NOVEL BASIC HEALTH CARE PROVISION FUND IN NIGERIA: CAN WORKFORCE FOR SERVICE DELIVERY IMPROVE?

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Abstract. Health financing policies are political decisions that involve all stakeholders because of its potentials in altering allocations in the budget and statuesque. This important economic tool should always be used in economic policies of nations especially in developing economies because of the wrongly perceived notion that there is no investment case for health. The government of Nigeria in 2014 signed into law the National Health Act. This Act made provision for additional funding to the health sector through earmarking to the tune of about $200 million annually, with the fund called the Basic Healthcare Provision Fund (BHCPF). The study aims to determine how many more health workers will be employed in the Nigerian health force using the earmarked funds in the health sector at the primary level of care. The study is a quantitative study design that involved the use of primary data from the BHCPF's implementation tracking tool. Data was collected during a health facility assessment in four systematically selected states in a random manner, which is in the first phase of the BHCPF implementation. This study showed that about 91,946 people will be employed directly into the Nigeria's health system if the Basic Health care Provision Fund is successfully implemented. This will in turn bridge the gap in human resource for health especially in the rural areas and improve the quality of service delivery at primary health care level in Nigeria. Therefore more funds should be allocated to the health sector to create jobs and bridge the gap in human resource for health in the underserved areas.
Keywords: *health, financing, BHCPF, health workforce, Nigeria*

Introduction

Health financing policies are political decisions that involve all stakeholders because of its potentials in altering allocations in the budget and statuesque. This important economic tool should always be used in economic policies of nations especially developing economies. There is a wrongly perceived notion that there is no investment case for health as health is seen rather as a consumption goods (WHO, 2005). It is therefore crucial that research base evidences where it is available are provided on investment case for health. Health financing is concerned with how financial resources are generated, allocated and used in health systems (WHO, 2010a). The discussion on financing health therefore is on how to generate enough resources for the health system,

pool the resources and strategically use the resources to purchase health care for citizens. It is also to run an all-inclusive health system that is devoid of access barriers and how to improve efficiency, quality and equity in healthcare within these economies (WHO, 2007). Another definition considers 'a good health financing system as one that ensures people can use needed services and are protected from financial catastrophe or impoverishment associated with having to pay for them. It provides incentives and users to be efficient (WHO, 2007). Therefore, any reform that sets to improve these health financing objectives and ensure citizens get the maximum benefits from it will be an ideal health financing reform.

In consideration of the fact that many African nations did not achieved Millennium Development Goals 2000-2015 and the need to set priorities to achieve the Sustainable Development Goals 2015-2030 especially goal 3 which concerns health and target 8 which centers on Universal Health Coverage has become a priority (UN, 2015). Devising mechanisms to finance health which focuses on public spending that guarantees equity and financial risk protections to citizens is seen as a cardinal tool for social protection. This has become imperative because the focus on financing UHC is on public funding with government taking the lead in all health financing functions.

Nigeria is one of the African nations yet to meet the Abuja declaration of 2001 which mandates all African heads of state to provide not less than 15% of their country's total budgetary allocation to health annually (WHO, 2010b). This poor funding of the health sector has contributed to the poor health outcomes and numerous health system challenges which ranges from high maternal and child mortality, over reliance on donor support, medical tourism, brain drain to high prevalence of communicable and non-communicable diseases. Understanding the strong positive correlation between health and economic growth and development, the government of Nigeria in 2014 signed into law the National Health Act. This Act in its section 11 makes provision for earmarked funds of not less than 1% of federal government consolidated revenue for the provision of minimum basic package of health care services to all Nigerians6. This fund called the Basic Health Care Provision Find (BHCPF) is to be implemented through three national gateways namely, the National Health Insurance Scheme (50%), the National Primary Health care Development Agency (45%) and the Emergency Medical Treatment by Federal Ministry of Health (5%) (FMOH, 2020; The Federal Government of Nigeria, 2014). However, the fund was first appropriated in 2018 fiscal year of about fifty five billion naira (N55.1billion naira i.e. about $200, 000,000.00) (FMOH, 2020).

The Basic Health Care Provision Fund however has an implementation guideline which recognizes the need for job creation through the health sector. This clause in the guideline recognizes the provision of the law that stipulates that of the 45% meant for the supply side financing, 10% of the fund shall be used for the development of human resources for primary health care (FMOH, 2020). The implementation guideline requires that the gateways must implement through the state structures at different state levels. In support of the general health system principle that the primary health care is the bedrock for a resilient and responsive health system in line with the Alma-Ata declaration of 1978 (WHO, 1978). The fund will be implemented in one primary health center in every political ward across Nigeria. The guideline requires that all implementing states must have a fully functional and well-staffed State Health Insurance Agencies, State Primary Health Care Development Agencies and a designated Primary Health Center in every political ward in Nigeria. The BHCPF is meant for all citizens in Nigeria; however the implementation guideline has criteria to be met by

states before such state can be considered. The first phase is made up of 19 states including the Federal Capital Territory that met the commencement criteria set by the national steering committee of BHCPF. The states are Edo, FCT, Katsina, Yobe, Delta, Lagos, Adamawa, Kano, Anambra, Kaduna, Imo, Bauchi, Bayelsa, Ebonyi, Oyo, Plateau, Osun, Abia and Niger with a total of 4754 PHCs inspected for the participating states. However all the 36+1 states have met the requirements during the second phase and accessed the fund.

The country has a huge human resource gap in all health professions which may be attributed to lack of funds needed to engage more health professionals in the discharge of health services. Currently, despite the efforts of Primary Heath Care Under One Roof (PHCUOR) which started in 2001 with the aim of coordinating the PHC activities including adequate staffing for effective service delivery, only about 20% of about 30,000 PHCs in Nigeria are functioning (Adewole, 2016). This lack of capacity to function optimally is due to many challenges including inadequate human resource at the primary health care level (Chinawa, 2015). However, in order to meet the human resource criteria for accessing the fund as contained in the implementation manual, many states are increasing the staffing at their primary health care centres. The Basic Health Care Provision Fund may have the potentials to change the narrative for a massive engagement of more Nigerians into productive venture in the health sector if implemented according to the implementation guidelines.

Granted that more funding through earmarking may possibly improve the unemployment situation in the country, another important issue is the human resource for health gap in Nigeria which has been attributed to poor funding to the sector (Aluko et al., 2019). Evaluation report of NEPAD on human resource for health in Nigeria indicated that severe shortage of qualified healthcare workers, lack of political will to recruit appropriate categories of health workers to practice within the scope of their respective training and inaccessibility of skilled care to many women are issues of serious concern to the researchers (NEPAD, 2013). The Nigerian National Strategic Health Development Plan II 2018-2022 considers human resource for health a priority area because of its contribution to abysmal health indices in Nigeria (FMOH, 2018). Therefore solving the hydra-headed human resource for health problems in Nigeria will not only be seen as a job creation function, but a catalyst to closing the gap on the health system building block required to achieve Universal Health Coverage in Nigeria.

Achieving health systems goal depends largely on the skills, knowledge, motivation and deployment of people responsible for delivery of health services (WHO, 2009). There is a direct positive link between numbers of health workers and population health outcomes (Speybroeck et al., 2006). Therefore, health reforms that improve the increase and sustainability of more health workforce should be encouraged. The health workforce is “all people engaged in actions whose primary intent is to enhance health” (WHO, 2006). Though there are many ways of assessing adequacy of the health workforce in a given population, it has been established that countries with less than 23 Physicians, Nurses and Midwives per 10,000 populations generally fail to achieve adequate rate for primary health care interventions (WHO, 2006). Human resource for health is one of the health systems building block and a critical pillar in the National Strategic Health Development Plan of Nigeria (FMOH, 2018). In Nigeria, the primary health care workforce include family physicians, public health physicians, general practitioners, nurses and midwives, pharmacy or pharmacy technicians, laboratory technicians, community health extension workers (CHEWs) and voluntary health

workers (Federal Republic of Nigeria, 2007). The inadequacy in the number of critical health workers in Nigeria is palpable. The national average for doctors is 12 per 100, 000 population, whereas the national ratio of nurses and midwives to 100 000 population stands at 21, the South West, North West and North East zones have 16, 11, and 18 respectively (Federal Republic of Nigeria, 2007). This study therefore will consider the potentials of BHCPF in increasing the number of critical workforce if implemented as designed or otherwise.

In this study, the general objective is to determine the potentials for improvement in human resource for health at the primary health care level that will guarantee better quality of service and job creation with more funding to the health sector using the earmarked fund in Nigeria called the Basic Health Care Provision Fund. To be more precisely, the specific objective is: (1) to determine how many more health workers will be engage to improve service delivery in to the Nigerian health force with the earmarked fund; (2) to compare the health workforce in Nigeria at the Primary Health Care level before and after the commencement of the implementation of Basic Health care Provision Funds; (3) to determine the potentials for job creation in the health sector using earmarking; as well as (4) to consider possible health policy reforms that will be used to create more jobs to Nigerians through the sector.

Materials and Methods

The research is a descriptive study that involved the use of primary data from the Basic Health Care Provision Fund Implementation tracking tool. The BHCPF-PHC tracking tool contains information such as presence of a serviceable physical infrastructure, presence and number of doctors, nurses, midwives, chew, jchew and other health workers. It also contains information on accessibility, presence and use of drugs in the facility and evidence of service delivery especially maternal and child health care. Data was collected during health facility assessment conducted in the selected states of Bauchi, Kano, Anambra and Ebonyi. Systematic sampling method was adopted randomly to select the states used in the study. From the 19 states participating in the first phase, the states were first divided into northern and southern states.

The first two states from both regions to submit readiness for assessment letter to the national secretariat of BHCPF were chosen. Therefore, Kano and Bauchi states were selected from the northern part of Nigeria while Anambra and Ebonyi were selected from the southern part of Nigeria. The four states of Bauchi (212), Kano (484), Anambra (326) and Ebonyi (171) had a total of 1193 primary health care facilities visited during the assessment exercise. The health facility assessment was conducted between February-September 2019 by a consultant, staff of National Primary Health Care Development Agency, National Health Insurance Scheme, and Federal Ministry of Health. All the 1193 PHCs in the four selected states were assessed. A desk review of all facility assessment data submitted by these four selected states in the first phase of the BHCPF implementation was conducted by a consultant recruited by the secretariat of BHCPF.

The selection criteria included states that have a complete baseline data of primary health facility assessment. The minimum human resource criteria for the two agencies are similar across the state levels. However, establishment of a functional state health insurance agency and a primary health care board are part of the requirement in the

implementation guideline. It is expected that there will be 20% increase in the strength of the health workforce at PHC level as contained in the monitoring and evaluation plan, thus the 20% workforce increase was extrapolated. The current PHC staff strength of the states and the number needed to commence the implementation of BHCPF was also analyzed. Descriptive statistics were used to present the data in line with the study objectives.

Results and Discussion

Table 1 indicated about 11 persons is required in each PHC to remain functional and render services based on the human resource need for a PHC in Nigeria. In the 8821 PHCs that will be used for BHCPF implementation, about 97031 health workers will be directly required at the PHC level across the Country. Nurse/ Midwives who play critical roles in the reduction of maternal and child mortality will be required about 2 per PHC and about 17642 in the Country

Table 1. *Primary Health Centre Human resource minimum basic requirements per ward for BHCPF in 8821 PHCs and projections for the 36+1 states in Nigeria.*

Human resource	No. required for BHCPF/facility in the manual	Total in 36+1 states at 8821 wards
Nurse/midwives	2	17642
Chew	1	8821
Jchew	2	17642
Lab technician	1	8821
Others + security	5	44105
Total	11	97031

Table 2 showed about 100,767 health workers will be directly involved in the implementation of BHCPF both at the agencies and the PHCs. However, in about 5 years of the implementation of this earmarked fund, about 120,920 health workers will be needed in the implementation across the Country. Health workers at the PHCs directly involved with service delivery at different points constitute the majority

Table 2. *Total number of people employable directly with State Social Health Insurance Agencies (SSHIA), Sate Primary Health Care Boards (SPHCB) using the current average staff strength and at Primary Health Centre (PHC) levels.*

Source of employment	Total number	Number at 20% increase in workforce projected in the first 5 years of implementation
SSHIA (Demand side agency)	1591	1909.2
SPHCB (Supply side agency)	2145	2574
PHCs	97031	116437.2
Total	100767	120920.4

Table 3 indicated Nurse/midwives which are critical health workforce were in short supply in most of the states studied. It ranged from only about 26 in Ebonyi to 197 in Bauchi. In the four states studied, only 494 Nurse/midwives were available when compared to about 2206 needed in the four states. The availability of Medical laboratory Technician was also inadequate as Ebonyi had only 9 in the entire PHCs in

the state while Kano had about 211. All other PHC health workers were also not adequate when compared to the number needed

Table 3. *Total workforce at PHCs presently in the four selected states (dated on December 2019).*

Health workers	States on current staff (on the expected number with BHCPF)				Total
	Anambra est. pop. (6012205)	Ebonyi est. pop. (3132788)	Bauchi est. pop. (7239313)	Kano est. pop. (14437756)	
Medical officer	1	3	10	8	22
Nurse/midwife	156 (472*)	26 (342*)	197 (424*)	115 (968*)	494 (2206*)
Chew	325 (236*)	271 (171*)	545 (212*)	657 (484*)	1798 (1103*)
Jchew	111 (472*)	108 (342*)	279 (424*)	350 (968*)	848 (2206*)
Medical lab technician	9 (236*)	12 (171*)	121 (212*)	211 (484*)	353 (1073*)
Community health officer and others	52 (1180*)	19 (855*)	117 (1060*)	142 (2420*)	330 (5515)
Environmental officers	0	28	191	381	600
Pharmacy technician	0	0	9	80	89
Community dentist	0	0	0	133	133
Volunteers	79	0	0	29	99
No. of political wards	236*	171*	212*	484*	-

*Notes: * means the human resource need per state based on the number of wards and the requirements in the implementation manual; est. pop. means estimate population.*
Sources: National Bureau of Statistics (2017).

The health sector has been unfairly treated most times in Africa during considerations for economic growth and development. Many non-health system actors do not understand the positive correlation that exits between health and development especially in the improvement of some macroeconomic conditions such as unemployment rate, underemployment rate, GDP growth rate etc. These thoughts are usually compounded with the inability of the managers in the health sector to demonstrate that health is not just a consumption commodity but and economic investment. In the United Kingdom, the National Health Service (NHS) an agency of government responsible for financial risk protection employs about 1.5 million people. The agency is considered the highest employer of labour in United Kingdom and one of the highest globally (Rolewicz and Palmer, 2019). Despite this large number of employment from a single sector, the NHS workforce is seen not to be enough for the country's health systems need. This study in Nigeria showed that a total of about 100,767 people will directly be gainfully employed with the Basic Health care Provision Fund if successfully implemented according to the guideline. This increase in the number of workforce will significantly improve the quality of service delivery at primary health care level. Another beauty of this increase in the workforce is the geographic equity that BHCPF will bring to the health system owing to the fact that it

will be in the entire political wards in Nigeria as against the previous over concentration of workforce in the urban cities. The indirect labour that this earmarked fund will bring through the entire value chains from different vendors to the economy is also an important economic gain to the country that needs to be considered.

Currently despite a huge population of about 195 million people, Nigeria's employment, underemployment and youth unemployment rates stand at 23.1%, 201.2% and 55.45% respectively (National Bureau of Statistics, 2017). Therefore, if this huge number of workforce is added into the employment data, it will significantly improve the unemployment rate and its attendant positive effect on the economy. It is estimated that more than 1 billion dollars is lost annually in Nigeria due to medical tourism (Abubakar et al., 2018). This is so because despite the poor funding to the health sector, the human resources for health challenges in Nigeria has not been addressed thus putting more pressure on the available human resource for health with associated poor quality of care. These consequently make health care seekers to lose confidence in the services delivered locally in the country. Therefore, providing solutions to human resource gap by engaging more health workers through funds like this will improve health outcomes equitably while reducing brain drain and medical tourism.

Despite the great potential of earmarked fund to generate more resources to the health sector, improve quality of service delivery and job creation, the health systems challenge of retention of health workforce in rural communities has always been a problem. However, evidences abound that when work force is recruited locally as in the case of BHCPF in Nigeria there is likelihood of retaining the critical health workers to work in their local communities (Awofeso, 2010). This is shown in a similar study in Thailand on strategies to respond to health manpower needs in rural setting. The study revealed that health workers trained and licensed locally and posted to practice in their local communities contributed significantly to the retention of workforce in rural settings (Nitayarumphong et al., 2000).

Conclusion

The study concludes that more Nigerians will be directly employed through the implementation of Basic Health Care Provision Fund if implemented according to the guideline. This earmarked fund also has the capacity to close the human resource gap and improves quality of service delivery at the primary level of care. In the recommendation, the support for improvement in the number of health workforce though earmarked funds should be encourage through legislation to ensure sustainability of quality health services at the primary health care level. It is clear from this study that more funds earmarked specifically for the health sector has good potentials for job creation; it is recommended that more funds should be allocated to the health sector to bridge the gap of unemployment and underemployment in Nigeria by the legislature since the health sector has the institutional and organizational framework to absorb more people. This will therefore directly reduce unemployment rate and contribute in the human capital development in Nigeria. Therefore, BHCPF should be increased from not less than 1% to something higher through the repeal of the National Health Act 2014.

The resources from earmarked funds for health such as the BHCPF should be used to incrementally increase the labour force especially in the rural and underserved communities yearly. The implementation gateways for earmarked funds should also

demonstrate this evidence of job creation and its contribution to the macro-economic improvement to the citizens. To ensure that this is achieved successfully, these evidences should be shared with the media, National Assembly and Ministries of Finance to justify the release of the funds to the health sector regularly. Since earmarked funds for health is a sustainable health financing source, it should be used for geographic targeting and to solve geographic inequity and challenge associated with over concentration of health facilities and health workforce in urban cities despite not accommodating the largest part of the population. Therefore the Ministries of Health should constantly monitor the improvements on equitable distribution of human resources especially the underserved areas such as the rural communities.

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Conflict of interest

The author conforms that there are no conflict of interest involve with any parties in this research study.

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