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A Review of Basic Health Care Provision Fund (BHCF) and Primary Health Care Assessment in Plateau State

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ABSTRACT: *The Basic Health Care Provision Fund (BHCPF) is a direct financial investment that funds Primary Healthcare (PHC), initiated by the federal government of Nigeria to improve the quality of services given to Nigerians. This study reviewed the BHCPF and PHCs assessment in Plateau State. This study was designed to know the level of influence of BHCPF and PHC on Plateau citizens across all the 17 LGAs in terms of healthcare. A desk review and longitudinal research designs were carried out on data already generated. The reviewed study adopted a mixed method design. The findings indicate that the general condition of most of the PHC facilities is an issue and there is also inadequate skilled manpower in the hospitals, long waiting hours, high cost of health services, lack of drugs and inadequate space. To reposition the BHCPF to better achieve its full objectives in Plateau State, the researchers recommended that Funding, Accountability and Transparency, Awareness Creation, Public-Private Partnership among other aspects discussed, be redefined in an updated policy version of the BHCPF the government is advised to begin the process on.*

KEYWORDS: primary health care, basic health care provision fund, ward health system, ward minimum health care package, consolidated revenue fund, plateau state.

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INTRODUCTION

Health gains oftentimes associated with income growth have been stubbornly slow in Nigeria in the past 25 years. One plausible reason for this stagnation is underperformance in the country's primary health care (PHC) system (Kress, Su and Wang, 2016). Africa's most populous country (Nigeria), has one of the highest rates of out-of-pocket spending (75%) and one of the lowest rates of health insurance coverage (4%). This, coupled with a fragmented and poorly resourced primary healthcare system, makes accessing even basic care an insurmountable challenge for most Nigerians. Despite political commitments and ambitious policies to improve and expand primary healthcare, Nigeria's primary healthcare system remains broken (Health Policy Plus, 2022). The inefficient system has persisted despite several efforts by the government to improve the coverage and quality of primary healthcare throughout the country. Nigeria's health sector is bedeviled by a number of challenges that contribute to poor health outcomes. Major among these challenges is the low government investment in the health sector. Signing of the National Health Bill into an Act at the twilight of the President Goodluck Jonathan's administration in 2014 was greeted with euphoria largely because it paved the way for implementation of the Basic Health Care Provision Fund (BHCPF). It was glaring that the healthcare sector in Nigeria had made little progress in providing adequate quality healthcare services; it remained a cause for concern for many Nigerians who continued to have access to inadequate healthcare services. Therefore, the euphoria was understandable because the BHCPF was envisaged to play a pivotal role in transforming Nigeria's unenviable health financing landscape characterized by suboptimal public investment as Nigeria government spends less than one percent of the country's GDP on health which is one of the lowest public investment in health in the world (Alawode, 2021).

The National Health Act (2014), under section 11, proposed a radical shift in health financing through establishment of the Basic Healthcare Provision Fund (BHCPF) as a catalytic funding mechanism to improve access to primary health care. The BHCPF serves to fund a Basic Minimum Package of Health Services (BMPHS), increase the fiscal space for health, strengthen the national health system particularly at primary health care (PHC) level by making provision for routine daily operation cost of PHCs, and ensure access to health care for all, particularly the poor, thus contributing to overall national productivity. The BHCPF is derived from an annual grant from the Federal Government of Nigeria, not less than one percent (1%) of the Consolidated Revenue Fund (CRF), grants by international donor partners and funds from any other source, private sector included. The BHCPF is implemented by 3 gateways namely, the National Primary Health Care Development Agency (NPHCDA) gateway which provides operational cost (Decentralized Facility Financing – DFF) and Human Resource for Health (HRH) for PHCs through the State Primary Health Care Board (SPHCB), the National Health Insurance Scheme (NHIS) now National Health Insurance Authority (NHIA) gateway which insures the most vulnerable Nigerians to access the BMPHS through the State Social Health Insurance Agencies (SSHIA) and the National Emergency Medical Treatment (NEMT) gateway which is expected to cater for emergency ambulance services.

Over the years, Nigeria's health care crisis has witnessed renewed attention as a result of the greater awareness of the militating factors and a better understanding of the interwoven connections between health and economic development. The primary level of health care in Nigeria is the first level of entry into the health system and also the most patronized because Primary health care (PHC) is the backbone of a health system; the foundational basis for the provision of healthcare services in Nigeria recognized by the Act in a series of sections designed to strengthen PHC. The strength of a country's primary care system is seen in the quality PHC initiatives experienced by its citizenry in terms of improving health outcomes. Unfortunately, less impact has been felt in the sector in Nigeria; health care has remained at the level of lowest standard of care because the availability of the basic health services provided by the PHCs especially the ones in the rural areas in a country; they are the main ones used as a yardstick to measure the extent of PHC development health wise. Using this yardstick as a means of measuremen, It is no secret that the state of primary healthcare in Nigeria is poor; decades of neglect by state and local governments, whose responsibility it is to provide primary healthcare services in the country, have resulted in inefficient and poor-quality primary healthcare service delivery across the country. Every day, vulnerable people, including pregnant women and children pay the price of this inefficiency (Abubakar, 2022).

As observed by Kress, Su and Wang (2016), researchers have sought root causes of poor PHC coverage in Nigeria, focusing largely on two factors. First, many argue that poor performance is due to lack of sufficient health care facilities. Some other scholars have argued that low PHC coverage is a result of an insufficient health workforce. The literature largely points to bottlenecks in PHC inputs, including health facilities and health workers, to explain Nigeria's poor performance in PHC coverage. However, these factors may not entirely convey the whole story. This article draws upon a detailed and holistic conceptual framework to examine Nigeria's primary health care system, focusing on Plateau State. The paper reviewed the extent to which Basic Health Care Provision Fund (BHCF) and Primary Health Care Assessment has fared in Plateau State in terms of healthcare services available at facilities, service delivery, common challenges to healthcare access, manpower in healthcare facilities and the health care services they provide from the available services in the PHC facilities.

MATERIALS AND METHODOLOGY

Data Sources

A variety of data sources were used in this article to understand the PHC performance in Nigeria generally and Plateau State in particular. Data sources were mainly secondary sources. They include the Baseline survey (BS) on the disease burden, universal health coverage, health-seeking behavior, knowledge attitude and perception of Plateau Residents on Social Health Insurance Submitted to Plateau State Contributory Healthcare Management Agency PLASCHEMA, November 2021 and additional data generated from relevant literatures that are of interest to the research.

Study Area
The primary study reviewed was carried out on the 17 local governments of Plateau State, located in the North Central region of Nigeria, covering a land area of approximately 26, 899 sq. Kilometers with an estimated population of about 3.5 million people. A multistage approach was employed to adopt communities into the survey. Two communities were selected in each Local Government Area (LGA); the ward where the local government headquarters is located was selected purposively and the other was selected randomly

Study Design and Population
A desk review and longitudinal research designs were carried out on data already generated/ researchers' observations. The reviewed study adopted a mixed method design; an admixture of quantitative and qualitative research approaches, comprising Household survey, Health facility assessment, Key Informant Interview (KII) and Focus Group Discussions (FGD). The respondents were selected purposively using knowledge of the community and health characteristics as pre requisite criteria. Data collected comprised of 3981 households' interviews, 325 health facilities, 119 key informant interviews, 6 Focused Group Discussions. Three hundred and twenty-five (325) primary healthcare facilities and 127 Private facilities (including pharmacies) were assessed.

Data Collection and Analysis of the reviewed Baseline Survey (BS)
On the reviewed study, quantitative data collection was carried out by experienced and trained data collectors selected across the 17 LGAs using structured electronic questionnaires on the ODK collect data tool. The questionnaire was formulated in English; mainly administered in English and Hausa. The research team conducted recorded and summarized qualitative data using the FGD/KII guide in the study instruments. Quantitative data analysis was conducted using a combination of MS Excel and SPSS applications. Qualitative data was analyzed using thematic frameworks based on NVIVO and later own transcribed to Excel.

Objectives
In General, the review is targeted at buttressing on the true state of Basic Health Care Provision Fund (BHCF) and Primary Health Care Assessment in Plateau State in terms of healthcare services available at facilities, service delivery, common challenges to healthcare access, manpower in healthcare facilities and the health care services they provide from the services available in the PHC facilities. In specifics, the aim of this article is to buttress on the identified root causes of PHC underperformance in Plateau State by the Baseline Survey (BS), highlight areas of future research in terms of operationalization of the PHCs and provide possible recommendations by which the policy makers in the health sector and future Health policy agenda can be shaped.

Present state of PHCs in Nigeria
Over the past decade, the Primary Health Care programmes budget remains weak as it has never met WHO's benchmark of 15% in the annual health budget of the Nigeria. A large aspect of the challenges is placed on this because operations are highly ineffective due to poor budgeting. Between 2019 and 2021, a consortium that includes ONE Campaign, National Advocates for

Health, Nigeria Health Watch, and Public and Private Development Centre, assessed the state of primary healthcare delivery in Nigeria. In accordance to standard protocol, the Primary Health Care Performance Indicators conceptual framework was used to examine Nigeria's PHC system and possible causes of underperformance. The aim was to identify the weak links, showcase the strengths and highlight opportunities for improvement in Nigeria's primary healthcare system. The assessment report, which was launched in July 2022, revealed the good, the bad and the extremely poor in primary healthcare delivery across the country. It also revealed the extent of implementation of the Basic Health Care Provision Fund (BHCPF) in Primary Health Centres (PHCs) across states in Nigeria (Abubakar, 2022). The assessment was conducted using 20 indicators that cover policy design; legislation and implementation at state level; health workforce and health products; community experiences; implementation of the BHCPF; budgetary allocation and release; and basic healthcare service delivery. It revealed that in the areas of immunization, nutrition and maternal health, only 19 of the 36 states and the Federal Capital Territory (FCT) achieved a score of 56% and above. The highest performing state, the FCT, achieved a score of 68%. Findings from this assessment also revealed that the first funding releases to the BHCPF pillars commenced in 2018. Despite the resources committed to achieve its objectives, there are still huge gaps in the implementation of the BHCPF at the state level. For instance, each state is required to identify and register at least one PHC per political ward under the BHCPF. All 36 states and the FCT submitted a full list of PHCs to the BHCPF secretariat claiming that they have the required number of PHCs per ward; only 11 have at least one functional PHC per ward. It further revealed that 26 states in Nigeria do not have at least one functional PHC per political ward (Abubakar, 2022). This is a huge challenge to the states and local governments affected. It buttresses the fact that Primary healthcare systems in over half of Nigerian states are weak because the assessment has effectively provided an update into the state of primary healthcare delivery in Nigeria. It is also a strong reminder that the responsibility for optimal functional primary healthcare delivery lies with the state and local government in Nigeria. The most concerning findings of the assessment is the inaccessibility of healthcare at community level, the poor state of public primary healthcare facilities, low health worker density, and lack of transparency in budgetary allocation and release. Almost all the states did not score well in these areas, Plateau Sate included.

The Ward Health System (WHS) and Ward Minimum Health Care Package (WMHCP)

The Ward Health System (WHS) represents the current national strategic thrust for the delivery of PHC services in Nigeria and utilizes the electoral ward as the basic operational unit for PHC service delivery. The Ward Minimum Health Care Package (WMHCP) was developed to address the current Ward Health System strategy to deliver PHC services and consists of a set of health interventions and services that address health and health related problems that would result in substantial health gains at low cost to government and its partners. It includes the following interventions: (1) Control of Communicable Diseases (Malaria, STI/HIV/AIDS), (2) Child Survival, (3) Maternal and New born Care, (4) Nutrition, (5) Non-Communicable Diseases Prevention, (6) Health Education and Community Mobilization

Minimum standards for PHCs in Nigeria

Following the development of the Ward Minimum Health Care Package in 2007, there was also the need to define and declare a set of Minimum Standards in the areas of health infrastructure, human and financial resources and provision of essential drugs and commodities for primary health institutions in Nigeria. This informed the development of the Minimum Standards for Primary Health Care in Nigeria document by the National Primary Health Care Development Agency (NPHCDA) in collaboration with major stakeholders in health including the Federal Ministry of Health, agencies, academia and public health experts, as well as development partners.

In an interview with Thisdaylive in 2021, the NHIS Executive Secretary, Prof. Mohammed Sambo, said that a lot of things have changed including the roll out of the Insurance scheme in all the 36 states of the federation and the Federal Capital Territory FCT. According to him, Nigeria now has 37 states that have started the implementation of the basic healthcare provision fund and based on the resources that we have delivered to them. He added that in all the coverage that has been done at the state level, some are basic health care provision fund (BHCPF) that they gave out to states. Some have covered about 70,000 people, some have covered 50,000 people, some have covered 20,000 people. All these are under the NHIS, now National Health Insurance Authority (NHIA), one of the three gateways of the BHCPF. This is a significant milestone, and the states should be commended. However, the big question is what is the level of coverage for the poor and vulnerable Nigerians, do they have access to healthcare services under the BHCPF.

Plateau State in perspective

In the bid to access BHCPF and accelerate the transition towards UHC amongst Plateau residents that the Plateau State Contributory Healthcare Agency (PLASCHEMA) was established. The Agency seeks to expand access to quality preventive, promotive, curative and rehabilitative healthcare through resource mobilization, risk pooling and strategic healthcare purchasing so as to mitigate OOP spending on healthcare to the minimum. For the agency to be able to periodically assess the impact of its effort towards delivering the aforementioned mandates, this reviewed baseline survey (BS) was conducted to particularly determine the level of health care coverage, access to health, healthcare services available at facilities, service delivery, common challenges to healthcare access, manpower in healthcare facilities and the health care services they provide in the PHC facilities for the Plateau population. Therefore, the survey serves as a catalyst for practical knowledge of present situation so as to bring about continuous improvement of the agency's approach to achieving its strategic objectives.

In Plateau State, the PHC work force comprise mainly of Community Health Extension Workers (CHEWs) and mid-wives, without doctors or pharmacist at facility level. There seem to be a skewed distribution of facilities in the state with most secondary and tertiary facilities located within the urban parts of the State. National Bureau of Statistics (NBS) household survey places male to female ratio at 51.1 to 48.9 and the average household size at 5.9. Individuals between age 10 and 19 years form the bulk of the state's population. Elderly people above 60 years only form approximately 3.7% of the total population.

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Reviewed Results from the Baseline Survey (BS)

Household survey

Socio-demographic characteristics of respondents/households

A total of 3981 household heads were interviewed during the household survey, most of household in the survey had a total number of members ranging between 16 and 20 people. Most of the household heads were young with their ages ranging between 26 – 30 years. About 25% of the respondents were influencers in the communities comprising of leaders of women, youth and elders' forums as well as traditional rulers. Table 1 below indicates the total number of household members captured in the study.

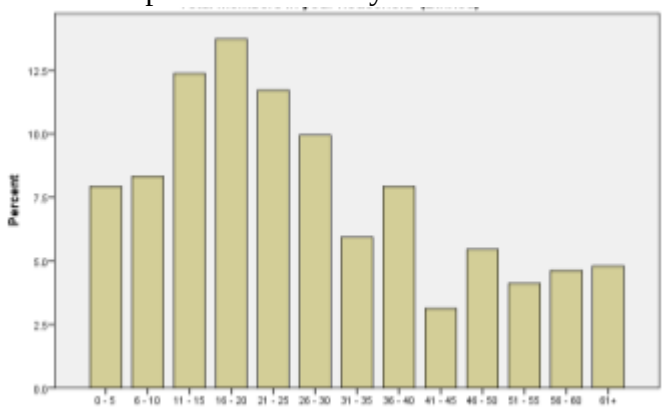

Table 1: total number of household members

The figures below in table 2 indicate the distribution of the respondents by place of residence across the 17 LGAs. Kanam LGA had the highest number of respondents (8.1%) while Bassa LGA had the least number of respondents.

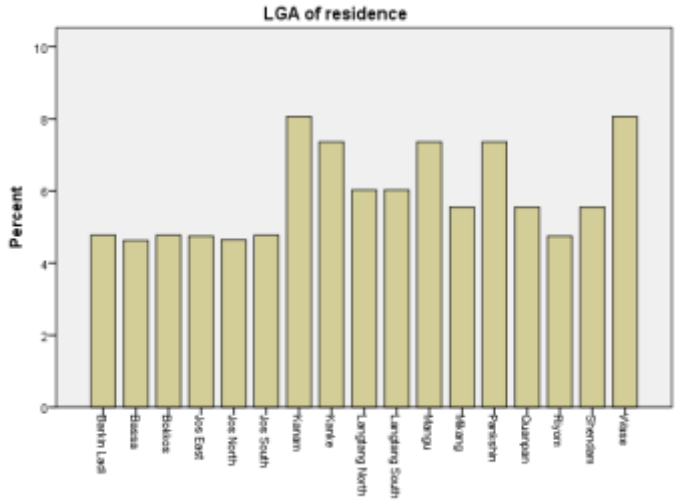

Table 2: LGA of residence of respondents

The figures below in table 3 show the ethnicity of respondents. People of ngas, Taroh, Boghom and Berom ethnicity had the highest representation. A considerable proportion of the respondents were of Mwagavul, Goemai, Izere, Fulani and Hausa ethnicity.

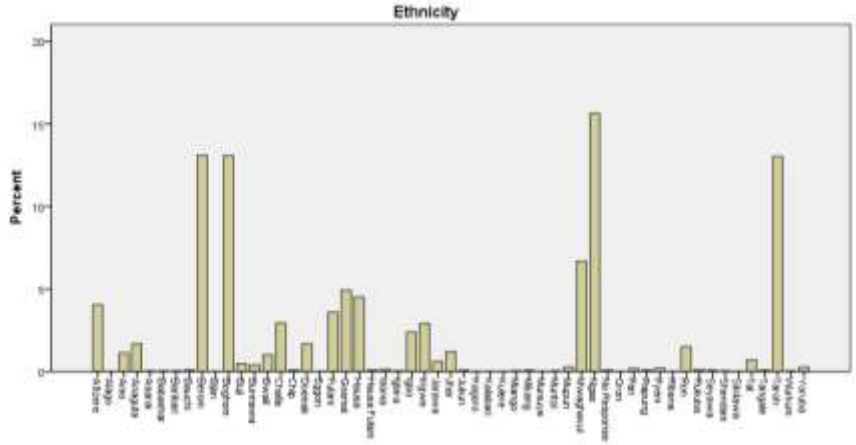

Table 3: Ethnic distribution of respondents

Available Healthcare Services at the PHCs
The below diagram in Table 4 illustrates the commonly available services at the PHC healthcare facilities in Plateau State. They include services like: Antenatal, immunization, family planning, admissions, laboratories, consultation, pharmaceuticals and the likes.

Table 4: healthcare services available at facilities

Health Facilities Capacity to Function
Table 5 below shows that a total of 325 PHCs were assessed to determine their readiness to provide basic healthcare services for the Basic Healthcare Provision Fund (BHCPF).

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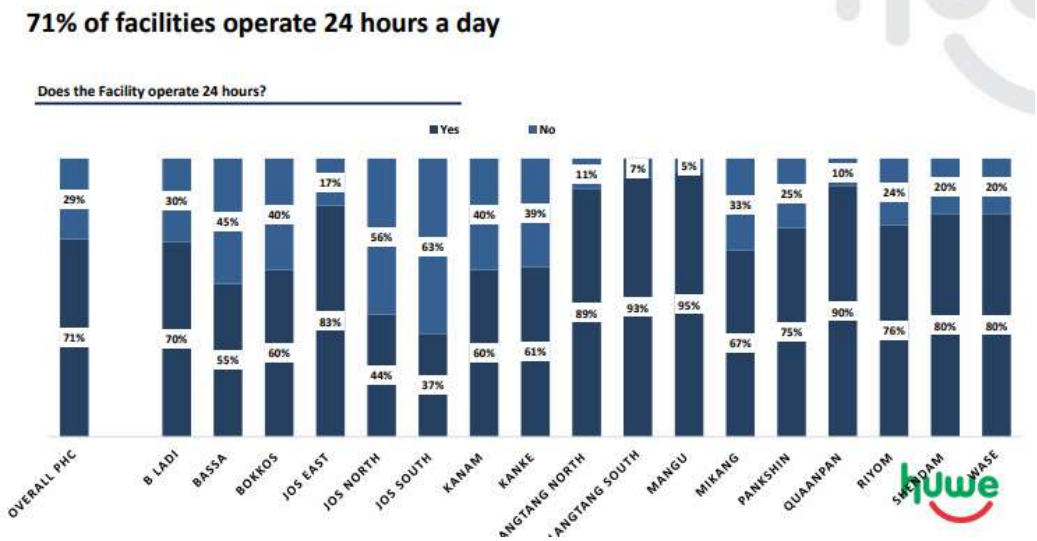

Table 5: Proportion of health facilities that operate 24 hours a day

Manpower in Healthcare Facilities

Table 6 below shows the 8 persons are the average number of workers per PHC facility in a day in all the 325 assessed.

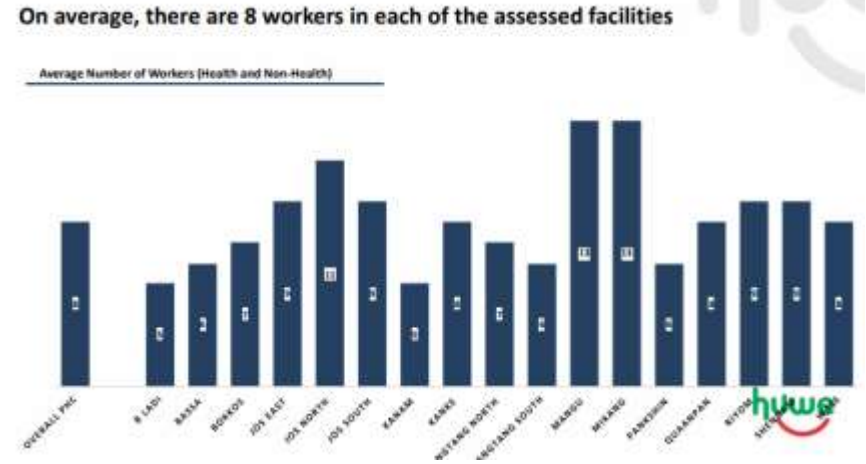

Table 6: average number of workers per facility

Absenteeism at Facility during Assessment

Table 7 below shows the level of absenteeism at facility during assessment; 40% of the workers were not on their duty posts at each of the PHCs assessed.

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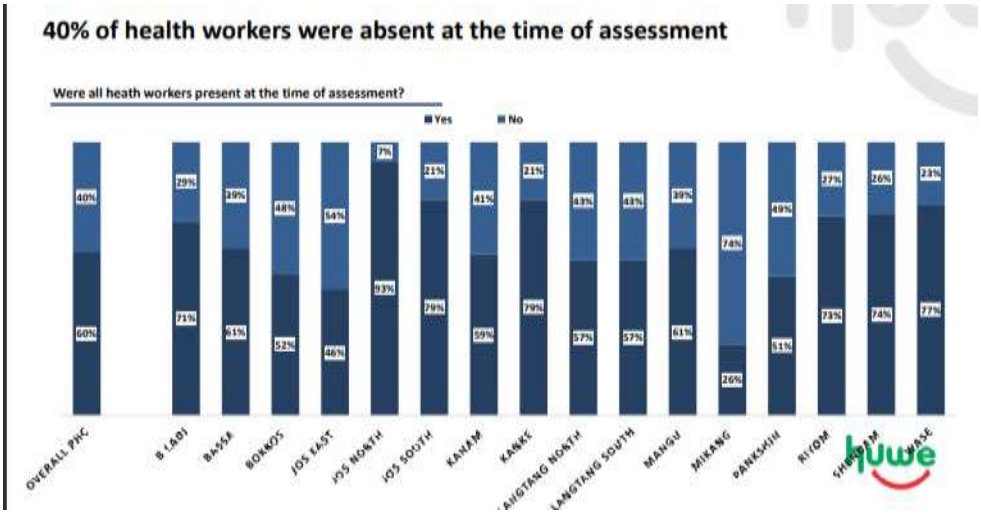

Table 7: Absenteeism at facility during assessment

Facilities that Provide Basic Emergency Care

From table 8 below, it shows that only 28% of the PHC facilities provide basic emergency obstetric care.

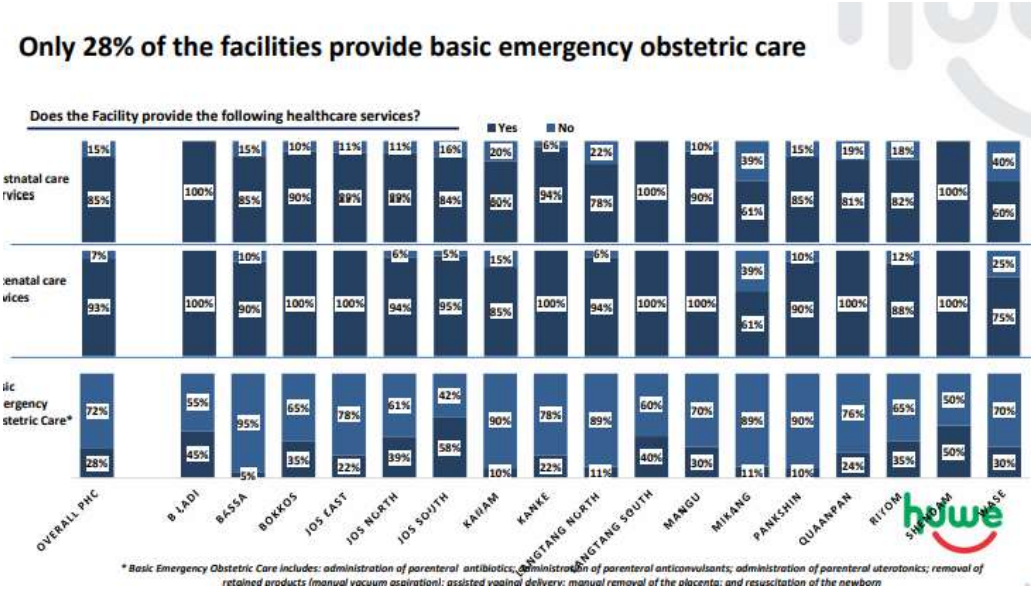

Table 8: Proportion of facilities that provide basic emergency obstetric care

Service Accessibility

Respondents highlighted that the major challenge they face when accessing healthcare is the high cost of healthcare. They complained of bad states of the roads and the terrain which leads to the hospital as some communities have no health facilities and have to access hospitals in nearby

communities. The attitude of health workers towards patients was also another issue highlighted by most of the respondents as an obstacle to service delivery utilization.

Challenges Limiting the Viability of PHCs in Plateau State

The graph (Table 9) and chart (Table 10) below highlight the common challenges encountered by respondnets while accessing healthcare services in PHCs. The most prevalent constraint to healthcare access was cost of healthcare (inaffordability). This was closely follwod by poor attitude of health workes and poor quallity of care. another relevant challenge encountered by a few of the households was poor roads.

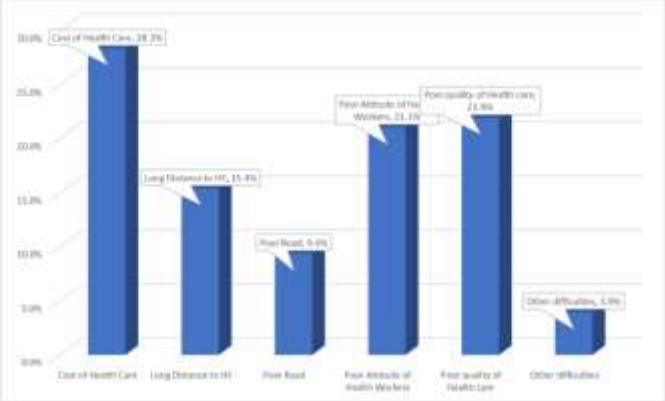

Table 9: common challenges to healthcare access

Table 10: challenges to accessing healthcare

DISCUSSION

This study reviewed the BHCF and PHC Assessment in Plateau State of Nigeria. Several factors were identified that relate to the benefits and challenges of the PHC's ability to improve healthcare services in the 17 local government areas. Almost all the respondents in the reviewed study stated that they either have a private, public or both facilities in their communities. The general condition of most of the PHC facilities was also an issue mentioned by the respondents. The respondents complained of inadequate skilled manpower in the hospitals, long waiting hours, high cost of health services, lack of drugs and inadequate space. Respondents highlighted that the major challenge they face when accessing healthcare is the high cost of healthcare. They complained of bad states of the roads and the terrain which leads to the hospital as some communities have no health facilities and have to access hospitals in nearby communities. The attitude of health workers towards patients was also another issue highlighted by most of the respondents as an obstacle to service delivery utilization. This is in line with the findings of Ibrahim, Konlan, Moonsoo, Kwetishe, RyuRo. & Kim (2023) in their study on Influence of Basic Health Care Provision Fund in improving primary Health Care in Kano state. The study revealed challenges associated with the conception and implementation of the BHCPF. The challenges of the BHCPF were funding delays (67.9%), poor financial management, and accountability mechanisms (58.2%). Facilities have a low capacity to offer essential healthcare services (60.7%), challenges with medical equipment in facilities (70.4%), poor staffing (65.8%), and poor infrastructure (87.8%).

Given that there is an obvious challenge in health services generally in Nigeria (Plateau State inclusive), PHC facilities in Plateau State that provide 24 hours essential services as seen in the Table 5 , especially in resource-limited settings, must be periodically monitored to ensure that the minimum quality, cost effective and acceptable services are provided to community members. Having a state and local government systems respectively that appropriately coordinates evaluation and monitoring systems, especially in PHC facilities, is cardinal to attaining health service goals in Plateau State. This will also help the evaluators have real time experience and discovery in other to help achieve at least 1 (one) fully functional public or private primary health care (PHC) facility in each political ward; at least 30% of all wards over the next 3 years, 70% within 5 years, and 100% within 7 years as stipulated in the objectives of BHCPF.

This study has also reeled out the concerns associated with health financing in Plateau State as it relates to BHCPF. A significant number of respondents are generally skeptical about the likely sustainability of health service programs; they doubt the viability of quality and affordable health care by the government through any means because many health-related programs in Nigeria had been unsuccessful due to obvious limited financial capabilities, financial mismanagement, corruption, technical, social, and environmental constraints. This study has therefore showed the factors that influence the provision of BHCPF in the primary health care system in Plateau State of Nigeria.

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Suggestions to Improving Access Quality Healthcare Services in PHCs in Plateau State

Table 11: suggestions to improving access healthcare

The figures above show respondents' suggestions to mitigating the difficulties of accessing care. In the word frquency diagram above, most of the respondents think that subsidizing healthcare by the government will reduce suffering while seeking care. A considerable proportion mentioned repair of bad roads, stock-in of medicines at all times, employment of more health workers and training of health workers to treat patients with respect as key solutions to adressing the difficulties of accessing care in their communities.

On paper, the BHCPF offers exceptional opportunity to reduce/eradicate healthcare disparities by providing a Basic Minimum Package of Health Services (BMHPS) in achieving universal health coverage (UHC) in line with Nigeria's core healthcare obligations; upholding constitutional rights to life and human dignity. To reposition the BHCPF to better achieve its full objectives, this study briefly discussed the following aspects as recommendations:

Funding:
With the obvious challenge of funding in the Nigerian Health system, even with the 1% Consolidated Revenue Fund (CFR) given by the previous governments should be revisited. The new administration should consider raising the CRF to 3% while mandating that all counterpart funding at all levels Public health activities occur at various government levels (federal, state, and local) be made available as at when due. If possible, they should be deducted from source as soon as state wide allocations are made. More innovative funding mechanisms could be explored too. E.g. Health taxes for the poor and vulnerable groups; it could be mandated on multinational companies/corporations, revenue generating government institutions, indirect taxes in goods and services etc with a special agency managing and disbursing generated funds.

Accountability and Transparency (A and T):

Ensuring prudent implementation of the BHCPF is vital for improving national health system. Therefore, the talk on A and T must go beyond theories and on-the-paper- efficiency. Valid practical steps must be taken to make sure that the scarce resources made available are used as appropriated for. The fact is that if the resources meant for various aspects of health sector challenges in Nigeria are prudently used, the system would have achieved far more than it has today. Dependent and Independent checks should be put in place to ensure that funds earmarked are rightly and adequately used.

Awareness Creation:
State governments should actively engage with the local government and both levels of government must also engage information professionals to reach out community members through community-based orientation and strategies in understanding government health grants and interventions targeted at identifying and tackling challenges on beneficial health packages, initiatives and programmes meant to benefit them. With the right and adequate knowledge, such engagements are essential for fostering community support and ensuring that no one is left out of the BHCPF.

Public-Private Partnership:
Leveraging public-private partnerships (PPPs) is crucial for strengthening healthcare systems in Plateau State. By leveraging private investment, collaborating with non-profit partners, information professionals and accessing private sector current technical expertise on improved service delivery (ISD), PPP models are very much needed in the Plateau Health system because the collaboration will spur governments at all levels to pool resources and combine the technical expertise of both sectors to enhance productivity and proficiency in the PHCs to enhance healthcare delivery.

Quality Improvement:
To enhance service quality, it is essential to build technical capacity of staff. This can be achieved mainly by training and re-training of staff (at all levels) through seminars, workshops, higher education etc. They become current and updated in the trends in medical field and PHCs across the world. They come back with new ideas and perspectives to approaching and solving health related issues, facilities, manpower and services.

CONCLUSION

The BHCPF framework gave a useful pathway into the Nigerian PHC system. Plateau Sate, like every other State in Nigeria, has a relative abundance of PHC facilities. While some of the PHCs have reasonable geographic access, many others do not. This is same with the workforce too. In all, the performance of the PHC system in Nigeria, Plateau State in particular, is hindered by key system, inputs, Health information and service delivery challenges. Plateau's story shows that

adequate numbers of health facilities and health workers are necessary but not sufficient for the running of an effective PHC. Indeed, important factors like effective governance, political will power and checks and balance on facilities, service and delivery capacity play a central role in strengthening PHC systems.

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