Strategic Health Purchasing in Nigeria: Exploring the Evidence on Health System and Service Delivery Improvements

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ABSTRACT

Well-functioning purchasing arrangements allocate pooled funds to health providers, and are expected to deliver efficient, effective, quality, equitable and responsive health services and advance progress toward universal health coverage (UHC). This paper explores how improvements in purchasing functions in three Nigerian schemes—the Formal Sector Social Health Insurance Program (FSSHIP), the Saving One Million Lives Program for Results (SOML PforR), and Enugu State’s Free Maternal and Child Health Program (FMCHP)—may have contributed to better resource allocation, incentives for performance, greater accountability and improved service delivery. The paper uses a case-study approach, with data analyzed using the Strategic Health Purchasing Progress Tracking Framework. Data were collected through review of program documents and published research articles, and semi-structured interviews of 33 key informant interviews. Findings were triangulated within each case study across the multiple sources of information. Improvements in benefits specification and provider payment contributed to some service delivery improvements in all three schemes: higher satisfaction with the quality of care in FSSHIP; increased use of insecticide-treated nets; greater prevention of mother-to-child HIV transmission; expanded pentavalent-3 coverage in SOML PforR; and greater service utilization in FMCHP. Resource allocation to public health facilities was enhanced and lines of accountability were better defined. These scheme-level improvements have not translated to system change, because of the small amount of funding flowing through these schemes and the high level of health financing fragmentation. The institutionalization of strategic purchasing in Nigeria to advance UHC will require raising awareness among decision makers, strengthening purchasing agencies’ capacity, and reducing fragmentation.

Introduction

Global commitment to achieving universal health coverage (UHC) has led to increasing attention on health purchasing, which is one of the key health financing functions that provides the critical link between resources mobilized for health and the effective delivery of health services.1 Well-functioning purchasing arrangements are expected to deliver efficient, effective, quality, equitable and responsive health services for the population and ensure progress toward achieving UHC.

Health purchasing refers to the allocation of financial resources (pooled via various collection mechanisms) to service providers to obtain services in the benefit package for the covered population.2 It involves the functions of benefits specification, contracting, provider payment, and performance monitoring, which are carried out through the institutional structures of purchasing agencies and other actors.3 These functions can be carried out more passively or more strategically.1,4–6

Strategic health purchasing refers to a set of active policy measures that link the transfer of pooled funds to the delivery of priority health services in a way that ensures quality, efficiency, and equity. Strategic purchasing aims to enhance health system performance and facilitate progress toward UHC.7–9

In 2019, the Strategic Purchasing Africa Resource Center (SPARC) and its technical partners mapped and assessed health purchasing functions, capacities and governance arrangements across the major health financing schemes in nine African countries, including Nigeria.10,11 Evidence from that analysis showed that a major challenge across the nine countries was the weak link between health purchasing functions and their influence on improving resource allocation,
incentives and accountability, as well as health system results of equity, access, financial protection, quality, efficiency and financial sustainability.\textsuperscript{12,13} There was limited evidence of the effect of strategic purchasing on health systems and service delivery outcomes in Africa.\textsuperscript{11,13}

This paper provides new knowledge to fill gaps in evidence on the health system results of strategic purchasing in Nigeria. These findings can help inform policies that will contribute to better purchasing of health services and greater efficiency in health financing. We adopted a case study approach to explore how health purchasing functions in three health financing schemes in Nigeria have contributed to improved service delivery and the intermediate health system results of better resource allocation, improved performance incentives, and greater accountability. The evidence provided in this paper supports the need for greater investment in strengthening strategic purchasing capacity in Nigeria’s health financing mechanisms.

**Methods**

**Analytical Framework**

Our analysis was guided by the Strategic Health Purchasing Progress Tracking Framework developed by SPARC (Figure 1).\textsuperscript{6} The framework focuses on key purchasing functions: benefits specification, contracting arrangements, provider payment, and performance monitoring, and the governance and institutional arrangements that provide oversight and accountability for effective implementation of the purchasing functions. The framework posits that when purchasing functions and governance arrangements are in place, the purchaser can directly influence (positively or negatively) the allocation of resources, the incentives that affect individual provider behavior, and accountability (through contract enforcement and performance monitoring). Resource allocation, incentives, and accountability can in turn affect overall progress toward UHC goals.

The framework also incorporates factors external to the purchasing arrangements that can either strengthen or weaken the power of purchasers to directly influence resource allocation and provider behavior. These include the share of total health funding managed by the purchaser, public financial management rules, and provider capacity. For example, lack of clear mandate and unclear division of authority among purchasing actors could limit effectiveness of purchasing.\textsuperscript{6} The distribution of power among the different actors also affects outcomes. For instance, when the purchaser has less political power than providers, the purchaser’s ability to influence provider behavior may be limited.\textsuperscript{6} Failure to understand these political and economic factors

![Figure 1. Strategic health purchasing progress tracking framework.](image-url)
might hinder effective implementation of strategic purchasing.

Study Design

We used a descriptive case study design to explore whether and/or how health purchasing has contributed to better service delivery, better resource allocation, incentives for providers to improve their performance, and greater accountability. We selected three health financing schemes for the case studies based on evidence that their purchasing arrangements included the main functions specified in the framework: the Formal Sector Social Health Insurance Program (FSSHIP), the Saving One Million Lives Program for Results (SOML PforR), and the Enugu State Free Maternal and Child Health Program (FMCHP).

Data Collection

We collected data through a review of 21 program documents and published research articles, along with 33 semi-structured interviews of key informants who were involved in purchasing arrangements in the respective schemes at the federal and/or state levels.

We sourced peer-reviewed articles published in English between 2010 and 2020 from Scopus, PubMed, Google Scholar, and the Directory of Open Access Journals, using a combination of key words including, “strategic health purchasing,” “Nigeria” “health financing”, “service delivery,” “outcomes,” “accountability,” “incentives for performance,” “resource allocation”.

We sourced published program reports, strategy documents, and guidelines from the websites of organizations that included government and nongovernment agencies. We sourced unpublished policy documents and program reports from the Federal Ministry of Health (FMOH). Given the overlap between programs implemented to achieve similar outcomes we used evaluation-based evidence including internal reports based on regular data collection.

We selected key informants based on their current job and/or job experience related to health financing and health purchasing. Interviewees included policymakers, senior health managers, program officers, finance officers, planning and procurement officers, health facility managers and technical partners. Interviews were conducted face-to-face, by telephone, or by e-mail between April and July 2020. The oral interviews were conducted by experienced researchers using a semi-structured guide that was developed specifically for this study and is based on the framework. All participants were informed of the objectives of the study and why they were selected and understood that their participation was voluntary. Oral key informant interviews were audio recorded with the respondents’ consent.

Table 1 summarizes the numbers of documents reviewed and key informants interviewed for each case study.

Data Analysis

Interviews were transcribed and findings on each health purchasing function and associated results were summarized in excel for each case study according to the sub-themes specified in the interview guide. The results of interest included effects of improvements in health purchasing functions on 1) service delivery, 2) resource allocation, 3) incentives for performance, and 4) accountability. The interview summaries and findings from document review were triangulated and narrative synthesis of data was performed for each case study.

Results

Case Study 1: Formal Sector Social Health Insurance Program

FSSHIP was established by Nigeria’s National Health Insurance Scheme (NHIS) in 2005 to provide health insurance for formal-sector employees and their dependents.14

Institutional Arrangements and Governance

NHIS and health maintenance organizations (HMOs)—private intermediaries—have the main responsibility for purchasing functions within the scheme. They determine contractual arrangements and make payments to providers for services delivered to beneficiaries using provider payment mechanisms. NHIS is the regulator and aggregator (risk and fund pooling), and it also performs some purchasing functions, including defining benefit packages and establishing provider payment rates and mechanisms. NHIS also influences decisions about which providers to contract, through its role in accrediting HMOs and facilities. HMOs are third-party administrators and the direct purchasers of health services; they make payments using the approved provider

Table 1. Number of documents and key informant interviews by case study.

|                      | FSSHIP | SOML PforR | FMCHP | Total |
|----------------------|--------|------------|-------|-------|
| Total Documents Reviewed | 9      | 6          | 6     | 21    |
| Program Documents and Reports | 1      | 6          | 1     | 8     |
| Published Research Articles | 8      | 0          | 5     | 13    |
| Key Informant Interviews | 14     | 14         | 5     | 33    |
payment mechanisms, and monitor provider performance. The purchaser-provider split in FSSHIP lies in barring HMOs from owning health facilities.

**Purchasing Functions**

**Benefits Specification.** FSSHIP has an explicit benefit package with gatekeeping and referral guidelines. The package was predetermined by NHIS at its inception but was found to be too restrictive and was subsequently expanded. Providers must adhere to standardized treatment protocols in order to ensure that they provide good-quality services to clients. NHIS also mandates prescription of generic only medicines, which is enforced through a medicines list that is reviewed periodically. Beneficiaries have a 10% copayment for prescribed drugs and a 50% copayment for some services subject to partial exclusion in the benefits package.

**Contracting Arrangements.** FSSHIP contracts with public and private health care facilities, using predefined terms that provide a specific package of health services to beneficiaries. Providers are fully accredited following a process of facility and personnel assessment, provisional approval, and two rounds of quality assurance visits by NHIS. Providers that do not meet personnel and facility requirements are denied a contract; contracts are terminated when gross violations of the contract terms occur.

**Provider Payment.** Health service providers are paid via capitation for primary care services and via fee-for-service payment for secondary and tertiary care services. The payment rates are fixed and determined through actuarial studies on the basis of the benefit package and NHIS budget. However, payment rates for some drugs and services can be negotiated on a case-by-case basis. HMOs manage purchasing of secondary services.

**Performance Monitoring.** HMOs monitor the performance of providers through routine service delivery reports submitted by providers and quarterly monitoring visits.

The interaction of elements of strategic purchasing that have been implemented in FSSHIP have resulted in varied levels of improvement in resource allocation, accountability, performance incentives, and service delivery.

**Resource Allocation.** Participating public and private health facilities have recorded an almost threefold increase from baseline in financial resources available for service delivery. Funds from the FSSHIP account make up as much as 36% of the total revenue of participating facilities, who use these funds to employ more health workers and improve physical and diagnostic infrastructure. Over the years, NHIS has also made efficiency gains in the FSSHIP pool. These efficiency gains include spending less to purchase services due to highly prioritized benefit packages, the use of generics-only policy which assures the lowest priced option for drugs, efficient verification of claims by providers and HMOs to lower the cost of services, and other improvements in capitation and fee-for-service reimbursement.

**Performance Incentives.** The purchasing arrangements in the FSSHIP were not found to contribute to improved incentives for providers to deliver high-quality services efficiently, mainly because of the unpredictability of the timing and amount of provider payments. The study found capitation payments were highly predictable in terms of amount but less so in terms of timing. Fee-for-service was less predictable than capitation in terms of both timing and amount. Providers were demotivated by delays in payment and arbitrary shortfalls in fee-for-service revenue.

**Accountability.** Little research has been conducted or published on how monitoring and evaluation of provider and system performance has affected accountability within FSSHIP. Evidence from a case study of the program in Enugu State shows that the existence of better accountability mechanisms has not translated to better stewardship and responsiveness to the needs of beneficiaries.

**Service Delivery.** Although a country-wide assessment of the FSSHIP has not been conducted, some researchers have examined the level of access and utilization of health services from NHIS accredited facilities. FSSHIP’s use of capitation as the provider payment mechanism has ensured that enrollees have access to primary care services and that required secondary services are paid for through fee-for-service. The clear specification of covered essential services has helped expand service coverage. High levels of satisfaction have been reported with ease of access to care, wait times, and hospital environment among FSSHIP beneficiaries. FSSHIP beneficiaries experience fewer delays and better quality of care compared to uninsured clients. Referral services are considered prompt and responsive to client needs. One tertiary hospital in southwest Nigeria reportedly achieved a 144% increase in health service
utilization in staff two years after the implementation of FSSHIP.21

**Case Study 2: Saving One Million Lives Program for Results (SOML PforR)**

The SOML PforR initiative is a Federal Government of Nigeria Maternal and Child Health Program supported by the World Bank, which provides incentives, based on achievement of results (health outcome). It is a broad-based investment program with six distinct health pillars—immunization, malaria control, nutrition, prevention of mother to child transmission of HIV, delivery of essential medicines to address common childhood illnesses, and strengthening of MCH delivery platforms. However, the program came to an end mid-year in 2020 due to the failure of the government to sustain it beyond the expiration of donor funding.

**Institutional Arrangements and Governance**

SOML PforR specified roles and responsibilities for various actors within a framework that aligned with service delivery goals for UHC, while ensuring effective coordination, transparency and accountability for resource utilization, and effective monitoring of purchaser and provider performance. The governance arrangements of SOML PforR include a purchaser-provider split with clear definitions of roles. The program has state-level steering committees that are responsible for purchasing and oversight, and it has a technical consultative group that provides technical support to the committees.22 Other functions of the steering committees include performance monitoring and evaluation to ensure achievement of targets and results. Service delivery is governed separately by the State Primary Health Care Development Agency, the local government health authority, and the ward development committees (WDCs).20

**Purchasing Functions**

**Benefits Specification.** The package of MCH services was comprehensive and provided the means of increasing the coverage of simple but effective interventions high-impact interventions targeted at pregnant women, children, and adolescents,26 with six corresponding maternal and child health indicators: 1) childhood immunization coverage using penta 3, 2) modern contraceptive prevalence rate, 3) vitamin A supplementation for children ages 6 months to 5 years, 4) skilled birth attendance, 5) HIV counseling and testing for women receiving prenatal care, and 6) use of insecticide-treated nets by children under age 5.

**Contracting Arrangements.** Interventions were carried out in all 36 states in Nigeria and the Federal Capital Territory. No selective contracting was used; public primary health centers were automatically selected to provide services.

**Provider Payment.** SOML PforR adopted the performance-based financing (PBF) approach, and the renewal of grants to states was tied to performance on the six key indicators and a quality-of-care index.20

**Performance Monitoring.** Provider performance was tracked through the DHIS2 platform and analyzed quarterly.23

The elements of strategic purchasing that were implemented in SOML PforR resulted in improvements in resource allocation, accountability, performance incentives, and service delivery.

**Resource Allocation.** SOML PforR enhanced resource allocation across states, local governments, and health facilities for priority primary health care interventions. All states received $1.5 million USD at the onset of the program.24 The funds were used to purchase insecticide-treated nets, maternal delivery kits, routine prenatal care drugs, sulphadoxine-pyrimethamine for IPTp, urine strips, HIV test kits, hemoglobin testing reagents, fetoscopes, examination lights, sterile scissors, cord clamps, and forceps. In addition, essential drugs and basic equipment were purchased and distributed to primary health centers, and PHC workers were trained in improving the quality of MCH service delivery.24

**Performance Incentives.** SOML created incentives for states and providers to increase coverage of the prioritized interventions. States were rewarded with more funds in the second round based on actual improvements in the disbursement-linked indicators. Community volunteers were rewarded with stipends for referring pregnant women to primary health facilities. Mama kits (containing sterile gloves, delivery mat, surgical blades, cord clamp, ligatures, cotton wool, antiseptic solution, and baby soap) were given to women who delivered in health facilities. Primary healthcare providers that performed better received more products, such as drugs, prenatal care delivery packs, and insecticide-treated nets.25

**Accountability.** Accountability mechanisms were introduced through Memoranda of Understanding (MOUs) between the Federal Ministry of Health (FMOH) and state governments, and periodic and regular performance appraisals (of providers and states).
These accountability mechanisms contributed to the achievement of specified objectives for quality, efficient and equitable service delivery. State governments abided by the terms of their MOUs with the FMOH by ensuring that SOML funds were used strictly for SOML interventions. There was also a gradual increase in data reporting over time. All program expenditures were tracked at the state level, and a summary report was produced annually. States were rewarded for achieving improvements in financial management and budget execution of expenditures linked to SOML PforR. The program’s grievance redress mechanism was effective in the prompt review of reports.

**Service Delivery.** The additional funds received through the intervention SOML, the priorities communicated through the benefits specification, and the financial incentives of the payment mechanisms contributed to improved service utilization as measured by key service indicators (Figures 2–8). Nationally, the index for combined coverage of these key services increased from 237 points in 2015 to 244% in 2018. Eighteen states (50%) recorded improvements in the key indicators and qualified for the next round of funding. Notable improvements were seen in the poorest-performing parts of the country—such as the northeast and northwest, with increases of 37 and 12.4 points, respectively, between 2015 and 2018. Significant improvements were reported in the use of insecticide-treated nets (12.4-point increase), prevention of mother-to-child HIV transmission (PMTCT) (5.7-point increase), and pentavalent-3 coverage (8.8-point increase).

**Case Study 3: Enugu State Free Maternal and Child Health Services Program**

Enugu State adopted the Free Maternal and Child Healthcare Program (FMCHP) in 2007, which removed user fees at the point of service delivery for pregnant women and under-five children based on a minimum services package. The program has been sustained due to high political will and the mobilization of domestic resources from State and local government allocations.

**Institutional Arrangements and Governance**

The program is governed by a steering committee (SC) and a state implementation committee (SIC); these are the purchasing agencies, and they are distinct from the state ministry of health that oversees service delivery—introducing a purchaser-provider split. The SC pools the funds and serves as the primary purchaser; the SIC serves as the financial intermediary between the SC and service providers. The SIC monitors district-level implementation of FMCHP, receives and verifies provider claims and recommends approved claims to the SC for payment. The state health board oversees district health boards and supervises district-level facilities, while the local health authorities supervises primary healthcare facilities.

**Purchasing Functions**

**Benefits Specification.** The benefit package is designed to ensure equitable access to quality MCH services for women and children in Enugu state. It includes free prenatal care, delivery care, and postnatal care for 42 days, as well as free treatment for malaria, acute respiratory infections, and diarrheal diseases in children under age 5.

**Contracting Arrangements.** Health services are purchased from both public and private providers. All health facilities and hospitals owned by the state government are automatically selected to provide free MCH services within the approved benefit package, with no contractual arrangements. Private providers must sign an MOU with the state ministry of health that lays out criteria for service delivery.

**Provider Payment.** Providers are paid fee-for-service guided by a fixed-fee schedule, and monthly salaries for health workers. Medicines, equipment, and other consumables are supplied directly to health facilities through an embedded drug-revolving fund system.

**Performance Monitoring.** Performance monitoring cascades down from the state health board, which oversees district health boards and supervises district hospitals and district-level health workers. The local health authorities supervise all primary health facilities and cottage hospitals and support health facilities in preparing claims and submitting them for payment.

The interaction of elements of strategic purchasing that were implemented in the FMCHP resulted in some improvements in resource allocation, accountability, and service delivery outcomes, as outlined below.

**Resource Allocation.** Allocation of health resources to public health facilities was enhanced as a result of the strategic purchasing arrangements. Despite some delays in payment to health facilities, sufficient resources (money, infrastructure, equipment, and supplies) for FMCHP were distributed to participating health facilities. However, funds raised for FMCHP stagnated between 2010 and 2016, and the criteria and procedure for allocating resources to health facilities were
The overall FMCHP budget did not increase, but better collection of state and local government contributions led to greater resource allocation to facilities. At inception, the collection of these contributions was passive and unpredictable. However, a direct deduction of state and local general revenue was unclear. The overall FMCHP budget did not increase, but better collection of state and local government contributions led to greater resource allocation to

**Figure 2.** Description of the three financing schemes reviewed—the Formal Sector Social Health Insurance Programme (FSSHIP), the Saving One Million Lives Programme for Results (SOML PforR), and Enugu State’s Free Maternal and Child Health Programme (FMCHP).
introduced in 2009, with the transfer made automatically to FMCHP, which improved the predictability of the revenue for the program.²²

**Performance Incentives.** Fee-for-service payment created some adverse incentives for both purchasers and providers and it did not provide predictable revenue for health facilities. Some purchasing decision makers used FMCHP funds for unauthorized purposes, thus depleting the pool of funds for service provision; and some providers and district-level officials inflated fee-for-service claims.²⁴ The average unauthorized expenditure was 34%, which exceeded all annual legitimate FMCHP spending between 2013 and 2016.³² The unpredictable revenue and frequent shortfalls for providers demotivated health workers and disrupted the revolving drug fund in many health facilities.

**Accountability.** Bureaucratic accountability structures were strengthened within the FMCHP. The oversight roles of stakeholders and lines of accountability were clearly defined and executed at various levels. Tools for
monitoring provider payment and performance were specified and used to ensure delivery of high-quality free MCH services.\textsuperscript{31} Supportive governance practices enabled review of questionable provider claims, direct facility financing, central procurement of drugs, and tracking of funds paid to providers.\textsuperscript{30,31} Nonetheless, citizen participation in designing benefits, reporting provider claims, and monitoring provider payment was weak.\textsuperscript{30}

\textbf{Service Delivery.} Figure 9 shows fluctuations in selected MCH indicators in the five years after FMCHP implementation in Enugu State. Pre-program data for the
state were not available on DHIS2. However, facility-based studies comparing service delivery outcomes before and after FMCHP implementation showed improvements in key indicators. Okafor et al. reported a 202.2% increase in prenatal care, a 151.8% increase in hospital deliveries, and a 16.4% decrease in maternal mortality in the state tertiary hospital in the three months following FMCHP implementation. A study by Uzochukwu et al. showed a threefold increase in under-5 facility attendance, an increase in total prenatal care visits from 120 to 5,724, and an increase in hospital deliveries from 0 to 678. Unfortunately, these early increases were not sustained due to conditions introduced for health facilities to demonstrate evidence of tax payment by beneficiaries in order to receive payment of claims.

Discussion
The findings show that progress in strategic purchasing has varied among the three schemes under study, but most progress is observed in the functions of benefits specification and performance monitoring. Less progress is observed in contracting and provider payment. Although output-based payment was introduced in all of the schemes to link purchasing to promised benefits, challenges with the predictability of the timing and amount of payment weakened the incentives, and
overbilling and inflation of fee-for-service claims occurred. The study shows that strategic purchasing is linked to some improvements in health system results and service delivery within individual schemes. Progress in making purchasing functions more strategic has led to better resource allocation, performance incentives for providers and accountability, and measurable service delivery indicators. The evidence validates the idea that strategic purchasing can facilitate progress toward UHC, and it underscores the need for more investment in strategic purchasing, including to expand the capacity of purchasing agencies to make strategic decisions. The purchaser-provider split used in SOML PforR enabled the purchaser to enforce (without prejudice) accountability of providers to beneficiaries. Similar findings have been reported in Thailand and Kenya.\textsuperscript{36–38}

However, due to the high level of fragmentation of resources and the multiplicity of health financing mechanisms at the federal and state levels in Nigeria, the resulting service delivery improvements in these schemes were not sustained, and have not had a broader, system-level impact. The amount of funding flowing through these schemes (including general tax revenue, federal and state social health insurance schemes' budgets, and donor funding) is low, at only 24% of total health expenditure in Nigeria. As much as 76% of total health expenditure is out-of-pocket spending.\textsuperscript{39} For Nigeria to see greater impact from purchasing reforms, resources must be pooled to improve purchasing power and thereby improve resource allocation, incentives to providers, and provider accountability for resources and the quality of health services.

The purchasers in all three schemes engage mostly public facilities to deliver services in the benefits package. However, there are more private facilities in number than public health facilities in Nigeria, and an estimated 37% of all care is delivered by private providers.\textsuperscript{40} Hence, incorporating private facilities in health financing schemes and strategic purchasing arrangements is likely to improve geographical access to care and promote pro-poor service utilization due to reduced travel cost and time, as well as increasing beneficiary satisfaction and financial protection. Strategic purchasing is also a way to ensure that private providers follow quality standards, report service delivery data, and have financial incentives for good performance.\textsuperscript{41}

**Consolidating and Institutionalizing Strategic Purchasing in Nigeria**

As progress is made in purchasing functions in Nigeria, it is necessary to institutionalize strategic purchasing by designing legal and regulatory frameworks that clarify purchasing roles and responsibilities, with clear communication to providers and beneficiaries (as has been reported in countries including Kenya).\textsuperscript{35} Benefits to clients should be optimized through robust benefits packages that are harmonized and institutionalized across the country. A comprehensive benefits package is required to improve financial protection against high out-of-pocket spending. A comprehensive benefit package could be arrived at
through cost-effectiveness analysis, demand estimates, policy analysis, and public opinion surveys.\textsuperscript{42} Other mechanisms, such as selective contracting and using provider payment to harmonize funding flows to providers, can also help improve purchasing.\textsuperscript{43} However, care should be taken to avoid the perverse incentives to providers that can result from the use of particular provider payment mechanisms (as reported in studies conducted in Nigeria and other countries).\textsuperscript{44,45}

Limitations of the Study

A major limitation of this study is that certain documented improvements in service delivery outcomes may not be fully attributable to specific interventions or health financing mechanisms alone, considering that multiple interventions were implemented concurrently. Moreover, since results were not disaggregated by type of provider, observed improvements in service utilization for key indicators in the SOML PforR may have resulted simply from higher-quality services offered by the private sector or a maturation effect. Although SOML PforR’s monitoring and evaluation mechanism was designed to regularly assess the impact of the interventions by analyzing health data, a public facility-based assessment may give a clearer picture of the impact. A second limitation is that comparative analyses were conducted using an analytical framework comprising four themes, namely: service delivery, resource allocation, incentives for performance and accountability. Further studies might consider expanding the analytical framework to gain broader insights into reforms that might enhance implementation of strategic purchasing.

Conclusions

This evidence synthesis shows that the purchasing functions of benefit specification, contracting arrangements, provider payment, and performance monitoring can interact to leverage better resource allocation, appropriate incentives for performance and better accountability. Improvements in purchasing functions therefore resulted in better access for the population to covered services of adequate quality and with financial protection. These improvements suggest that strategic purchasing can lead to more efficient, equitable and accountable deployment of resources, which can help strengthen overall health systems and facilitate progress toward UHC at the federal and state levels in Nigeria. Federal and State governments should entrench SHP as the main mechanism for purchasing health services. However, health system fragmentation in Nigeria is a fundamental challenge that prevents these positive effects from leading to systemwide improvements. The institutionalization of strategic purchasing within Nigeria will require strengthening the capacity of purchasing agencies and raising awareness of its benefits among decision makers in relevant departments, agencies, and programs, while also addressing fragmentation to reduce the number of pools, and channel out-of-pocket spending to prepayment. This will improve access to quality services and improve financial protection, which will spur progress toward UHC.

Author Contributions

All of the authors participated in data collection and analysis. OO and CM wrote the first draft of the manuscript, and all authors commented on subsequent versions of the manuscript. All authors read and approved the final manuscript.

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Ethical Approval

Ethics approval was obtained from the Health Research and Ethics Committee of the University of Nigeria Teaching Hospital.

Informed Consent From Participants

Verbal informed consent was before interviews were conducted.

Data Availability Statement

The datasets generated and analyzed during the current study are available from the corresponding author upon reasonable request.

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