A Critical Appraisal of Nigeria's Basic Healthcare Provision Fund (BHCPF) as a pathway towards Universal Health Coverage

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A thesis submitted in partial fulfilment of the requirement for the degree of Master of Public Health

By
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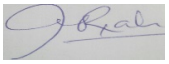
Signature - 

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Critical Appraisal of Nigeria's Basic Healthcare Provision Fund (BHCPF) as a pathway towards Universal Health Coverage

Abstract

Introduction

Low government health spending in Nigeria over the last two decades has limited the expansion of highly cost-effective interventions, inhibiting health outcomes and exposing large shares of the population to catastrophic health expenditures. In 2016, Nigeria government's health spending was 0.6 per cent as a share of GDP or just $US11 per capita. As the central government directs majority of its funding to tertiary and secondary health institutions, the primary health care receives less funding. This contributes to Nigeria's underperformance in critical health outcomes, with maternal mortality remaining at 576 deaths per 100,000 live births, which is 2.6 times the global average; and one out of every eight children die before reaching their fifth birthday.

This study aims to evaluate the Basic Health Care Provision Fund (BHCPF) in order to make recommendations that will help optimize BHCPF and minimize fragmentation in healthcare system.

Methods: The study is a literature review using Joseph Kutzin's descriptive framework for the analysis of health care financing arrangements at national level. The use of this framework to analyze the BHCPF is to highlight the existing situation in Nigeria's health system in relation to health care financing and resource allocation, and to support the identification and appraisal of policy options.

Findings: The review of literature showed that BHCPF scheme is starting well in addressing structural inefficiency by the creation of the Ward Health System (WHS) which is deployed through many stand-alone initiatives. However, much needs to be done in harnessing the various initiatives with the WHS; and also in integrating public health programmes into BHCPF activities in order to minimize financial fragmentation, duplication of efforts and wastage of resources.

Recommendations: Integration of public health and vertical programmes into the BHCPF would be a sure way of minimizing fragmentation when coupled with the redesigning of payment systems.

Conclusions: The study examined the design and implementation of the BHCPF using Kutzin's framework, came to the deduction that there is much more to be done in tackling fragmentation, wastage and corruption. However, following some of the recommendations based on the study may help address these challenges.

Keywords: Nigeria, Basic Health Care Provision Fund, universal health coverage, health financing and Ward Health System.

Word count: 12,178

1. Introduction

The Basic Health Care Provision Fund (BHCPF) is a programme of the federal government of Nigeria, deployed to bypass some of the pitfalls of existing health financing arrangements. Some of the pitfalls include restriction of flexibility to operationalize and manage health Funds which leads to inefficient resource allocation as well as inadequate appropriation, stringent "cash-backing" or unpredictable fund releases. The BHCPF or the "fund" as it is often called in health planning circle – a mandate of the 2014 National health Act now getting funds to the tune of at least one per cent (1%) of the consolidated revenue of the federation without passing through the rigors of annual budget defense at the legislative arm of the government is indeed a milestone. The BHCPF which will provide additional revenue to fund primary healthcare services and help Nigeria to achieve universal health coverage (UHC), will also be complemented with counterpart funds from states and local government areas (LGAs).

My interest in this study takes its root from my experience (which spans over a decade) working at the health and human services secretariat of the federal capital territory administration on health policy, planning and financing, public health as well as supply chain management. The knowledge of the intricacies of budgeting for health, inadequate appropriation, stringent "cash-backing" or unpredictable fund releases makes the topic of the study appealing to me.

The need to structure health care financing in order to improve health care provision has been the concern of successive governments in Nigeria. The federal, state and local governments with individual considerable autonomy are duly responsible for the allocation and utilization of their resources. Health care provision is also decentralized among the three levels of government, each with significant independence. Each tier of government sets and follows its health priorities with nominal interference from the other tiers.

In Nigeria, the primary care is the entry point to health care providing essential primary care services. The local government Councils (LGAs) which have general control of the facilities own and fund Primary Health Centers (PHCs). However, the management of primary care services was by a combination of a plethora of government ministries and agencies, non-governmental organizations including some development partners. The fragmentation of primary care service management, funds and other resources, is the most precarious issue plaguing this tier of care.

Public financing of health in Nigeria like health care management is also intricate, highly fragmented and lacks coordination, thereby contributing to a sub-optimal health system performance. In Nigeria, about seventy-two percent of the burden of disease is mainly from communicable, maternal, neonatal and nutritional diseases; many of which are preventable and curable with highly cost-effective intervention packages at the primary health care and community level.

The thesis is a literature review that aims to evaluate the Basic Health Care Provision Fund (BHCPF) using Joseph Kutzin's descriptive framework for the analysis of health care financing arrangements in Nigeria at the national level. I will also analyse the operational guide-line, current implementation and assess the performance of the Fund in establishing a nation-wide scheme. The analysis and discussions will be structured around the framework to highlight the existing situation in Nigeria's health system in relation to health care financing and resource allocation, and to support the identification and initial appraisal of policy options.

In line with my findings, I will make recommendations that will help optimize the contributions of the Basic Health Care Provision Fund financing model towards achieving Universal Health Coverage (UHC) and the reduction of fragmentation in the health financing arrangements.

Chapter 1: Background information on Nigeria and its health system

Nigeria comprises 36 self-governing states and the Federal Capital Territory and 774 local government areas (LGAs) as sub-division. The 9555 wards of the 774 LGAs constitute the lowest political units. Nigeria practices the federal system of government with devolution of power between the three tiers (federal, state and local government). The three levels of government in Nigeria with their considerable autonomy are duly responsible for the allocation and utilization of their resources (2). Health care provision is also decentralized among the three levels of government, each with significant independence. Both the earlier National Health Policy and the National Health Act of 2014, assign roles and duties to each level. However, the various tiers do not adhere to their roles in practice. The non-adherence is because the roles are not well laid out in the National constitution.

Tertiary health services assigned to the federal government are provided through their network of teaching hospitals and specialist hospitals across Nigeria. However, some states own and finance tertiary health care facilities within their domain. Although state governments provide secondary health care specialized services (assigned to them) through their numerous hospitals under their control, the federal government also provide secondary care services through their twenty-two medical centres across the country (see Table 1) (3).

Figure 1.1: Map of Nigeria and its geographical divisions

Table 1.1 - List of all Federal Medical Centres (4).

S/N	Name of Hospital	Location	State
1	Federal Medical Centre	Abeokuta	Ogun
2	Federal Medical Centre	Asaba	Delta
3	Federal Medical Centre	Azare	Bauchi
4	Federal Medical Centre	Bida	Niger
5	Federal Medical Centre	Birnin-Kebbi	Kebbi
6	Federal Medical Centre	Birnin-Kudu	Jigawa
7	Federal Medical Centre	Ebute-Meta	Lagos
8	Federal Medical Centre	Gombe	Gombe
9	Federal Medical Centre	Gusau	Zamfara
10	Federal Medical Centre	Ido-Ekiti	Ekiti
11	Federal Medical Centre	Jalingo	Taraba
12	Federal Medical Centre	Katsina	Katsina
13	Federal Medical Centre	Keffi	Nassarawa
14	Federal Medical Centre	Lokoja	Kogi
15	Federal Medical Centre	Makurdi	Benue
16	Federal Medical Centre	Nguru	Yobe
17	Federal Medical Centre	Owerri	Imo
18	Federal Medical Centre	Owo	Ondo
19	Federal Medical Centre	Umuahia	Abia
20	Federal Medical Centre	Yenagoa	Bayelsa
21	Federal Medical Centre	Yola	Adamawa
22	Federal Medical Centre	Jabi	FCT

Source: https://www.health.gov.ng/index.php?option=com_content&view=article&id=137&Itemid=503

1.1 Health and Epidemiological profile

In Nigeria, communicable, maternal, neonatal and nutritional diseases accounts for seventy-two percent of the burden of disease. More than half the disability-adjusted life years among children under age five is attributable to neglected tropical diseases and malaria, diarrhea, lower respiratory and infectious diseases. Malaria incidence, the number one cause of premature death in the country, also accounts for nearly half of out-of-pocket health expenditures with most of these conditions preventable and curable with highly cost-effective intervention packages (5). There is evidence showing that only fifteen out of every hundred married women use one method of family planning while the average total fertility rate is as high as 5.5 children per woman. (6)(7). At 576 deaths in every 100,000 live births – 2.6 times the global average, Nigeria has one of the planet's highest maternal mortality– and one in eight children dying before their fifth birthday.

1.2 Overview of National expenditure on health

Nigeria spent N588 billion (US$ 2.2 billion) or 0.6 percent of GDP in 2016, which was well below the 5% of GDP benchmarks. The government health spending when considered as a share of total government expenditure was also low at at 6.1 percent equivalent to US$ 11 per capita . This fell below the recommended benchmark of US$ 86 per capita required to deliver

a basic set of health services for low and middle income country; which is a reflection of its low ranking of the health sector (Table 2) (8). Though Nigeria's current low spending on health may be attributable to her dwindling macro-fiscal context, her health expenditure history during economic booms remains consistently low. The macro-fiscal context or framework comprises a medium-term fiscal framework and fiscal rules or targets. The framework provides the circumstance for target setting, determination of policy choices as well as the preparation of credible revenue and expenditure projections. The main function is the attainment of fiscal and sustainable debt objectives taking cognizance of fiscal risks (9)(10).

Table 1.2 - Report on Trends in Catastrophic Health Spending
Using 10 percent Threshold, By Country

	GDP pc, (constant 2010 US$)	Govt. health expenditure as % govt. expenditure	Total health expenditure (THE) as % GDP	Govt. health expenditure as % GDP	Govt. health expenditure as % THE	Out-of-pocket expenditure as % THE	External health expenditure as% THE	THE pc, USD	Govt. health expenditure pc, USD	Catastrophic headcount at 10% threshold‡	Latest year available for catastrophic headcount
Timor-Leste	968	2.4	1.5	1.3	90.4	9.6	31.6	57	52	2.59	2001
Kenya	1076	12.8	5.7	3.5	61.3	26.1	27.6	78	48	5.89	2005
Yemen, Rep.	1101	3.9	5.6	1.3	22.6	76.4	6.4	80	18	17.06	2005
Myanmar	1266	3.6	2.3	1.0	45.9	50.7	21.8	20	9		
Cameroon	1294	4.3	4.1	0.9	22.9	66.3	11.1	59	13	10.78	2014
Cote d'Ivoire	1385	7.3	5.7	1.7	29.4	50.8	9.4	88	26	15.25	2008
Vietnam	1596	14.2	7.1	3.8	54.1	36.8	2.7	142	77	9.81	2014
Zambia	1621	11.3	5.0	2.8	55.4	30.0	38.4	86	48	0.29	2010
Ghana	1660	6.8	3.6	2.1	59.9	26.8	15.4	58	35	3.11	2005
Nicaragua	1813	24.0	9.0	5.1	56.4	37.5	5.5	178	100	29.39	2014
Sudan	1837	11.7	8.4	1.8	21.4	75.5	2.6	130	28	.	
Bolivia	2317	11.8	6.3	4.6	72.1	23.1	3.2	209	151	8.23	2002
Philippines	2506	10.0	4.7	1.6	34.3	53.7	1.4	135	46	6.31	2015
Nigeria	2563	6.1ǂ	3.7ǂ	0.6ǂ	15.7ǂ	75.2ǂ	7.6ǂ	71ǂ	11ǂ	24.77	2009
Congo, Rep.	2923	8.7	5.2	4.2	81.8	17.5	4.0	162	132	1.97	2011
Indonesia	3693	5.7	2.8	1.1	37.8	46.9	1.1	99	38	3.61	2015
LMIC	***2182***	***10.0***	***5.8***	***3.3***	***54.4***	***38.8***	***14.9***	***139***	***80***	-	-
LIC	***604***	***9.9***	***6.2***	***2.5***	***41.1***	***40.3***	***33.0***	***40***	***15***	-	-
SSA	***1949***	***9.9***	***5.9***	***2.8***	***49.6***	***35.9***	***26.5***	***104***	***57***	-	-

Sources: World Bank (2017). World Development Indicators; for ǂ data is for 2016 and comes from Federal Republic of Nigeria (2017). National Health Accounts 2010-2016; for ǂ data comes from World Bank-World Health Organization (2017). Universal Health Coverage: Financial Protection in Health (Report on Trends in Catastrophic Health Spending Using 10 percent Threshold, By Country. Version: 4 May 2017). Note: Catastrophic headcount refers to the percent of households who spend more than 10 percent of their household income on health expenditures

1.3 Health Financing for Universal Coverage

The health disparity between and within Nations prompted the 2005 World Health Assembly resolution on Universal Health Coverage (UHC). The resolution advised member states to offer health financing systems that provide people with access to adequate and quality healthcare services that do not cause financial hardship on utilization (11). The World Health Organization defined health financing for universal coverage in the following words.

"Financing systems need to be specifically designed to: provide all people with access to needed health services (including prevention, promotion, treatment and rehabilitation) of sufficient quality to be effective; [and to] ensure that the use of these services does not expose the user to financial hardship" (12).

1.3.1 What is Universal health coverage?

Universal health coverage (UHC) is the mechanism of providing accessible and suitable health services to the entire population without financial hardships. The concept of universal health coverage was first utilized by Germany in 1883 to improve the health status of its young population. The concept now connotes ensuring that all people have easily reachable needed health services of appropriate quality; the use of these services does not expose the user to any financial hardship (13)(12). The current concept of UHC exemplifies one of the health systems goals – financial protection – together with intermediate objectives relating to improved health system performance – the prospect that the population obtain the health

services they need and that the services are of appropriate quality to be effective. The aspect of UHC that relates to the use of needed services of useful quality links directly to the concept of ***adequate coverage*** - the prospect that an individual will get an intervention that they need and have improved health status as a result. Separating the concept of ***adequate coverage*** into its parts, it amounts to

- ❖ reducing in a given population, the gap between the need for services and the utilization of those services. The assumptions, in this case, would be that:
  - i. all persons requiring intervention are aware of their need;
  - ii. all persons having an awareness of their need can use the required services.
- ❖ They were safeguarding the quality suitability of services to increase the probability that they will improve (or promote, restore, contingent on the intervention) the health status of the users.

The above exposition shows UHC as a set of objectives that health systems trail; but not a scheme or a specific set of arrangements in the health system (14).

Primary health care is the underlying mechanism and the most efficient and cost-effective way to achieve universal health coverage around the world. Therefore, countries will need to strengthen and further build people-centred PHC systems that deliver quality products and services (15)(16).

To enable the effective and efficient performance of the health system, there is a need for the generation of suitable amount of revenue, effective risk pooling, provision of appropriate incentives, resources allocation for efficient and equitable interventions and services. This underscores the importance of health financing as a component of any health system.

1.3.2 Functions of Health Care Financing

The three essential functions of health financing are (17):

i. **revenue generation or collection;** which deals with the sources of revenue for health care, the contribution mechanism, and the agents that collect the revenues. The sources of revenue can be from individuals, households, employers, foreign and domestic non-governmental organizations, foreign governments and multicultural agencies. The contribution mechanism can be through direct Taxes (such as payroll taxes); indirect taxes, voluntary pre-paid contributions, direct payment to provider at time of use, grants and loans.

ii. **Pooling of resources** is the gathering and management of funds in a manner that ensures that individual contributors are protected against the risk of having to pay the full cost of care out-of-pocket in the event of illness.

iii. **Purchasing of services** is the allocation or spending of money either for the direct provision of services or the procurement of services from providers for beneficiaries.

Buyers of health services are typically the Ministry of Health (MOH), Social Security agencies, insurance organizations, and individuals or household (who pay out of pocket at time of using care).

Health financing in Nigeria is very complex and highly fragmented. Health financing comes from resources of the three tiers of government - with weak coordination between and amongst them, private expenditures by insurance, employers or individuals through out-of-pocket, and funds for development assistance from international donors. The lack of coordination of these different sources of funds leads to duplication of efforts and poor accountability (18).

1.4 Sources of healthcare financing in Nigeria

1.4.1 Government

Healthcare financing responsibilities are shared amongst the three levels of government (Federal, State, and LGA) in Nigeria. The Federal is concerned with the tertiary health sector whilst the State is concerned with both secondary and primary health care.

1.4.2 Basic Health Care Provision Fund (BHCPF)

The BHCPF or "The Health Care Fund" was established under Section 11 of the National Health Act (19), as the principal funding vehicle for ensuring access to the Basic Minimum Package of Health Services (BMPHS). It also serves to increase the fiscal space and overall financing to the health sector. It is expected that the associated increase in service delivery arising from this funding, would assist Nigeria to achieve Universal Health Coverage (UHC).
The National Health Act stipulates that funding of the BHCPF would be derived from contributions including

a. A Federal Government of Nigeria grant which is not less than one per cent (1%) of the Consolidated Revenue of the federation within the Mid-Term Expenditure Framework (MTEF). An MTEF is an all-inclusive, government spending plan that links policy priorities to expenditure allocations within a fiscal framework which is usually over a three-year planning period (20).
b. Grants by international donor partners;
c. Funds from any other source.

The administrative guidelines (21), also stipulated that from the fund,

- 50% would be used to finance the BMPHS by NHIS,
- 45% through the National Primary Health Care Development Agency (NPHCDA) would be utilized to support primary health care systems and PHC facility operations (medicines, medical equipment, infrastructure and staffing);
- while 5% is for emergency medical treatments. The NPHCDA component of the fund operates based on the principles of Primary Health Care Under-One-Roof (PHCUOR). This would include elements of direct facility financing to point of service delivery.

The NPHCDA Gateway, 45% of the BHCPF would be utilized in the following manner:

- 20% for PHC drugs, consumables, and vaccines
- 15% for PHC Infrastructural development and transportation
- 10% for PHC human resource development

States and local governments are also required by the law to provide 25% of the cost of any project to be implemented with the BHCPF within their locality as counterpart funding.
Within the NPHCDA Gateway, a proportion of the funds would be utilized as additional funding for the procurement of bundled vaccines for immunization while the balance funds would on a quarterly basis be released to the SPHCBs. The SPHCBs would in turn periodically release operational cost to PHC facilities as Direct Facility Funding (DFF), to meet basic operational cost for drugs, commodities, minor repairs, outreaches, local retrieval of vaccines for routine services and running of utilities in the PHC. Other aspects of the funding at State level would be utilized for PHC human resource development that would support the PHC Revitalization goal of one functional PHC facility per political ward.
The specific proportion of the BHCPF utilized for vaccines, DFF and human resource development may differ annually depending on related issues such as level of fulfillment of the funding requirement of vaccines and priorities of benefitting states.

Similarly, funds through the NHIS Gateway would be utilized to purchase a Basic Minimum Package of Health Services (BMPHS) from the PHC facilities and to a lesser extent from Secondary Health Care facilities for referred cases. The nature of provider payments shall be as determined by the NHIS i.e. fee-for-service, capitation or modified fee-for-service depending on the level at which care is provided and nature of care provided. The specific content of the BMPHS and the method of purchaser payments would be as contained in the relevant guidelines for BHCPF programme implementation (21).
All BHCPF facilities would operate a bank account with signatories derived from the facility and community. Funds received by PHC facilities from all sources would be expended based on a set of 'financial management system protocols' involving the use of quarterly business plans and monthly activity plans which would be the basis for 'cashless payments and transfers' to vendors and end-users for the provision of services and commodities. LGHA would initially endorse quarterly business plans which would then be approved at the SPHCBs prior to funding release to the Primary Health Centres.

1.4.3 Donor Agencies

Agencies such as WHO, UNICEF, World Bank, Bill and Melinda Gates Foundation, other Non-Governmental Organizations (NGOs) and Private Individuals have formed an important segment of the sources for health care financing in Nigeria. They finance health programs directly as well as provide funds and technical assistance to the government on implementing the national health agenda.

1.4.4 Out-of-pocket-expenditure (OOPE)

In Nigeria, 70% of the total expenditure on health is private expenditure. 90% of this private expenditure is out-of-pocket. Out-of-pocket expenditure therefore remains the main mode of financing health care in the country (22).

1.4.5 Insurance

Within Nigeria, there are four main types of insurance for health; the National Health Insurance Scheme (NHIS), State Health Insurance Scheme, Community Based Health Insurance and Private Health Insurance.

1.4.5.1 National Health Insurance Scheme (NHIS)

The NHIS was established to ensure universal health coverage for Nigerians (23). It became operational in 2005. It is a social security establishment that is meant to provide a sustainable funding source for the improvement of health care delivery. It is a form of financial security to the health needs of Nigerian citizens. The main objective of the NHIS is to remove any socioeconomic hindrance to the access to health care services. Presently, the Law that established the NHIS requires the following categories of people to register:

- The Federal Government's employees.
- Private sector businesses with 10 or more workers.

The operation of the NHIS is through a prepayment contributory system called capitation. This is paid by all registered members every month regardless of whether or not they use the services. What each member pays is determined by what the person earns. Typically, an employee pays
5% of his/her basic salary while the employer pays 10% of the employee's basic salary. It is however not uncommon for the employer to pay the entire contribution. The healthcare benefit of these contributions has a coverage that includes the employee, a spouse and four biological

children below the age of 18 years. Additional dependents or a child above the age of 18 could be covered on the payment of additional contributions by the principal beneficiary. It is pertinent to note that someone who is paying considerably less (because of a lower income) can have access to the same level of care as someone who is paying much more. This helps to provide equitable access to health care in Nigeria (24).

Despite the benefits of the scheme, there are many challenges associated with NHIS that has hindered the achievement of universal health coverage. A major limitation of the NHIS is its inability to cover majority of Nigerians. Since the NHIS Act was signed into law in 1999 and became operational in 2005, only about 2% of the Nigerian population has been enrolled as at 2014. This limitation is also related to the challenges of poor funding and insufficient risk pooling. Other challenges like weak governance and poor infrastructure also need to be addressed to improve the scheme and accelerate the country towards the attainment of universal health coverage (25).

1.4.5.2 State Health Insurance Scheme (SHIS)

In an attempt to get larger number of Nigerians covered under a health insurance scheme, the State supported Health Insurance Scheme (SSHIS) was conceived under the NHIS Act. As a result, states can set up their own health insurance scheme. This development has led into some states enacting their own laws for the scheme. In many of the states that have made progress in establishing the SSHIS, it is made compulsory for the public workers as opposed to the voluntary arrangement of the NHIS. States have adopted different strategies to get as much funds as possible into the pool of fund. Essentially, the funding of SSHIS is from multiple sources which include the premium paid by the public workers (which is certain percentage of individual consolidated salaries), the counterpart contributory fund by the government, compulsory solidarity contributions from residents who are registered in the private insurance scheme, consolidated funds (from the BHCPF) and grants from donors and other agencies. One major advantage of the SSHIS is the fact that the states are able to be in charge and health care delivery is closer to the people. In addition, more people are covered (23).

The SSHIS is not without its shortcomings. Many states have not also been able to key into the scheme. Due to the fragmentation of the pool of funds, states have more work to do in terms of sourcing for fund, risk pooling, accountability, governance and regulations. There is also need for the states to increase the states' investment in health to improve the quality of care at both the primary health care and secondary care levels.

1.4.5.3 Community Based Health Insurance Scheme (CBHIS)

CBHIS can be described as a mechanism where households in a defined geographic area with varying demographic characteristics finance the costs associated with health services for the community and as such are involved in the management of the scheme and the organization of the healthcare services (26). The target of the community-based health insurance scheme (CBHIS) is the informal workers and rural members of the Nigerian population in line with the NHIS operational guideline (24). This is an effort to get more people, especially the rural dwellers and the vulnerable, to benefit from social security. The NHIS also play a key regulatory role in the establishment of a CBHIS and participants in the non-profit social insurance. In order for a community to establish a CBHIS, the following laid down NHIS operational policy must follow:

1) A mutual health association (MHA) must be formed and registered with an associated bank account.
2) An individual or household can become member voluntarily and they contribute an agreed amount.
3) A seven-man representative board of trustees (BOT). Representative is elected by the contributing enrollees. The BOT include the chairman, Secretary, a treasurer and other four members.
4) The BOT is responsible for the collection of contributions, payment of the healthcare providers and opening and operation of an NHIS accredited bank account. The BOT also has executive powers.

It is essential for the CBHIS to define the service or set of services it covers. Typically, such schemes focus mainly on the primary health care services. The funding sources for this mechanism of health insurance includes the contribution from members, subsidies from the government or/and subsidies from donors.

1.4.5.4 Private Health Insurance (PHI)

Private health insurance is based on the concept of the distribution of risk between the sick and the well. The PHI is often "risk-rated," meaning that those who are judged more likely to need health care pays a higher insurance premium. Payments in to private health insurance schemes are often paid out-of-pocket of the individual or on behalf of the individual by their employers. This arrangement often limits the private health insurance cover to employees and preventing the benefits from reaching the lower income populations and those in the informal sector (27).

1.5 Models of Health Care Financing

1.5.1 Input financing

Traditionally within Nigeria health care financing has taken the form of input-based financing. This is a line-item approach whereby government, donors or individuals finance a health facility or health authority through the provision of inputs such as human resource, equipment, medicines and infrastructure. The approach has often hamper flexibility and lead to inefficient resource allocation.

1.5.2 Results based financing

Results based financing shifts attention from inputs to outputs and over the course of time to outcomes. Within a results based system, health providers are at least partially funded on the basis of achieving a certain set of results. Usually both the quantity and quality of health care services that are provided determine the amount of funds that a health facility would receive. This approach also gives the health facilities a greater level of autonomy and accountability, promotes decentralization and applies private sector management practices in public structures. The results based financing approach has been piloted in Nigeria in Adamawa, Nasarawa and Ondo since 2011 through the Nigeria State Health Investment Project with significant positive results (28).

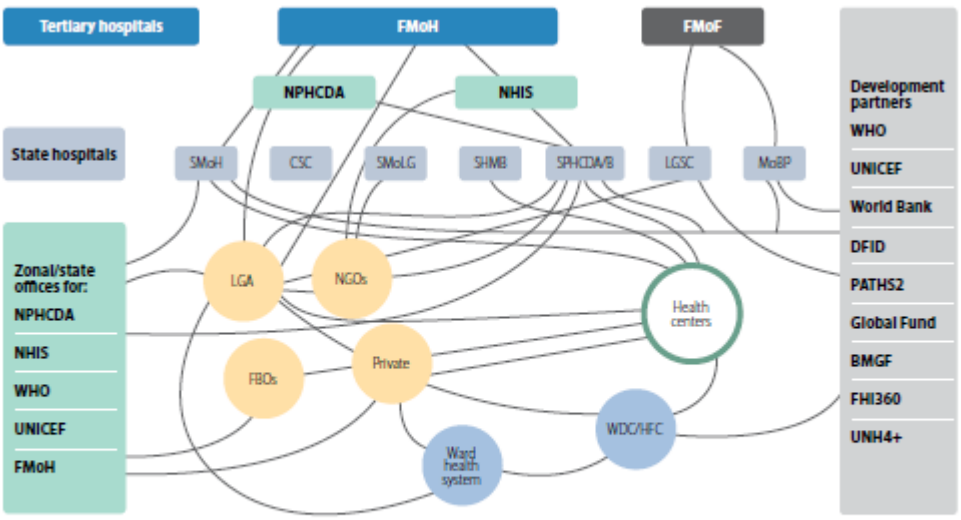
1.5.3 Direct facility financing

This involves directly providing financial resources to the health facility. It differs slightly from the result based financing because it does not necessarily reward outputs and outcomes but enables facilities to identify and fund their priority needs for effective operation and provision

of quality care. Under this mechanism, facilities who demonstrate increased utilization by clients and fulfils identified quality criteria are rewarded with further fund transfers; while poor performers are sanctioned by reduction of the funds transferred or exclusion. The BHCPF adopts this method of financing.
Both result based and direct facility financing require the facility to have high levels of financial autonomy and operate bank accounts with at least two signatories from the health workforce and the community.

1.6 Health System Management and Funding in Nigeria

The Federal government remains the highest contributor to health financing with most of its expenditure skewed towards tertiary health services, while the primary health care is the most poorly funded (29). The resultant institutional fragmentation leads some states to provide tertiary services in State-owned Teaching Hospitals while the Federal Government ventures into Secondary health services through Federal Medical Centers and Specialist hospitals. The federal government simultaneously funds (partly) the primary health Centers in all the States in conjunction with the States and the Local Councils.
The primary care level, which is the entry point to health care consists of the health posts, clinics, health centres and comprehensive health centres providing essential primary care services. The local government Councils (LGAs) which have general control of the facilities own and fund PHCs. Each tier of government sets and follows its health priorities with nominal interference from the other tiers (30). However, the management of PHC services was by a combination of the state ministries of health, ministries of local government affairs, the Ministry of Budget and Planning, state hospitals management boards, faith-based organizations, non-governmental organizations, the NPHCDA, the Federal Ministry of Health, the National Health Insurance Scheme and other development partners (3). The fragmentation of PHC service management, including management of staff, funds and other resources, is the most precarious issue plaguing this tier of care (see Figure 1) (2).



Key: FMoH, Federal Ministry of Health; FMoF, Federal Ministry of Finance; NPHCDA, National Primary Health Care Development Agency; NHIS, National Health Insurance Scheme; SMoH, State Ministries of Health; CSC, Civil Service Commission; SMoLG, Ministries of Local Government Affairs; SHMB, State Hospitals Management Board; SPHCDA/B, State Primary Health Care Development Agency/Board; LGSC, Local Government Service Commission; MoBP, Ministry of Budget and Planning; WHO, World Health Organization; UNICEF, United Nations Children's Fund; LGA, local government area; NGOs, nongovernmental organizations; FBOs, faith-based organizations; WDC/HFC, Ward Development Committee/Health Facility Committee; DFID, Department for International Development; PATHS2, Partnership for Transforming Health Systems phase II; BMGF, Bill & Melinda Gate Foundation; FHI360, Family Health International 360; UNH4+, United Nations Health 4+

Figure 1.2-Organization of primary health care delivery (6).

Public financing of health in Nigeria like health care management is also intricate, highly fragmented and lacks coordination, thereby contributing to a sub-optimal health system performance. The three main sources of financing primary health care in Nigeria are (Figure 3) (1)

- ❖ Government funding of primary health care – federal, state and local government area (LGAs) with weak interaction between them;
- ❖ private expenditures by insurance, employers or individuals through out-of-pocket;
- ❖ donor funds which are usually off-budget and flow directly to service delivery points

The lack of coordination of these different sources of fund results to fragmentation. Fragmentation results from the historical and persistent practice of "funding programmes" (such as HIV/AIDS, TB, Malaria and Family Planning). Fragmentation, which is the act of giving budgets to programmes that autonomously procure and or implement a set of interventions for some disease/condition in disdain of the "general health system", even though both serve the same population groups; is a sore source of inefficiency. The inefficiency impedes collaborative planning and implementation amongst the programmes and between the "general health system" and the programmes; and this frequently leads to duplication of efforts, wastage of resources and corruption (31).

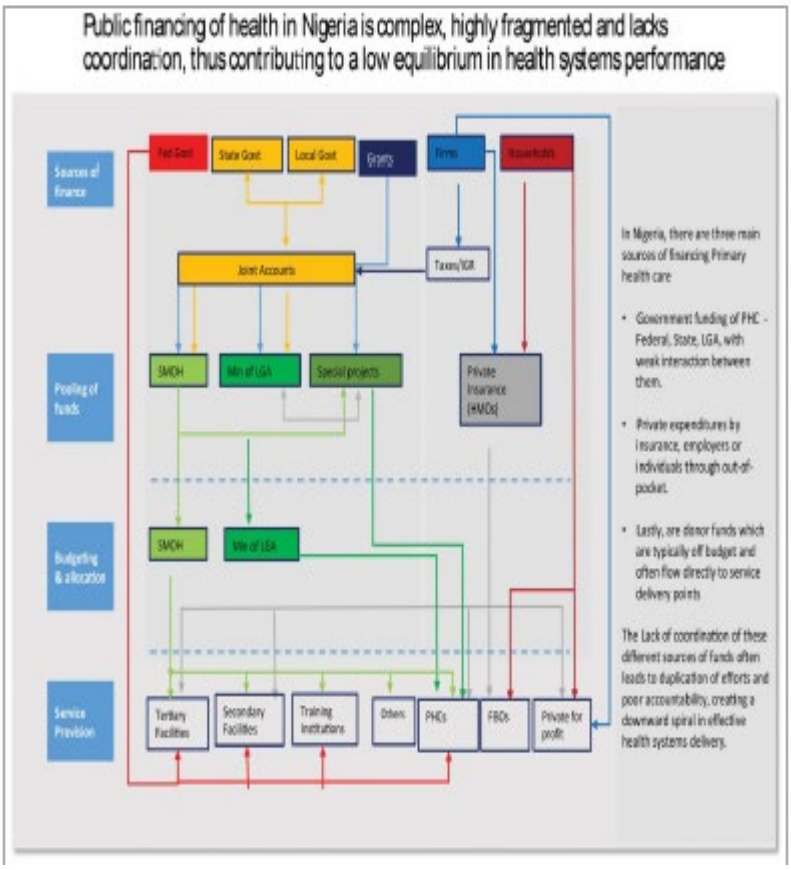


Figure 1.3. Chart Showing the Health Care Financing Space in Nigeria (1).

It is for the above-stated reasons that Nigeria seeks to strengthen its primary health care services through the BHCPF. The Basic Healthcare Provision Fund was authorized by the National Health Act of 2014 to improve service delivery at the primary care level with the aspiration to mitigate the inequality in access and improve the country's sparse health indexes. The fund

estimate, which is at least one per cent of consolidated federal revenue as contained in the Medium Term Expenditure Framework (MTEF), can also source for funds from donors and International development partners.

Closely related to financial fragmentation is the misalignment of the policy instrument of health financing with each other and with the targeted policy objectives. The misalignment can trigger policies to be ineffective or be detrimental to the achievement of the policy goals (14).

This study aims to contribute to solutions that will help remove or minimize financial fragmentation and help align policy instruments of health financing with policy objectives.

Chapter 2: Problem statement/Justification, objectives, methodology and limitations of the study

2.1 Problem Statement/Justification

Health financing in Nigeria is very complex and fragmented. The three primary sources of health financing in Nigeria are public - by the three tiers of government; private expenditure - through insurance, employers or individuals (through out-of-pocket). The public funding is rather complicated, fragmented and uncoordinated. Both Federal and State governments partly fund Primary health care in conjunction with the Local Government Councils. Although the federal government remains the highest contributor to health financing, there has been a misallocation of funds to the secondary and tertiary levels of care to the detriment of primary care which has the highest utilization (29). Financial allocation to health at the local government level is mostly limited to the payment of salaries. The other source of financing is from development partners or donor funds that are often off-budget and streams either directly to service delivery points or through the single-disease vertical programmes (32). The fragmented health financing arrangements above lead to duplication of efforts, wastage of resources, poor accountability, and poor service delivery. The financial arrangements also overburden the individuals and household members as health expenditure is mostly out-of-pocket, resulting in economic hardship and impoverishment with an attendant high prevalence of preventable diseases (33).

Authorised by the National Health Act (NH Act) in 2014, the Basic Health Care Provision Fund (BHCPF) derives its financing from the consolidated revenue of the federation within the Mid-Term Expenditure Framework (MTEF), with a sum not less than one per cent of the MTEF value and from grants by international donor; targets universal health coverage through the provision of basic healthcare package to its entire population (29). There is scarcity of peer-reviewed literature on the implication of financial fragmentation and the misalignment of policy instrument of health financing and policy objectives.

There is need, therefore, for a study that explores the possible contributions of Basic Healthcare Provision Fund financing model towards achieving UHC and the reduction of fragmentation in the health financing arrangements.

2.2 Overall Objective

To critically evaluate Nigeria's Basic Healthcare Provision Fund financing model in order to make recommendations that can help to optimize BHCPF to minimize fragmentation and contribute to a coordinated approach to primary health care as a means to advance towards UHC in Nigeria.

2.3 Specific Objectives

1. To describe the Basic Health Care Provision Fund (BHCPF) financing model using Joseph Kutzin's descriptive framework.
2. To explore main contextual factors that influence the BHPF model and realization of policy goals as depicted by the Joseph Kutzin's descriptive framework

3. To explore the challenges to the Basic Healthcare Provision Fund using Joseph Kutzin's descriptive framework
4. To make recommendations that can contribute to the reduction of fragmentation in health financing, improve on the coordination of Health Financing, as well as move the Nigeria health system towards Universal health coverage.

2.4 Methodology

The paper is a literature review using different keywords to retrieve necessary articles and publications on the topic. The online search involves using VU Library, Google Scholar, Web of Knowledge and PubMed to retrieve peer-reviewed articles using keywords "Basic Healthcare Provision Fund", "Nigeria", "Health financing arrangements", "Primary healthcare". Key reports included are those of the World Health Organization, Federal Ministry of Health, Nigeria.

2.4.1 Introduction of the framework

The study uses Joseph Kutzin's descriptive framework (see Figure 3) for analysis of health care financing arrangements in Nigeria at the national level. The framework is a tool for descriptive analysis of the key functions, policies, and interactions within an existing health care system (34). The use of this framework to analyze the Basic Healthcare Provision Fund is to highlight the existing situation in Nigeria's health system in relation to health care financing and resource allocation, and to support the identification and initial appraisal of policy options.

The framework incorporates all the components of health financing together with the policies shown in Figure 3 (revenue collection, pooling, purchasing and policy on rationing benefit entitlements) and makes explicit the interactions of these, how they relate to the population and to the health system functions of service provision and the "stewardship of financing" which include governance, regulation and provision of information.

The use of Kutzin's framework in combination with an evaluation of system performance will help to answer all the research questions in terms of the realization of the specific objectives through in-depth analysis of the disaggregated elements of health financing sources, resource allocation methods as well as other related organizational and institutional provisions.

2.4.2 Description of the conceptual framework

The concept shown in the framework in Figure 3 is a purposeful flow of funds across four separate organizational bodies in all systems, but the various functions shown do occur, though they may not be apparent or acknowledged. The ultimate purpose of the framework is to shed light on existing policy devices using the descriptive framework to provide a "checklist" that will ensure the consideration of each sub-function, resource allocation mechanisms, policies on population entitlements and obligations, and the stewardship arrangements for the system as a whole.

The arrows in "population" column illustrate links between each of these health system functions and the population or individuals within the population. The central pillar in figure 3 depicts the flow of 'pooled' funds in the health system from the collection point up to service providers. In the framework, pooled funds include all resources that are organized on behalf of

groups of people or the entire population, other than out-of-pocket payments by individuals to providers. The column on the left depicts "stewardship" - regulation and information to improve policy outcomes. The focus is on critical issues in regulation and information provision in each of the functions and policy on benefits and fees. The regulation and information provision is to enable each of these markets to perform better in terms of public policy objectives. Of course, different agencies of government (or branches of the same agency) could implement the regulations in different geographic areas. However, a standard set of measures and messages should apply.

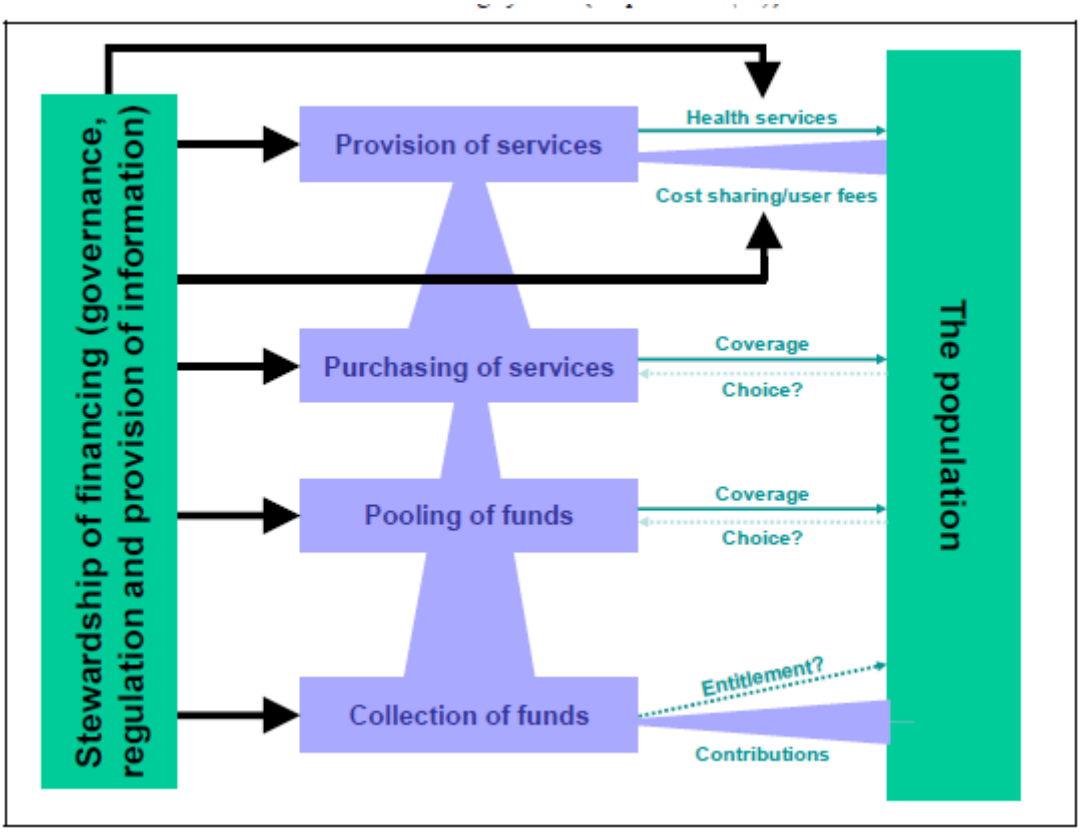


Figure 2.1 - Joseph Kutzin's Descriptive framework for country-level analysis of health care financing arrangements **(15)**

2.5 Limitations of the study

The BHCPF is just taking off in Nigeria and there is limited literature evaluating its performance. Official information about the population covered and how they access services offered by the scheme is not available. List or number of accredited providers in each of the eighteen participating states are not available. The data on population covered by the BHCPF is also not available. The literature review for this thesis is based on unpublished literature, published papers, guidelines of the scheme and reports.
Therefore, any errors that occurred, especially in unpublished literature, guidelines of the scheme and reports may affect the validity of the work, analysis and interpretation which may in turn have affected the reliability and validity of my work.

Chapter 3: Study results and findings

The following are the presentation of the study results and findings using the framework in Figure 1 starting with the central column which depicts the flow of 'pooled' funds in the health system from sources to service providers – revenue collection, pooling of funds, purchase of services and service provision.

3.1 Revenue collection

The three sources of revenue for the Basic Health Care Provision Fund are, an annual federal government grant that is not less than one per cent (1%) of its consolidated revenue (CRF), funds from international donor partners, and from any other sources. All collected revenue are lodged in the BHCPF Treasury-single-Account (TSA) domiciled at the Central Bank of Nigeria (CBN) (29).

The first grant (from the Federal government of Nigeria) of one per cent (1%) of the 2018 MTEF was fifty-five billion naira (N55 billion) while the World Bank is supporting the implementation of the BHCPF through a grant of twenty million United State dollars (US$20million) from the Global Financing Facility (GFF) which allows for the setup of the implementation and institutional arrangements for the BHCPF in three pilot states, namely Abia, Osun and Niger states from 2018 to 2021 (35)(36). Only eleven million and five hundred thousand dollars (US$11.50 million) or fifty-eighty per cent (58%) of the twenty-million-dollar World Bank grant has been drawn down into the BHCPF account with the CBN as at May 2020 (36).

In Nigeria, parallel or straight line revenue sharing formulas limit their ability to address regional fiscal and equity concerns. Oil revenue is shared in part on a derivation basis (that is, 13 percent of oil revenue is taken off the top and goes back to oil producing states), with the remaining share distributed via the vertical formula. The horizontal formula applied to states for the distribution of Federation Revenue predominantly follows a principle of equality – that is all states receive an equal share – with population, size, level of social development, and fiscal capacity playing a more minor role (Table 3). In other words, fund disbursement by the federal government are not only non-equalizing but they favor the wealthier oil producing states.

Additionally, the measure used to determine health need is based on inputs – number of hospital beds and health personnel. This is a poor measure of health need for two reasons. First, wealthier states are more likely to have more hospital beds and health care workers. Second, it incentivizes states to push for more facilities rather than focusing on health outputs (for example, number of fully immunized children) or outcomes (for example, child mortality) which, as highlighted earlier, differ widely across regions.

Table 3.1- Horizontal revenue sharing formulas applied to States

Principle	Federation Account Revenues (percent)	VAT Revenue (percent)
Equality	45.23	40.00
Population	25.60	10.00
Population density	1.45	
Internal revenue effort	8.31	
Landmass	5.35	
Terrain	5.35	
Rural roads/inland waterways	1.21	
Potable water	1.50	
Education	3.00	
Health	3.00	
Derivation	0.00	50.00

Source: World Bank (2013). Public Expenditure and Financial Accountability (PEFA) Assessment.

Table 3.2 - Revenue shortfalls, Naira billions (2015-2017)

2015			2016			2017		
Projected	Actual	percent change	Projected	Actual	percent change	Projected	Actual	percent change
3.5	2.3	-34.6	3.9	2.9	-24.9	5.1	4.4	-14.0

Source: Budget Office of the Federation. Budget Speech (Years 2016-2018) and The 2018-2020 Medium Term Expenditure Framework and Fiscal Strategy Paper.

3.2 Pooling of Funds

Pooling refers to the allocation of funds from collection agencies (according to different probable allocation methods) to one or several pooling institutions (34). The BHCPF fund flow to the pooling agencies (also known as "gateways") as laid down in the National Health Act is as follows (35):

3.2.1 The 1% federal government grant

1. Fifty per cent (50%) of the Fund shall be used for the provision of the basic minimum package of health services to citizens, inaccredited primary or secondary health care facilities through the National Health Insurance Scheme (NHIS);
2. Forty-five per cent (45%) of the fund which is disbursed through the National Primary Health care development Agency (NPHCDA) shall be expended as follows:
    i. Twenty per cent (20%) of the Fund shall be used to provide essential drugs, vaccines and consumables for eligible primary healthcare facilities;
    ii. Fifteen per cent (15%) of the Fund are for the provision and maintenance of facilities, equipment and transport for eligible primary healthcare facilities;
    iii. Ten per cent (10%) of the Fund shall be used for the development of human resources for primary health care;
3. Five per cent (5%) of the Fund which is to be administered through the federal ministry of health is to be used as follows:
    i. Two and half per cent (2.5%) to Nigeria center for disease control (NCDC) to improve Nigeria's emergency preparedness response which include reference laboratories and delivery of relevant strategies and objectives necessary to achieve its goals;
    ii. Two and half per cent (2.5%) is to be utilized for road traffic accident related emergency medical treatment covering a range of activities.

The funds are to flow as direct credits from the BHCPF account at the Central Bank of Nigeria to the different accounts of the pooling organizations (as depicted in Figure 4) also domiciled at the CBN (37).

Out of the fifty-five billion naira (N55 billion), which was the one per cent grant, the federal government only released one quarter of the sum, amounting to about thirteen billion, seven hundred and seventy-five million naira (N13.775 billion) for disbursement to the pooling agencies mentioned above on 17 May 2019. The breakdown of the disbursement showed that 50 per cent (N6.5 billion) went to National Health Insurance Scheme (NHIS), National Primary Health Care Development Agency (NPHCDA) got 45 per cent (N5.8 billion), 2.5 per cent

(N327 Million) to federal ministry of health and 2.5 per cent (N327 Million) Nigeria Centre for Disease Control (NCDC) (38)(39).

There was a sub-national allocation on 11 September 2019; of the 50% (N6.5billion) fund from the NHIS to fifteen (15) prequalified State health insurance schemes (SHIS) and the federal capital territory (FCT), who on behalf of the NHIS will purchase services from participating facilities in their various states. Analysis of the allocation showed that Kano got the topmost amount of nine hundred and forty-eight million naira (N948 million) while Bayelsa got the lowest amount of one hundred and sixteen million naira (N116 million). The list of the beneficiaries and their respective allocation is shown in Table 5 (37)(38). However, the criteria used for this allocation was not available in literature.

Table 3.3 – Sub-national allocation of NHIS N6.5 Billion to SHIS (40)**.**

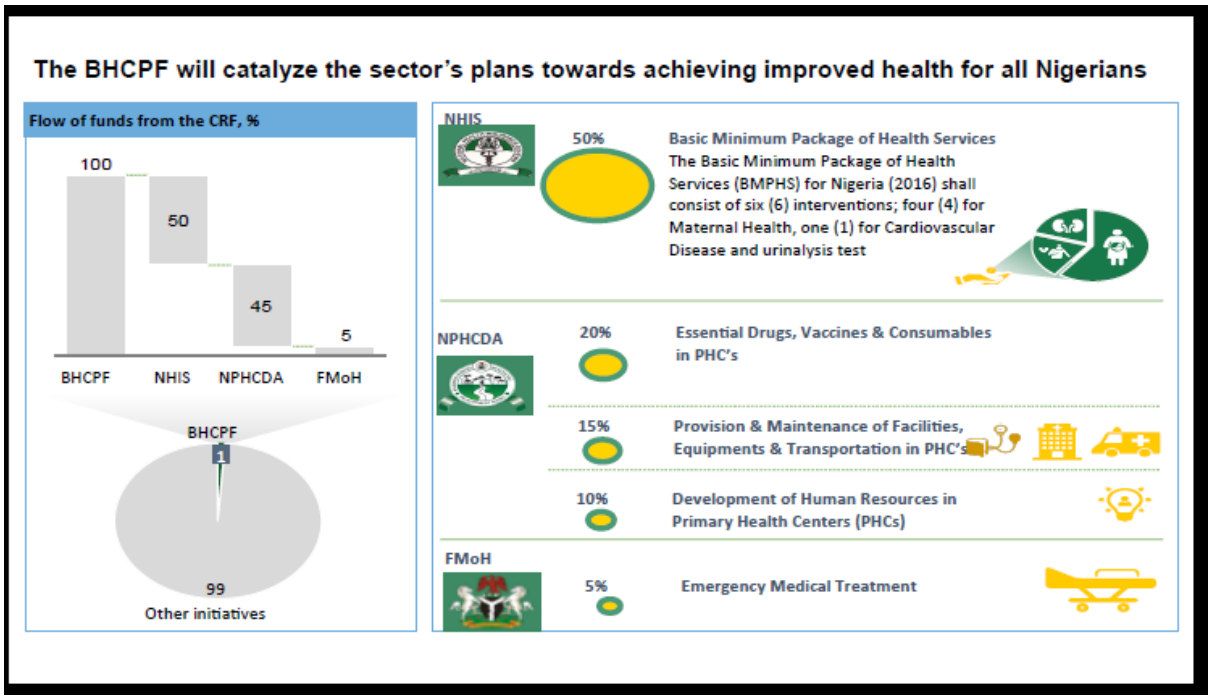
S/No	State Health Insurance Scheme (SHIS)	Allocation in millions (₦)
1	Kano	948
2	Lagos	672
3	Katsina	636
4	Kaduna	552
5	Bauchi	530
6	Oyo	449
7	Delta	394
8	Adamawa	342
9	Anambra	338
10	Plateau	337
11	Edo	301
12	Imo	301
13	Yobe	270
14	Ebonyi	230
15	Federal Capital Territory	118
16	Bayelsa	116

3.2.2 The World Bank grant

The twenty-million-dollar World Bank grant for BHCPF implementation in the three pilot states of Abia, Niger and Osun are to be used as follows (36):

- Seventeen million dollars (US$17 million) is for strengthening Primary Health Care Services through the NHIS pathway and
- Three million dollars (US$3 million) is for strengthening Health Management systems for the BHCPF implementation through the NPHCDA pathway.

Figure 3.1 Chart depicting flow of funds from BHCPF (account) to the pooling Agencies



3.3 Purchase of Services

Purchasing in health systems is the distribution of pooled funds to providers for the provision of health care services detailed in an agreed benefits package for the covered population (41). Purchasing Involves three sets of decisions –

- identifying services to be purchased,
- choosing service providers based on certain criteria, and
- determining the modalities of payments to providers.

Purchasing is usually undertaken by an acquiring organization which may be an insurance scheme, a Ministry of Health, or an independent agency. Pooling and purchasing aids coverage of individuals. That is, pooled funds are used to purchase services for some or the entire population. Important things in purchasing, the purchasing agencies, the market structure of purchasing as well as the mechanisms used to purchase (34).

3.3.1 Identifying services to be purchased

The focus of the BHCPF is on current health priorities in Nigeria which are reproductive, maternal, child, adolescent health plus nutrition (RMNCH), non-communicable diseases screening and emergency medical services (with emphasis on road traffic injuries (RTIs) (37). Therefore, the focus of the BHCPF set the tone of the services to be purchased under the NHIS and Emergency Medical Treatment (EMT) pathways as different benefit packages with different payment mechanisms.

3.3.2 Choosing service providers

The procedure for choosing service providers was in two parts. The first is the health facility assessment and accreditation while the second is the conditions to be fulfilled by each state for its accredited health facility to participate.

The main conditions to be fulfilled by states wishing to benefit from the BHCPF are adoption and implementation of the Primary health care under one roof model (PHCUOR) with the establishment of State Primary Health Care Board/Agency (SPHCB/A) and the establishment of State Health Insurance Scheme (SHIS) (35).

The PHCUOR policy prompted the establishment of the state primary health care development agencies/boards (SPHCDB/A) with the mandate of integrating the responsibilities for personnel recruitment, training, supervision and remuneration of health workers as well as the maintenance of physical infrastructure. It is the availability and functionality of the infrastructure and the quality of services provided in the facilities that underpins the assessment and accreditation of the facilities by the BHCPF. Although the number of accredited facilities were not available, fifteen states were prequalified as at February 2019 (see Table 1) for funding through the 1% federal government contribution while three states (Abia, Niger and Osun) were prequalified for funding through the World Bank grant of twenty million dollars (US$20 million).

The services (RMNCH) set out for purchase under the NHIS pathway consist of nine interventions. The NHIS pathway funds the purchase of the RMNCH services provided. The operation of the NHIS gateway is restricted to health care providers in the rural area of Nigeria in order to improve access and quality of care in rural areas. In Nigeria context, rural area will be defined based on population size of the "conurbation" – built-up area (35).

Operation of the NHIS Gateway (35)

a) The NHIS Gateway will be implemented as a pro-poor programme, in the rural areas in the first 5 years of its operation. The services will be extended the the urban areas thereafter.

The EMT Gateway (35)

The services to be purchased under the emergency medical treatment for road traffic injuries are pre-hospital care and transport, initial evaluation, resuscitation and in-hospital care (both surgical and non-surgical emergencies). The 2.5% fund from the EMT pathway funds the purchase of the services. The day-to-day operational aspects of the EMT Gateway is assigned to pre-accredited healthcare providers and facilities who will be responsible to the Ministerial Fund Oversight Committee (MFOC), Emergency Medical Treatment Committee (EMTC) and Federal Ministry of HealthFMoH. The MFOC acting as purchasing agency, shall contract accredited Ambulance Service Providers nationwide, including the Federal Road Safety Corps (FRSC), State Ambulance Services, National Emergency Management Agency (NEMA), Private Sector Ambulance Service Providers and Voluntary Sector Ambulance Service Providers on a 3-year provisional engagement.

Table 3.4 - Six Routes with Road Traffic Injuries/Fatalities in Nigeria (35)

	ROUTE	NO OF RTI FATALITIES (2015)
1	Abuja–Lokoja	293
2	Lagos–Ibadan	154
3	Doka–Kaduna	94
4	Onitsha–Awka	74
5	Lagos–Ore	57
6	Abeokuta–Lagos	51

Source: Federal Road Safety Commission - Annual Report 2015; https://frsc.gov.ng/#1510226806361-3-9

Figure 3.2 –Accident hotspots as at 2015

Source: Federal Road Safety Commission - Annual Report 2015; https://frsc.gov.ng/#1510226806361-3-9

Operation of the EMT Gateway (35)

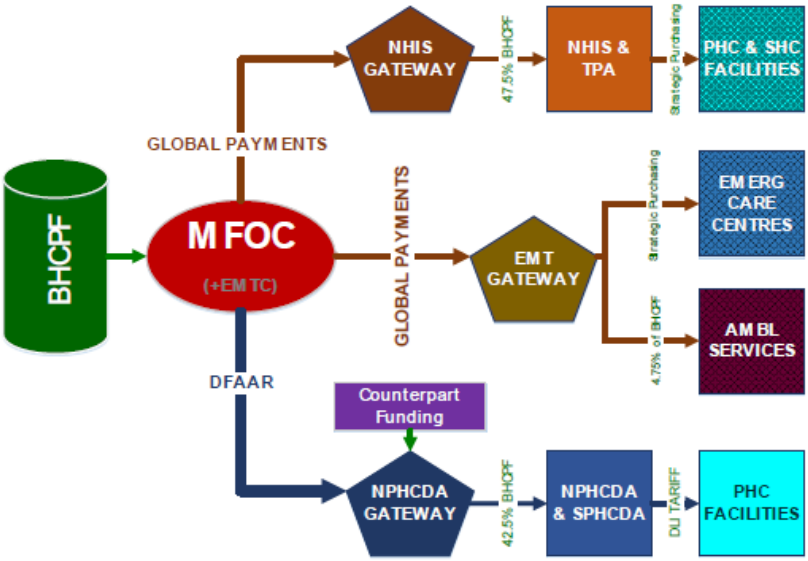
a. Operation of the EMT Gateway in the the first three (3) years of will be as an ***Intervention*** programme, to address the incessant high mortality resulting from Road Traffic Injuries (RTIs).
b. Six (6) accident-prone routes (***Accident Hotspots***) in Nigeria will be covered (Table 4) during the period.
c. During this initial period, there is a ***Universal Emergency Number (***limited to 3 or 4 digits***)*** that is valid throughout the catchment areas, available from every telephone device (landline or mobile), easy to remember and dial and toll free.
d. Accredited Emergency Care Providers within 30 kilometer radius of the ***Accident Hotspots*** will participate in this initiative.

3.3.3 Payment Mechanism

The payment to accredited providers who have rendered service for both the NHIS and EMT pathways is by the "Global payment mechanism". The model which is modified 'fee-for-service" process is a retrospective and claim-based system. The monthly payment for services rendered by accredited providers on the NHIS pathway is through the state health insurance

scheme on behalf of the NHIS while the payment to providers under the EMT pathway is also through the state health insurance scheme (see figures 6)(35).

Figure 3.3 - Disbursement Gateways and Fund Governance (35)

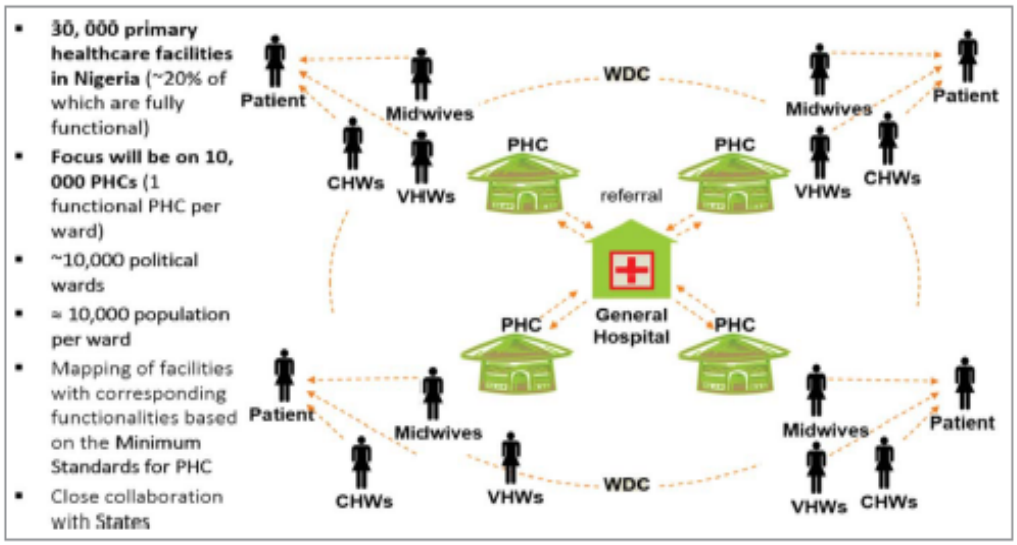


3.4 Provision of Services - Primary health care services

A major objective of health financing reform was to provide health facilities with incentives to streamline infrastructure, reduce fixed costs such as utilities and reallocate savings to direct patient care (42). In Nigeria, the Ward Health System (Figure 5) was adopted as a national strategy for delivery of quality PHC services in Nigeria for improved health outcomes and as a model of implementation for achieving Universal Health Coverage (UHC) (43). The Ward Health System (WHS) is based on the use of political wards as the catchment area to target PHC interventions using the ***hub-and-spoke model*** of primary health care. The Ward Health System requires at least one functional Primary Health Centre which will also serve as ***gate keepers***; controlling the upward referral of clients in the ward. The Ward Health System model links a cluster of primary health care centers to a secondary facility within a Local government area (LGA). The intervention projected some investments for the strengthening of at least one secondary care facility per local government area (1). The Primary Health Centre is to coordinate and supervise all the health services within the ward both at the facility and community levels.

The communities hosting the health facilities are actively involved from the planning stage all through the construction of the health centres to handing over of the health centres to their Ward Development Committees (WDC) to ensure ownership and effective management of services. Managerial support for the WHS is to be provided by the Ward Development Committees/Village Development Committees. Under the Ward Health System, the Primary Health Centre is the referral facility for all the other PHC facilities in a political ward. Each ward is subdivided into a maximum of six (6) health areas comprising of groups of

villages/communities. Each health area has health facilities made up of health posts, clinics and outreaches all linked to the Primary
Health Centre and are supervised by a resident Junior Community Health Extension Worker.



Note: WDC = Ward Development Committee; VHWs = village health workers; CHWs = community health extension workers

Figure 3.4 - Hub-and-Spoke Model for Primary Health Care Ward Health System (1).

3.4.1 Types of Facilities –The Ward Health System

Based on the Ward Health System (43), the three recognized PHC health facility types are:

i. Health Post to cover a population of 500 to 2,000 persons in a settlement or village.
ii. Primary Health Clinic to cover a population of 5,000 to 10,000 in a group of settlements, neighbourhood, villages (village areas) or communities.
iii. Primary Health Centre to cover a population of 10,000 to 30,000 in a political ward

The goal of WHS is to improve and ensure access to sustainable, quality, acceptable and affordable health services with full participation of people at the community level and thereby achieve Universal Health Coverage (UHC).
The provision of the incentives by the BHCPF is through the NPHCDA gateway. The fund provides funding to eligible Primary Health Care facilities for specific areas of healthcare including, provision of essential drugs, vaccines and consumables; provision and maintenance of facilities, equipment and transport; development of human resources. The payment mechanism is the decentralized facility financing (DFF) or result-based (RBFF) process (see Figure 6). Funds are released to providers quarterly for operational expenses with both "front-loaded" followed by "completion-linked" incentive payments.
The WHS is being deployed under six different stand-alone initiatives.

3.4.2 Primary Health Care Under One Roof (PHCUOR) (44)

Primary Health Care (PHC) is based on clearly defined principles which need to be translated into practice through the existence of structures and managerial processes. While remarkable progress has been made in primary health care development in Nigeria, the system has

remained weak and the health outcomes suboptimal due to multiple challenges in various aspects of the health system framework. The unsatisfactory governance system which largely results from fragmentation has continued to undermine the delivery of primary health care in Nigeria. The existence of multiple administrative frameworks (State Ministry of Health, State Ministry of Local Government & Chieftaincy Affairs, State Ministry of Women Affairs, Local Government Service Commission and sometimes the Office of the Executive Governor) at the state level with concurrent and overlapping responsibilities for primary health care has been the bane to the delivery of high quality, efficient and equitable health services.

The National Primary Health Care Development Agency in collaboration with key stakeholders introduced the "Primary Health Care Under One Roof" (PHCUOR) initiative as part of a new governance reform designed to improve primary health care implementation at state and sub-state levels. Primary Health Care Under-One-Roof is a policy for the integration of all PHC services under one authority - State Primary Health Care Board/Agency (SPHCB/A) to reduce fragmentation in PHC management and service delivery.

Bringing "Primary Health Care under One Roof" is modeled after the World Health Organisation guidelines for integrated district-based service delivery (45); which is based on the following:

1) Integration of all PHC services under one authority (SPHCB), consisting of health education, promotion, maternal and child health, family planning, immunization, essential drugs, nutrition and treatment of common ailments.
2) A single management body controlling services and resources, the implementation of which will require repositioning of existing bodies.
3) Decentralized authority, responsibility and accountability with roles and responsibilities at the different levels are clearly defined.
4) The PHCUOR employs the concept of ***three ones*** with a singular management, planning and monitoring and evaluation structure.
5) There is the operation of an effective referral system between/across the different levels of care.
6) An Enabling legislation and regulations incorporating the principles of PHCUOR is also enacted.

3.5 The Population

In Figure 1, the connection between revenue collection and the population points to the fact that all funds come from the population (other than funds donated by other agencies or external donors). The reverse link, labelled "entitlement" indicates contributions made on behalf of individuals (34).

The covered population under the BHCPF is a "group" which falls within the reproductive, maternal, child, adolescent health (RMNCH) plus nutrition, non-communicable diseases screening and emergency medical services for road traffic accident victims from participating states. The conceptual approach is the continuum of care in two scopes. The first size takes the mother to child linkage and the rendering of health services through every stage of life while the other recognizes the delivery of integrated preventive and therapeutic health interventions across service platforms from the community to the primary health centers and to the secondary facilities by refferals. The The group is a fraction of the whole population that the PHC serves (37).

3.6 Stewardship of financing – Regulation and Provision of Information

Stewardship of financing which is the same as the governance arrangements for the implementing as well as the provision of regulation and information to enable the system to deliver better results. The stewardship is further subdivided into governance, regulation and provision of information. The BHCPF has the governance structure depicted in Figure 7 (35).

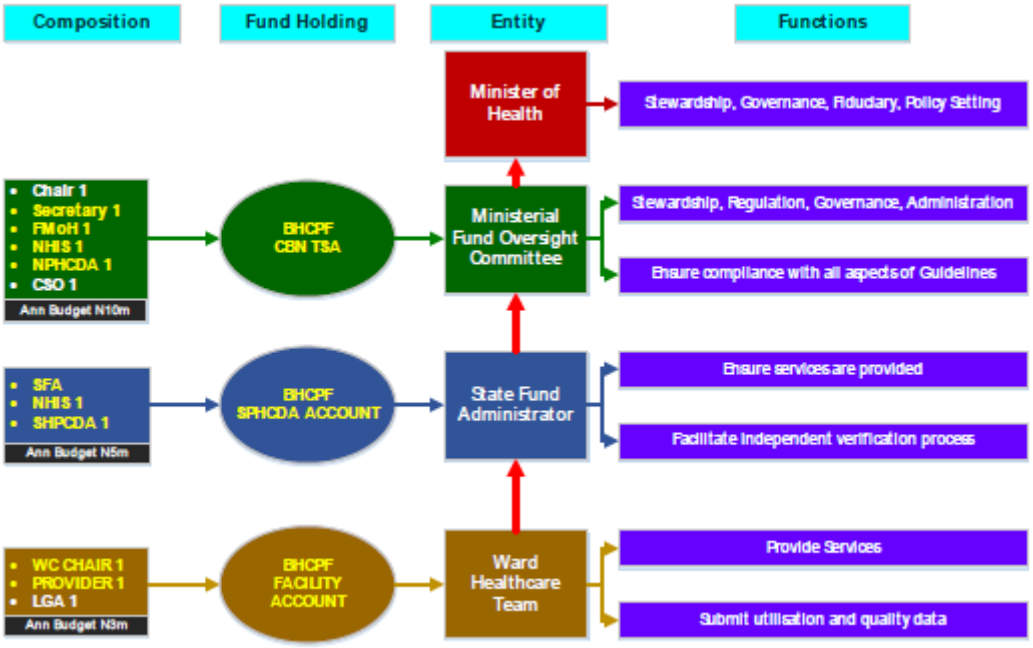


Figure 3.5 - Governance Structure for Administration of the Fund (35).

Chapter 4: Discussion of findings

The discussion of my study findings is in relation to the components of the conceptual framework introduced in Chapter 2. Finally, the challenges affecting the BHCPF model design and implementation will be discussed.
The results from this thesis indicate three key contextual factors that are essential in the success of BHCPF in Nigeria following an analysis along the lines of Kutzin's framework - the fiscal context, the structure of public administration and decision-making, and the rules governing public financial management.
While the fiscal capacity is government's ability and readiness to gather public revenues, the fiscal capacity does not fully explain the level of government health spending [in Nigeria]. The literature reviewed for this study indicate that the current 1% of the consolidated revenue allocation from the federal government to the BHCPF is grossly inadequate (46). In addition, the findings suggest the biggest challenge for Nigeria's health sector is low government spending. Nigeria has a weak revenue mobilization efforts at 4.8% of GDP (47).

4.1 The challenges to the Basic Healthcare Provision Fund

4.1.1 Efficiency in pooling resources

Fiscal transfers between government are a common in fiscally decentralized nations like Nigeria for the redistribution of need-based income. In Nigeria, the straight line revenue sharing formulas raises concern on the ability to address regional equity and fiscal apprehensions.

4.1.2 Allocating and using resources

The distributional consequences of the system's structural problems will make the poor agonize more from inefficiencies; to the extent that the out-of-pocket expenditure (OOPE) that the reform is trying to minimize can still manifest in the form of "informal payments" while the inefficiency problem spills over to become a transparency issue. The partial coverage given to part of the population in prequalified states has already excluded sizeable part of the population while the coverage does not exclude or protect the "partially" covered group from OOPE because any intervention that is not included in the benefit package has to be paid for out-of-pocket.

4.1.3 Accountability and Transparency

The partial coverage of a fraction of the population by the BHCPF scheme has not addressed the issues of drug revolving scheme, user fees and informal payment which are usually paid out of pocket. The issues can complicate the problem of accountability which become a transparency issue. Meaningful change seemed to require the creation of a new agency to pool funds and purchase services – namely, a health insurance fund. The establishment of the BHCPF is a critical reform implementation step and need to be at the level of a ***new agency,*** which would be a means to establish new institutional arrangements that create opportunities to drive broader health financing reforms. Simply creating the new agency is not enough to make it an effective agent of change. A new agency needs to be accompanied by measures to create or strengthen the purchasing function. The current global payment mechanism does not give room for progressive autonomy and innovation by the providers. Part of the process of establishing a strong purchasing agency, creating the appropriate incentive environment and avoiding contradictory policies is also to establish clear governance and accountability arrangements for the agency.

There may be no significant improvement in financial protection, equity and transparency or health, as long as the health system continuously "waste" a considerable amount of public resources allocated to it. Requesting for an increase in public allocation to health may become an up-hill task if the system cannot show that the current resources are being used efficiently. (48). Good governance and accountability may also be associated with consistent analysis and reporting on the performance of the financing system against well-defined policy objectives.

4.1.4 Integrating Public health programmes into the BHCPF

The reduction of fragmentation and changing of the incentive structure are some of the cardinal objectives of the BHCPF. However, the scheme seems to be ignoring public health services and public health programmes in health financing reform and policy analysis. The financing arrangements for these services need reform. The separate existence of these programmes within the health system leads to financial fragmentation, duplication and wastage.

Chapter 5: Recommendations and Conclusion

5.1 Conclusion

This thesis has examined the design and effecting proper implementation of BHCPF using Kutzin's framework infering that there are chalenges with financing rules and mechanisms, fragmentation due to none integration of vertical programmes.

As Development assistance for health (DAH) for public health programmes rounds out, the remaining sources of health financing will come under intense pressure.

However, following some of the key recommendations based on the literature reviewed may help address these challenges and help advance UHC through BHCPF in Nigeria. Nigeria's future success depends on the government's commitment to continuously fund and implement the provisions of the National Health Act – with budget allocation to the BHCPF.

5.2 Recommendations

5.2.1 Establishment of public and social accountability mechanisms

Public and social accountability mechanisms should be established to ensure the success of the BHCPF

5.2.2 Redesign payment systems

The payment systems under the BHCPF should be redesigned to create or reinforce incentives for improving service delivery.

5.2.3 Reduce fragmentation - Integration of public health and vertical programmes and the

vertical programmes would be a sure way of minimizing fragmentation.

Adoption of MTEF by state governments

All state governments should be encouraged to adopt the medium term expenditure framework of budgeting

5.2.4 Measuring and communicating results on the performance of the health sector.

Measurement and prompt communication of results should be established.

5.2.5 Institutionalize processes for regular communication of results on performance

The federal government of Nigeria must also institutionalize processes for regularly communicating results on the performance the BHCPF. This will be important for securing additional resources from subnational governments, donors, and private citizens. The lack of reporting requirements or formal mechanisms to consolidate information on health budget and expenditure at all level of government and across agencies (for example, FMOH, NPHCDA, NHIS), including the lack of transparency and accountability in the government system overall have greatly limited the governance and effectiveness of the health system.

5.2.6 Addressing challenges and knowledge gaps at sub-national level

State capacity to implement the BHCPF is at different stages across the country. Therefore, the FMOH must develop manuals/plans for improving national and state-level processes under the NHIS and NPHCDA gateways, assess state-level readiness, and support states in introducing the BHCPF. There are many factors influencing the demand for health insurance in developing countries – the most common being knowledge of the scheme, proximity to local health care facilities, perceived quality of local providers, and affordability of the premium.

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