on her concurrent legislative list, where the three tiers of government were vested with the responsibilities to promote health; the Primary Health Care is to provide general health services of preventive, promotive, curative and rehabilitative nature to the population. This then implies that the provision and the maintenance of health care facilities at this level is largely the responsibility of Local Governments with the support of State Ministries of Health and within the pivot of national health policy (Abiodun, 2010).

The health facilities are presently in sorry state of decay, service level is reduced, failed recruitments of qualified health personnel, inefficient storage data and materials, inefficient management of the hospital environment. Similar to these problems were in the works of Hsia et al (2012) in Sub-Saharan Africa and Flessa et al (2011) in Tanzania. There is a need for accountability and to bring the service close to the people, stakeholders must be in partnership for decision making. There is therefore a need for effective partnership among the stakeholders.

1.2 Problem Statement

A Plethora of problems bedeviling PHC facility could be traced to the inefficient asset management, this manifests in low maintenance of hospital infrastructure, inadequate power and water supply, low or non-ambulatory services. Where ambulances are available they are either broken down or no fuel to power the vehicles; the power plants in the hospitals are broken down hence infrequent power supply.

There are no enough vehicles for workers to perform their task especially to the rural areas. It was found that maintenance culture of the existing vehicles is poor, while PHC vehicles were used for other purposes other than health related activities (Adeyemo, 2005). Insufficient number of medical

personnel as well as their uneven distribution and the qualified ones concentrate more at the state capitals to the neglect of the rural areas. Another problem encounter by the PHC service is the issue of managing the hospital environment. The hospital environment is in a sorry state where large refuse dumps are common sights, hospital refuse is not collected regularly, laundry services are also not adequate due to scarcity of water, hence hospital dirty linings are frequently recycled which can cause easy spread of diseases.

There are evidences of low community participation, "It is a truism that the cornerstone of PHC is community involvement but to a large extent this has become crisis ridden problem throughout the Local Governments," (Adeyemo, 2005). Other problems are the general misuse and abuse of the scarce resources, human, material and financial resources by some political and administrative leadership. This manifests in increase in wage bills, over dependence of the LGA on Federal, State and International Agencies. The internally generated revenue is returned to the local government purse, it is not used to maintain the facilities.

The majority of health data gathered at the health care facilities are inconsistently stored. Data collection is performed by medical or administrative staff of the health care facilities in a monthly, quarterly or yearly routine. Hence, health information systems are reported to function insufficiently. Although some form of cooperation exists between the government and the private sectors (donor agencies), there is no defined responsibilities, risk sharing and no commitment of the private sector.

Similarly, lack of continuity of LGA leadership poses another problem. There is high degree of leadership turn-over as well as lack of continuity in Local Government leadership as different people chair affairs of the local government area at differing political dispensations, in most cases without continuity in policy implementation. This accounted for inconsistencies in health policy decisions. Undoubtedly, the problems facing LGA – PHC are legion and in-exhaustive. Poor asset management, poor environmental management, poor financial base and political instability have been the basis for

unsuccessful implementation of most government policies and programmes on health care delivery. Thus, the facility management of the PHC should be 'vertically unbundled', to give room for easy competition and the involvement of the private sector in financing.

2.0 Location

Lokoja is located between latitude 7°49' north of the equator and longitude 6 ° 44' east of the Greenwich meridian. It is a city located where two rivers meet, a confluence town (between river Niger and Benue) ;(figure 1).The annual growth rate of 2.5% gives the rise in population in 1991 as, 43,784 and projected in 2003, to 82,483. However, the 2006 population census was recorded as 195,261 (NPC, 2006).Increase in population puts pressure on available facilities.

The study Area.

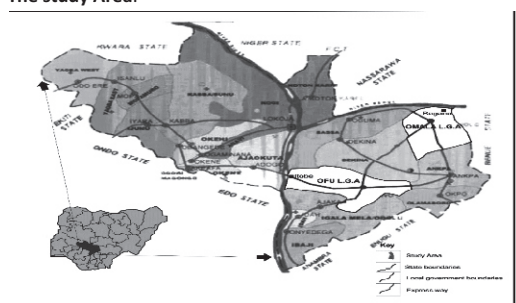


Figure 1 Lokoja in Kogi State, Nigeria

2.1. Knowledge and experiences in study area.

The goal of the Nigeria National Health Policy (1987) is to bring about a comprehensive health care system, based on primary health care that is promotive, protective, preventive, restorative and rehabilitative to all citizens within the available resources so that individuals and communities are assured of productivity, social well-being and enjoyment of living. The health services, based on PHC, include among other things: education concerning prevailing health problems and the methods of preventing and controlling them, promotion of food supply and proper nutrition, material and child care, including family planning immunization against the major infectious diseases, prevention and control of locally endemic and epidemic diseases and provision of essential

drugs and supplies (Adeyemo, 2005). Even though PHC have made much progress in the 1980s, its goal of 90% coverage had not been achieved to this date; it is still bedevilled with the economic strains of structural adjustment that permeated the Nigerian economy throughout the late 1980s. Many international donor agencies such as UNICEF, World Health Organization (WHO) and the United States Aids for International Development, (USAID) embraced the programme and participated actively in the design and implementation of programmes at that level (USAID, 1994). During this period most of the contributions came from donor agencies, assistance and funds were withdrawn by his agencies in 1993 during the political crises in Nigeria. Until the return of democracy in 1999 when assistance returned ,this crises had caused the deterioration of the infrastructures to a very abysmal level especially at the rural areas.

Community participation was institutionalized in Nigeria through the creation of District Development Committee (DDC) and the Village Development Committee (VDC) (World Bank, 2003).

The LGA is divided into various health districts/wards so as to enhance maximum benefit of the principle of decentralization of the health sector whereby people are made to participate and mobilized in the PHC processes (Adeyemo, 2005; Federal Ministry of Health, 2004); (World Bank, 2003).

3.0 Related Literature on governance and private sector partnership

This section reviews the concept of Neoliberalism the various models of partnerships and unbundling of services.

3.1 Neoliberalism and Complexity of Governance

Neoliberal urbanism is a concept in urban governance where the market forces are allowed to dictate economic policies and thence the management policies; by the rise of various forms of state-mediated market rule, by privatized and contractualized governance and by widespread subordination to economic reasons (Theodore and Peck, 2011).

The importance of policy and service delivery have been emphasized in Koppenjan (2012), where actors interdependently acts as core initiators of sustainable management networks. However interdependent actors of network governance can be helpful to eliminate unrealistic government policies, excessive governmental bureaucracy, lack of viable national development strategy, lack of employment opportunity, as identified by Bromley (1990). Because as according to, Klijn and Koppenjan, (2007), network governance model helps policy to be succeed when collective action is undertaken to recognize an extensive purpose or overcome common negative forces. But complexity of these net woks will require guidance and management of interactions (Meir and O'Toole, 2007). Therefore for effective governance there must be balances in planning between the whole and the parts, as this allows a visionary emphasis on values which include social justice and equity in sustainability, civic empowerment, community and human flourishing (Healy, 2011). Davidson (1996) in his own work envisages a frame work of multiple actors to share visions to commit themselves to action to achieve it. Therefore planning for facility management requires techniques or methodology that have been changed by identification of contingency and complexity of specific histories and challenges of localities in diverse parts of the world.

3.2 The Concept Public Private Partnership (PPP)

Governments in most countries of the world are faced with challenges of managing and financing infrastructural services. As the capacity of the public sector to implement many projects at one time remain limited, governments now see the need that partnership with the private sector is an attractive alternative to increase and improve the supply of infrastructure services.

PPP is a cooperative venture or contractual arrangement between public agencies and private sector partners toward clearly defined public or social needs. It utilizes built-in expertise, experience, and human resources available in the private sector in the provision of services that are normally the responsibility of government. PPP

involves a sharing of resources, risks, and benefits between the public and private providers based on clearly defined terms of agreement. A PPP arrangement includes a financial arrangement that clearly defines how the initiative will be financed and whether financing will be shared. It needs a strong management information and monitoring system to support the definition of targets and performance evaluation (ADB, 2011), (Grimsey et al, 2002).

PPPs are not to be confused with privatization, where a service or facility is fully transferred to the private sector by sale/disposal, including all the associated assets and liabilities, for operation according to market forces. PPP sees the temporary transfer of a service or facility to the care and responsibility of the private sector through a long-term lease agreement, with the service or infrastructure potentially returned to government control at the completion of the contract term. The extent to which the government regains ownership at the completion of a PPP depends on whether the facility or service was originally owned by the public sector and the terms of the PPP agreement (Colverson et al, 2012).

In the 1990s new reforms began to affect developing countries for transfer of the delivery of social and infrastructural services to the private sector and NGOs (Batley, 2001; Kirkpatrick et al, 1995).

This was attributed to market failure, services include street cleaning, waste collection, hospital cleaning and power supply, then later health and education. Few countries such as the United Kingdom and Chile had complete privatization of social infrastructure services. What was common then was contractual relationship where government retains ownership and private firms tender for contracts (Savas, 2000). Also there are reforms in Africa, Asia, where services have been contracted out , subsidies to nonprofit hospitals, however series of contracting have been reported in the Asian countries, like Thailand(Salamon,2002); (Du Gay,2000). The environment under which the PPP concepts were applied in Tanzania and in most other developing countries needs improvement. The areas for improvement

include understanding, accepting, supporting, approving and getting exposure to the use of the PPPs concepts by both the private the public sector. In this regard there is a need for capacity building and development in various forms including training (formal and/or informal). The sector needs also capacity building and development by way of empowering it through provision of equipment to implement PPPs contracts. This could be done by various ways including giving better environment for the sector to access loans, credits and grants facilities under various arrangements including government guarantee schemes.

The case of the management of waste disposal, and street cleaning and maintenance, PPP procurement method is already being used in New Zealand (Harris, 2003). It is essentially a partnership between public sector organizations and private sector investors and business for the purpose of designing, planning, financing, constructing, providing and/or operating infrastructure, facilities or related services (Leiringer, 2003).

Different types of PPP have been put into practice in worldwide infrastructure development. These have been prompted due to limited financial resources available to the public sector for financing infrastructure development in countries of Asia, Africa, Europe and North, Central and South America. According to World Bank (2002), there have been 662 transport projects with private participation these process have attracted US\$135 billion in investment during 1990 to 2001. Various lessons can be taken from these PPP initiatives (World Bank, 1999; World Bank, 2002; Harris, 2003).

Dantas et al., (2006), explains that PPP environment requires the analysis of not only operational but also social, political and economic criteria. These criteria play a major role to achieve success of any PPP project. The World Bank (1999) reports that factors such as land use, population and economic growth surrounding the asset influence directly and indirectly the structure of the PPP project. Therefore, the use of cost benefits analysis should be applied as one of many steps to evaluate PPP project but not the only one. Hence

the applicability of PPP methods and tools should contribute to other key areas such as financial, risk and law issues. It would contribute to produce more realistic assumptions and estimates to cost benefit analysis and consequently to decrease the risk and increase the changes of financial success of the PPP projects (Bing et al, 2005).

Zhang et al., (2001) argued that apart from the benefits of PPP, International experiences have shown that there can be many issues affecting the successful implementation of these partnerships. The main issue is related to assumptions and estimations conducted during the planning process, that a properly structured PPP can efficiently achieve better results than public sector.

Recent international PPP experiences have shown that extensive planning actions are required in order to manage the risk of PPP failure (World Bank, 1999). There are differing models of PPP, however the option of model selected for partnership will depend on the available framework (Pierson and McBride, 1996).

The PPP process involves unbundling the costs and the risks inherent in delivering the project and allocating them to the partner best able to absorb and mitigate them. The ability of the public and private sector partners to efficiently and effectively mitigate each risk should govern the allocation of each risk.

3.3 Prevailing Public Private Partnership Management Models

A plethora of PPP models have emerged over the years, they were found to vary mainly by ownership, responsibility for investment, assumption of risks, duration of control, this could further be classified into five broad categories in order of general increased involvement and assumptions of risk by the private sector (UNESCAP, 2011). This model could further be classified in five, based on assumed risk level of the private sector. These categories are affermage or lease, and management contracts, turnkey contracts, concessions, Private finance initiative (PFI) and private ownership.

(1) Affermage/Lease

In this category, the operator (the leaseholder) is responsible for operating and maintaining the infrastructure facility (that already exists) and services, but generally the operator is not required to make any large investment. However, often this model is applied in combination with other models such as build-rehabilitate-operate-transfer. In such a case, the contract period is generally much longer and the private sector is required to make significant investment. The arrangements in an Affermage and a lease are very similar. The difference between them is technical. Under a lease, the operator retains revenue collected from customers/users of the facility and makes a specified lease fee payment to the contracting authority. Under an affermage, the operator and the contracting authority share revenue from customers/users. In the affermage/lease types of arrangements, the operator takes lease of both infrastructure and equipment from the government for an agreed period of time. Generally, the government undertakes the responsibility for investment and thus bears investment risks. The operational risks are transferred to the operator. The main merits of this model include the following:

That it can be implemented in a short time; that also significant private investment is possible under longer term agreements. In some countries, it is legally and politically more acceptable for strategic projects like ports and airports. While the demerits are that – it has little incentive for the private sector to invest, particularly if the lease period is short; almost all risks are borne by the public sector; it is generally used for existing infrastructure assets. Considerable regulatory oversight may be required (UNESCAP, 2011).

(2) Supply and management contracts

This is a contractual arrangement for the management of a part or whole of a public enterprise (for example, a specialized port terminal for container handling at a port or a utility) by the private sector. Management contracts allow private sector skills to be brought into service design and delivery, operational control, labour management and equipment procurement. However, the public sector retains the ownership of facility and equipment. The private sector is assigned specified responsibilities concerning a service and is generally not asked to assume commercial risk.

The private contractor is paid a fee to manage and operate services. Normally, the payment of such fees is performance-based. Usually, the contract period is short, typically three to five years. The demerits are that efficiency gains may be limited and little incentive for the private sector investment; almost all the risks are borne by the public sector; it is applicable mainly to existing infrastructure assets (UNESCAP, 2011).

(3) Turnkey

Turnkey is a traditional public sector procurement model for infrastructure facilities. Generally, a private contractor is selected through a bidding process. The private contractor designs and builds a facility for a fixed fee, rate cost, which is a criteria in selecting the winning bid. The contractor assumes risks involved in the design and construction phases. The main purpose was to set-up the system so that eventually a local company could take over for a longer period. The Private sector involvement is generally low and for a short-term. Typically, in this type of arrangement, there is no strong incentive for early completion of the project. The main merits of this model include the following: it is a well understood traditional model; contract agreement is not complex; generally, contract enforcement is not a major issue. While the demerits of this model are that the private sector has no strong incentive for early completion, all risks except those in the construction and installation phases are borne by the public sector. Low private investment for are for a limited period and only limited innovation may be possible (UNESCAP, 2011).

(4) Concessions

In this form of PPP, the government defines and grants specific rights to an entity (usually a private company) to build and operate a facility for a fixed period of time. The government may retain the ultimate ownership of the facility and/or right to supply the services. In concessions, payments can take place two ways: concessionaire pays to government for the concession rights or the government may pay the concessionaire, which it provides under the agreement to meet certain specific conditions. Usually, such payments by the government may be necessary to make projects commercially viable and/or reduce the level of commercial risk taken by the private sector, particularly in a developing or untested PPP market. Typical concession periods range between 5 to 50 years. The main merits of this model include the following: that the Private sector bears a significant share of the risks; high level of private investment; Potential for efficiency gains in all phases of project development and implementation and technological innovation is high. While the demerits includes: highly complex to implement and administer; difficult to implement in an untested PPP market; may have underlying fiscal costs to the government; negotiation between parties and finally making a project deal may require long time; may require close regulatory oversight and contingent liabilities on government in the medium and long term(UNESCAP, 2011).

(5) Private Finance Initiative (PFI)

In the private finance initiative model, the private sector remains responsible for the design, construction and operation of an infrastructure facility. In some cases, the public sector may relinquish the right of ownership of assets to the private sector. The public sector purchases infrastructure services from the private sector through a long-term agreement. PFI projects, therefore, bear direct financial obligations to the government in any event. A PFI project can be structured on minimum payment by the government over a fixed contract tenure, or minimum contract tenure for a fixed annual payment, or a combination of both payment and

tenure. The asset ownership at the end of the contract period is generally transferred to the public sector. Setting up of a Special Purpose Vehicle (SPV) may not be always necessary here. A PFI contract may be awarded to an existing company. For the purpose of financing, the lenders may, however, require the establishment of an SPV. The PFI model also has many variants (Nwasike, 2012).

In a PFI project, as the same entity builds and operates the services, and is paid for the successful supply of services at a pre-defined standard, the SPV / private company has no incentive to reduce the quality or quantity of services. This form of contractual agreement reduces the risks of cost overruns during the design and construction phases or of choosing an inefficient technology, since the operator's future earnings depend on controlling the costs. The public sector's main advantages lie in the relief from bearing the costs of design and construction, the transfer of certain risks to the private sector and the promise of better project design, construction and operation.

The UK public sector has spent the 20-year life of UK PFI attempting to create the necessary capacity. For many years there seemed to be too little appreciation in the higher civil service ranks of the extent of the difficulties of complex procurements' (Lonsdale, 2011). In many ways, PFI, the public sector has become too reliant on expensive external expertise, and the expertise has tilted towards financial skills. The main merits of this model are that Private sector may bear a significant share of the risks; there is high level of private investment; potential for efficiency gains and innovation is high; attractive to private investors in an untested or developing PPP market and it is most suitable for social sector infrastructure projects (schools, dormitories, hospitals, community facilities, etc.). While the demerits are complex to implement and manage in terms of the contractual regimes; government has direct financial liability; negotiation between parties may require long time; regulatory efficiency is very important; contingent liabilities on the government in the medium and long term, Allan (2001); (UNESCAP, 2011).

Private Public Partnership can again take another form as, joint ventures (JV), leasing, contracting out or management contracts, and various forms of public-private cooperation. Some examples are:

Build-Operate-Transfer (BOT), although the actual delivery mechanism includes Design-Build-Operate-Maintain (DBOM), Design-Build-Finance-Operate (DBFO), Build-Own-Operate (BOO) and Rehabilitate-Operate-Transfer (ROT), BOT (Build Operate Transfer). These are contracts where the private sector takes primary responsibility for funding (financing), designing, building and operating the project. Control and formal ownership of the project is then transferred back to the public sector. An example is the nature of partnerships of a BOT. BOO was used in South Australia to finance water treatment. The DBFO (Design, Build, Finance and Operate), OM & M (Operate, Maintain and Manage) contract and the other three are O & M (Operate and Maintain) contracts. The O & M contracts range from 5 to 10 years in length Cooperative arrangements that occur between governments and private entities are more informal than many of the equity partnerships and concession-type franchise arrangements for social housing projects in the United States (Colverson et al, 2012).

However the demerits stated are general for main stream discussion and are not realistic to specific individual examples. Because it is not unusual to find in theoretical arguments where the positives outweighs the negatives on the topic with the PPP, therefore care should be taken in assessing the suitability of PPP for a project to reduce risk associated with agreements.

3.4 Models for unbundling services

The bundled form of services requires unbundling to offer multiple services. This is seen as the main mechanism for subsidizing services to poor patients. Unbundling also promotes competition and it makes cross-subsidies between different lines of businesses more transparent, identifies more precisely the subsidies needed to deliver services to the poor and improves management accountability (WDR, 1994), Morrell, et al., (2012).

(a) Optimization process method (OPIK)

According to Lennerts et al (2005), the Optimization processes method (OPIK) was applied to some hospitals in some German hospitals to determine services to be privatized. The method analyzed the business processes in the participating hospitals with a focus on the interaction between primary (medical) and secondary (facility management) business processes. Findings showed detailed enabling the establishment of far reaching standards for performance of facility management services, this project created the bases for the introduction of efficient holistic facility management structure and process (table 1). The table shows the basic materials unbundled based on floor space allocation, allocated quantity and order related allocation.

Table: 1 Services Unbundled for privatization

Allocation basis :floor space in m ²	Allocated on quantity basis
Outside farcialities	Waste disposal
Operation	Bed conditioning
Building maintenance	Information technology service
Technical maintenance basic rent	Fleet management
Pest control	Hygiene advice
Cleaning	Maintenance of medical equipment
security	Cooling services
	Catering
	Sterilization service
Order-related allocation	
Office supply	
Caretaker services	
Reprographics services	
Mail services	
Removal services	

Source: Lennerts et al (2005)

(b)The Benefit Model

The benefit model of local finance was first developed in 1977. By William Mercer, it was initially known as the Mercer model. This is a way of municipal finance, decentralization of and sourcing of finance from the local (Lewis, 2006). This is for greater efficiency in the hospitals. It has been documented that about 20% to 30% of hospital costs are not related to core processes, such as health services performed in order to cure patients but on non-core processes as can be defied as falling within the facility management processes (Lennerts et al, 2007). The volumes of these

processes have been found to correspond to about 18 billion euro annually (Statistisches Bundesamt, 2006).

3.41 Unbundling Hospital Facilities

Arguments to be considered in the intervention of PPP mainly discussed in the literature includes market failure, public goods, equity (or merit good) to unbundle the services in deciding the ones that can be privatized. This has been explained further as:

1. Market Value argument.

This method considers the main arguments as -

- The market failure argument- where general monopoly is to be considered as economies of scale becomes a barriers to competition from new entrants, with only one supplier'
- The Scale of investment – here resources required must be too enormous for private sector.
- Externalities, positive and negative externalities or side effects must be considered. This has to do with non-excludability of the services i.e. whether the individuals cannot be excluded from a service.
- Price elastic demand, whether demand is not affected by prices.
- Barriers of entry that is barriers of entry into the market competitors.

2. Clinical Pathways for Activity cost

This method was developed as a basis for activity based cost management, developed in the 1980s in the United States following the introduction of the DRG system, which offered a means of specifying the product of health care (Strobel, 2004). The core element of the clinical pathway is the standardization procedure, which is used to for standardizing facilities in the hospital, taking account of differing needs of each department. This is will help to decide what to privatize.

3. Cost allocation for facility management in Hospitals

The ultimate consumer in the hospital system is the patient, therefore in health delivery system patients are priority, whose interests are represented by a purchaser of care, such as a sickness fund. The clinical units in the hospital also have the responsibility to generate revenue for the hospital with income based on the number of patients treated, adjusted for case –mix (Strobel, 2004).

4. Product model of transparency management

Here the product of facility management is the delivery of services European committee for standardization (2005), that facility management is to provide support to the core process of a business, a set of criteria for products to be supplied was compiled as services need to be performed for benefit of the customer, it must be possible to define a comprehensible basis for allocation, the efforts to acquire quantities needed must be reasonable, the customer should be able to influence the quantity of the product. These products need to be measureable in a way that cost can be allocated to it.

3.5 Selecting Partnership model applicable

The table 2 is a summary of characteristics of Partnership categorization, to select one that i.e. relevant to this study, consideration is given to one the fits in the three stakeholders i.e. the Government, public and the private sector. Here the Supply & management contract is selected where government contributes in money terms and rules, the private sector implements the rules and develop the infrastructure. The community in turn protects the investment. In Supply & management contract, partnering may be in the form of outsourcing, maintenance and operation management, capital assets owned by the public, the lease method is another good method that could be applicable where the infrastructure is not

yet on ground(see table 2). Nigerian procurement method is full of lack of trust between the client and the contractors. Whereas, these methods are profit oriented business-like arrangement,

partnering is a mutually beneficial risk-sharing arrangement. It emphasizes close monitoring and involvement of clients in project development (Akintoye et al., 1999).

Table 2 Characteristics of the Partnership models

Classification of Models	Main variants	Ownership of capital assets	Responsibility of investments	Assumption of risk	Duration of contract (Years)
Supply & management contract	Outsourcing	public	public	public	1-3
	Maintenance/management	public	Public/Private	Public/Private	3-5
	Operational management	public	public	public	3-5
Turnkey	public	public	public	public/Private	1-3
Affermage/Lease	Affermage	public	public	public/Private	5-20
	Lease				5-20
Concession	Franchise	public	public	public/Private	3-10
	BOT				15-20
Private ownership of assets and PFI type	BOO/DBFO	Public	Public	Public	Indefinite
	PFI	Public/private	Public/private	Public/private	10-20
	Divestiture	private	private	private	indefinite

Source: Adapted from, United Nations, (2011)

4.0 The applicability of the public private partnership to the primary health care facilities through Action planning

The action planning is used here to implement PPP, the essential elements here is to include the people and institutions involved, their participation in the process and the selection of key strategies. This is to be carried out through the process in steps as, problem identification, institutions and stakeholders, goal and objectives, resource gathering, data collection, appraisal and prioritize, implementation, then monitor and evaluate (Davidson et al, 2015).

4.1 Identifying Infrastructure Needs and Selecting Priorities

While long-term municipal investments require long-term financing instruments, such

investments should also be selected and designed in the context of a longer 3, 5, or 10-year, development plan. Capital investment planning a procedure and also an instrument for selecting, developing, and implementing an investment program under a rolling multiyear framework that guides, corresponds and transforms to the annual development plan. The preparation of a local capital improvement plan should include 3 phases, that is the:

(a) Identification and prioritization of the infrastructure needs and required capital expenditures; (b) assessment of the external resources needed, local priorities, and what is feasible and (c) determination of the best combination of resources and funding, as depicted in figure 2. An approved CIP is often a published document that informs both the potential financiers and the stakeholders (citizens, firms, potential investors, and municipal entities), (Frieire, 2014).

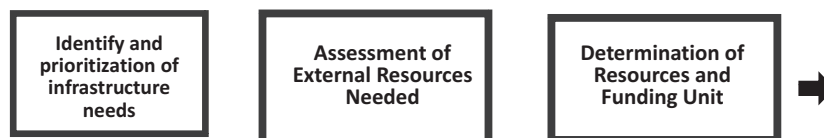


Figure 2 Framework for Drafting Capital Investment Plans (Adapted from Frieire, 2014)

4.2 Core function analyses (to decide services to be unbundled)

The services to be unbundled are subjected to analyses using the benefit model theory. This is based on whether services are for public good, equity, inexcludable or excludable, or whether the services are marketable. I.e. they have

the potential for competition and potential for cost recovery and public obligation and environmental externalities. A hypothetical example is given below with description and characteristics. From the major components of hospital facilities. The table below was created showing functions and characteristic (table 3).

Table 3 Core functions

	Major Components	Description/Characteristics
1	Clinical Services	Clinical Services
2	Clinical support systems	The local government provides Medical Technology, Examination and Testing Services. It includes all diagnostic services such as laboratories, x- ray, scans amongst others, are paid by individuals
3	Health Promotion	Local government to improve the health of the community as a whole. Including building healthy public policy, providing appropriate health information and education
4	Asset Management	The government provides accommodation, facility, utilities and services from public tax
5	Health management and administration	This includes legal, administrative, Workforce and Human Resource management and financial management from public tax
6	Revenue generation	It includes billing from treatment and services
7	Waste management	Segregation collection .transportation, and disposal of hospital waste done by government agency
8	Information and record keeping	The information and record keeping is done manually on cards and shelved in a card room by staff at minimal fee

This components were then given ratings(weights) to find out their marketability, each component was then subjected to 3 levels of scale, where 3-means high marketability, 2=medium marketability and 1=low marketability. An average value of less than 2.5 indicates the service is not

marketable hence cannot put in the hands of private investors hence no PPP (table 4).The average ratings on the table reveals that only clinical services and the hospital management administration should not be privatised.

Table 4 Potential for partnership (Marketability)

S/NO	Core Function/ Major Components	Potential for Competition	Potential for Cost Recovery	Nature Of Good or Service	(Environmental) Externalities	Equity Concerns	Potential for partnership (average ratings)
1	Clinical Services	High (3)	High (3)	Public good (1)	High (1)	Many (1)	1.8
2	Clinical support systems	High (3)	High (3)	Private good (3)		Medium (2)	2.5
3	Asset management	High (3)	High(3)	Private good (3)	Medium (2)	Medium (2)	2.7
4	Hospital management and administration	Medium (2)	Medium (2)	Public good (1)	Medium (2)	Many (1)	1.7
5	Information and record keeping	High (3) High (3)Private good (3)	High (3)	Private good (3)	Medium (2)	Medium (2)	2.7
6	Waste management	Private good (3)	Private good (3)	Private good (3)	Low (3)	Medium (2)	2.7
7	Revenue generation	High (3)	High (3)	Private good (3)	Medium (2)	Medium (2)	2.7

4.3 Applying PPP to facility management.

To apply the PPP to health facility management in the study area, after the initial manager which is the local government have unbundled what is privatizable. A private sector consortium is then formed, which a special company is called a "special purpose vehicle" (SPV) to develop, build, maintain and operate the asset for a contracted period, this is the step 1. In scenario where the government has invested in the project, it is typically (but not always) allotted an equity share in the SPV (Barlow et al, 2013). The consortium is usually made up of a building contractor, a maintenance company and bank lender(s). It is the SPV that signs the contract with the government and with subcontractors to build the facility and then maintain it. This complex arrangements and contracts guarantee and secure the cash flows and makes PPP projects prime candidates for project financing. As typical as it is it could be a hospital building financed and constructed by a private developer and then leased to the hospital authority. The private developer then acts as landlord, providing housekeeping and other non-medical services while the hospital itself provides medical services (World Health Organization, 2000).

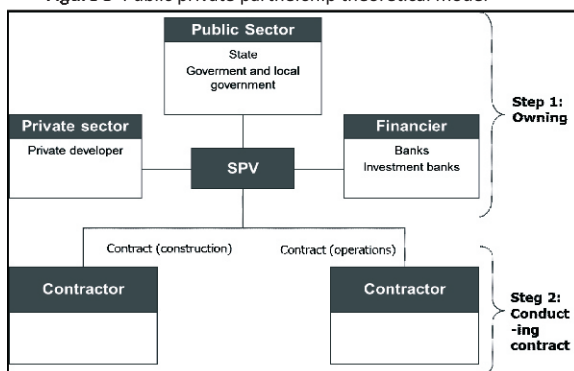
waste management, laundry services and maintenance of the environment. The contractor then may apply the cost benefit analysis to define expenditure, long time profit and then risk (figure 3).

5.0 Conclusions and Discussions

There is also an increasing recognition that reliance on rational decision models and 'technocratic' approaches to problem solving have largely been ineffective in dealing with the challenges of financing public institutions. Urban decision makers must therefore take a queue in devising and applying inclusive financing health facilities management strategies in the study area. The PPP partnership model was implemented in the study area through the action planning strategy.

The concept of the public private partnership (PPP) has no doubt emerged as a way of partnership between stakeholders in management of public facilities. This method commits the shareholders to share resource, risk and benefits. Strategies of PPP have been applied to the study area and various strategies have been examined with their pros and cons. The benefit theory was used in unbundling services necessary for PPP, because not all services can be handed over to private sectors, especially where excludability probability is very high, the government will have to continue to render or subsidize these services for the common good of the people. Hence the contract method was selected as most suitable for the study area. Even though no one method is really mutually exclusive, more than one method could be applied at the same time depending on the situation. As in Healey (2011) that, "the heart of urban governance lies in the combined, co-evolving relationship multi actors and therefore city planning and governance is not a responsibility of a particular institution, or experts or even government but a collective responsibility".

Figure 3 Public private partnership theoretical model



The second stage is the contracting, where the components of the facilities will be given out to contractors to manage. Here this may include

Few countries such as the United Kingdom and Chile had complete privatization of social infrastructure services. What was common then was contractual relationship where government retains ownership and while private firms tender for contract. Also there are reforms in Africa, Asia, where services have been contracted out, subsidies to non-profit hospitals; however series of contracting have been reported in the Asian countries, like Thailand, New Zealand, Tanzania etc.

A key lesson from experiences in New Zealand and other countries studied is that PPP should be carefully planned and presented based upon simple, transparent and strategic principles. The examination of all international experiences shows that PPP has to be carefully applied. Success and failure of these partnerships have the main issues associated with PPP as the assumptions and estimations conducted during the planning process which reflects on the risk of PPP programme. The result is that macroeconomic stability and size of markets are important determinants of PPPs in infrastructure. The evidence also suggests that in developing countries regulatory environments are important consideration in determining PPP projects. countries with small size of the market have low number of PPPs (Macedonia, Montenegro, Kosovo), while those with big size of the market have high number of PPPs such as Turkey, Romania and Bulgaria(Sava,2002).

Even though the application of PPP to some programmes have failed in some countries , example privatization of water in Bolivia, Thailand, Malaysia, Bangladesh; health services in Jamaica, and the Philippines had PPP Units whose performance fell far short of their objectives. Therefore there should be no assumptions that a PPP Unit will perform well, simply because it is created with good intentions (Salamon, 2002).

Opportunities to enhance the PPP should include additional support to health service provider's post-construction and better communications with the public to improve PPP project outcomes. As the PPP model evolves into more sensitive policy areas such as health care, care must be taken to clarify the nuances of the PPP model in order to effectively manage the elements of sociality and political rhetoric that can have significant influence on PPP project outcomes.

Benefits of PPPs are many for the Government, private operators and public at wide. The Government benefits cost effective and quality services which are offered in shorter time, thus meeting public needs. Also the private sector besides the business objective, specializes in a certain area and becomes more experienced and competitive offering the opportunity to export such experience in other countries.

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