

Implementing Health Policy in Nigeria: The Basic Health Care Provision Fund as a Catalyst for Achieving Universal Health Coverage?

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ABSTRACT

In 2014, Nigeria adopted a new law for its healthcare system, which mandated the establishment of a novel health-financing mechanism, the Basic Health Care Provision Fund (BHCPF). The BHCPF was created to provide sustainable funding with a view to fast-tracking Universal Health Coverage (UHC) and improving health outcomes in Nigeria. This article places Nigeria's UHC reform process in the broader context of social policy implementation in Africa to illustrate the extent to which interactions between different agents, contextual factors such as Nigeria's federal character, as well as changing conceptualizations of social policy at a global level, shape views on how best to implement UHC. The article is based on the careful examination of three different versions of implementation guidelines for the BHCPF combined with qualitative data collected during fieldwork. It argues that there is a discrepancy between the Nigerian government rhetoric of putting into place a system that improves access to healthcare and the actual practice of implementing UHC via the BHCPF. In reality, a range of controversies surround the ongoing operationalization of the BHCPF, contributing to the perpetuation of a social policy environment that allows poor health outcomes and significant health inequities in Nigeria to persist.

INTRODUCTION

This article adds to the literature that investigates the dynamics and factors shaping domestic healthcare sector reform processes, and explores how changing conceptualizations of social policy shape views on how best to implement universal health coverage (UHC) at the national level. It does this by providing a novel empirical analysis of the ways in which different agents, their interactions, context-specific structures and consumption

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norms, as well as global processes and narratives, affect the implementation of a specific health policy in Nigeria and, in turn, the form UHC is taking in the country. Social policy making across countries depends heavily on the balance of political power between advocates for private service delivery and supporters of solidarity-based universalism (Yi et al., 2017). Health, as an area of social policy, is illustrative of tensions between the rhetoric of universalism and practices of selectivity (Greer and Méndez, 2015; Koon and Mayhew, 2013; Rizvi et al., 2020). While, in the 1970s, comprehensive primary health *care* (PHC) was meant to be a human right, as articulated in the 1978 Alma-Ata Declaration,¹ more recent calls for universal health *coverage* pay less attention to the way healthcare services are provided (Fischer, 2018). The contemporary notion of universalism is vague, which is likely to be one reason for the broad adoption of UHC in the first place, and for the considerable range of different modes of operationalizing UHC on the ground (Fischer, 2018; MacGregor, 2017; Stuckler et al., 2010). As a result of the fuzziness of the concept of UHC, national healthcare systems across the world take distinctive shapes and forms and differ with regard to who bears responsibility for financing and providing healthcare, what segment of the population is supposed to receive services and under what conditions.

Working in the tradition of Critical Political Economy, I scrutinize the impact on healthcare provisioning and consumption in Nigeria of the relations and contestations between different agents and context-specific structures, the diverse meanings that groups of people associate with the consumption of healthcare, and global processes (such as neoliberalism and the ensuing promotion of private sector involvement in healthcare systems) (Bayliss and Fine, 2020; Fine and Saad-Filho, 2016). To this end, a significant proportion of my analysis relies on information gathered during interviews and focus group discussions conducted with more than 130 individuals, who play different roles in Nigeria's healthcare system. A total of 50 interviews and 12 focus group discussions took place in Nigeria between January and April 2019. With the aim of gaining a comprehensive understanding of the Nigerian UHC reform process, my interview participants were selected through purposive sampling. I targeted representatives from civil society, the three levels of government,² two parastatal agencies leading Nigeria's UHC reform process, international organizations, private health insurance companies and public and private healthcare providers. Within these categories,

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1. The Alma-Ata Declaration emphasizes the universal human right to a comprehensive set of primary healthcare services, going beyond the right to receive medical treatment only in the case of sickness (Yi et al., 2017: 5).
 2. Nigeria operates a three-tier federal system of governance (federal, State and local levels), including a system of fiscal decentralization which enables sub-national levels of government to levy taxes (Oduola, 2006). The Federation of Nigeria consists of 36 States and the Federal Capital Territory (FCT), further divided into 774 Local Government Areas (LGAs). Each LGA is responsible for 10–20 political wards.

I reached out to key representatives and then applied snowball sampling until theoretical saturation was reached. At the same time, this article builds on a thorough analysis of three different versions of the implementation guidelines for the Basic Health Care Provision Fund (BHCPF).³ The BHCPF is a novel public healthcare funding mechanism introduced in 2014 when the first-ever law to formally govern Nigeria's healthcare system, the National Health Act (NHAct), was signed, which made the attainment of UHC an explicit policy objective. Civil society celebrated the adoption of the 2014 NHAct as a major milestone on Nigeria's journey towards UHC, not least because of the establishment of the BHCPF that is expected to assure a sustainable funding flow to the country's debilitated primary healthcare system.

Nigeria's healthcare system is amongst the worst performing in the world, with maternal and child mortality rates surpassing national and international benchmarks. According to the United Nations (UN) Inter-agency Group for Child Mortality Estimation, every tenth child in Nigeria dies before its fifth birthday. Nigeria's under-five mortality rate of 111 deaths per 1,000 live births in 2022 compares unfavourably with countries such as Ghana (44 deaths) or South Africa (22 deaths).⁴ Maternal health outcomes are similarly inadequate: two out of five deliveries did not take place in a health facility in 2018, potentially explaining why 31.3 per cent of female deaths are maternal (NPCN and ICF, 2019: 223, 377). Overall, with an average life expectancy of 53 years, Nigeria falls well below the average of 71 years for low- and middle-income countries.⁵ An analysis of data from the 2018 Demographic and Health Survey (DHS) further highlights the prevalence of health inequalities across Nigeria, with higher neonatal and child mortality rates in poorer households (NPCN and ICF, 2019), as illustrated in Figure 1.

A major factor explaining poor health outcomes and significant health inequalities in Nigeria is that public healthcare delivery continues to be chronically underfunded. Data from the World Health Organization (WHO) show that Nigeria spent only 0.5 per cent of its GDP on health in 2019 — well below the sub-Saharan African average of 2 per cent. With only 4.2 per cent of total government expenditure spent on health in 2020, Nigeria fails to honour its commitment, made as part of the 2001 Abuja Declaration.⁶ At the same time, social insurance coverage in Nigeria is low, estimated to be 5 per cent in 2020 (NHIS, 2020). This puts pressure on already vulnerable households to cater for their healthcare needs privately. Consequently,

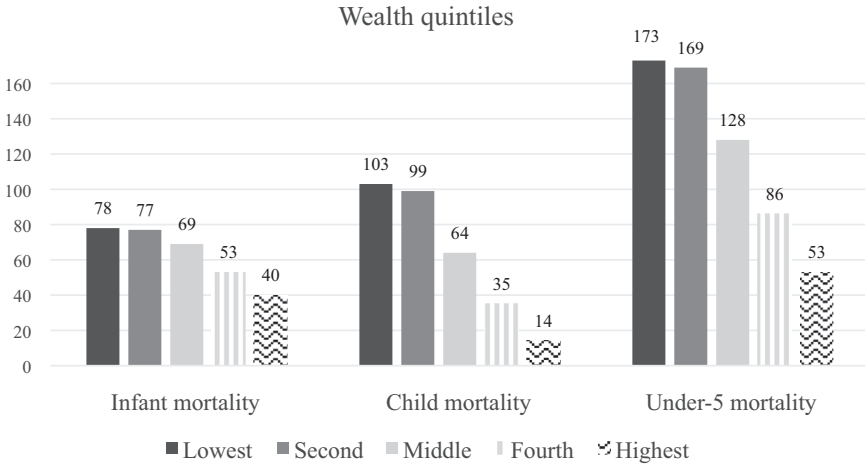
3. Adopted in December 2016, November 2018 and September 2020, respectively. See FMOH (2016, 2018, 2020). Only the 2020 Guidelines are available online.

4. See United National Children's Fund (UNICEF) statistics: <https://data.unicef.org/topic/child-survival/under-five-mortality/> (accessed 20 April 2023).

5. See World Bank Open Data: <https://data.worldbank.org/indicator/SP.DYN.LE00.IN?locations=XO> (accessed 20 April 2023).

6. In 2001, African Union member states adopted the Abuja Declaration, committing to allocate at least 15 per cent of their annual public budgets to the health sector.

Figure 1. Mortality Rates, Nigeria



Notes: Infant mortality: the probability of dying between birth and first birthday; Child mortality: the probability of dying between first and fifth birthday; Under-5 mortality: the probability of dying between birth and fifth birthday

Source: Author's illustration based on 2018 DHS data (NPCN and ICF, 2019)

out-of-pocket (OOP) healthcare expenditure in Nigeria amounts to a staggering 76.6 per cent of current health expenditure (FMOH, 2019), the highest level on the continent (Mo Ibrahim Foundation, 2020).

Given the extraordinary dependence on OOP, hopes were high that the establishment of the BHCPF would swiftly lead to an increase in public funding to improve access to healthcare and reduce financial hardship relating to catastrophic healthcare spending. However, the Federal Government did not make its first allocation to the BHCPF until 2018, four years after the NHAct was enacted. Then, after the BHCPF was formally launched in May 2019 and a first disbursement of 5.6 billion Nigerian Naira (approximately US\$ 15.7 million) was made in September 2019, its implementation was halted again a few months later. The interruption followed objections made by Nigeria's National Assembly that the 2018 BHCPF implementation guidelines were not in compliance with what the NHAct had envisaged. Since then, new guidelines have been adopted (referred to henceforth as the 2020 Guidelines) and the BHCPF has resumed operations. Yet, the limited nature of available government funding, as well as a range of contestations concerning how to best operationalize the BHCPF within the confines put into place by the NHAct, impact its success in serving as a genuine driving force towards UHC. Crucially, according to the budget proposal for 2023, the BHCPF is expected to receive as little as 47.6 billion Nigerian Naira in 2023 (US\$ 108 million). This compares to 2.74 trillion Nigerian Naira (US\$ 6.2 billion) earmarked for the defence and security sector (FGN, 2022).

In this article, I highlight the discrepancy which persists between the Nigerian government's rhetoric, claiming to be putting in place a system that will facilitate universal access to healthcare, and the actual practice of implementing UHC in Nigeria via the BHCPF. I argue that the BHCPF, as currently operated, is unable to deliver on the promise of making healthcare equitably and universally accessible. Rather, it provides minor additional public funding to channel selected healthcare services via public and private healthcare facilities to targeted population groups.

The article proceeds as follows. I first discuss the literature on the political economy of UHC, within which my research is situated. I highlight the contemporary trend of prioritizing narrowly conceived social safety nets over universal and publicly funded and operated social service delivery systems. I then introduce the current set-up of the BHCPF and outline how it is expected to improve access to healthcare in Nigeria. The following section then presents four key areas of contestation which show that, while the Nigerian government has adopted the target of UHC in discourse and by law, it falls short of putting into place a functional system that can provide healthcare for all Nigerians in practice. The final section concludes and places Nigeria's healthcare system reform process in the broader context of social policy making in Africa.

FROM COMPREHENSIVE PRIMARY HEALTHCARE FOR ALL TO A BASIC MINIMUM SERVICE PACKAGE FOR THE FEW

The notion of what universal and integrated social policy entails has narrowed significantly in practice. In the 1950s and 1960s, comprehensive social policies such as free education and healthcare and universal transfers (such as pensions, child grants and disability benefits) were deemed essential to improve human well-being (Lavinás, 2017). For example, after Nigeria gained independence in 1960, policy makers used public revenues to fund the public provision of social services, including free education and healthcare (Adésinà, 2012; Odeyemi and Nixon, 2013). At this time, investments in social sectors were considered crucial to nurture productive citizens who could support Nigeria's post-colonial development project (Adésinà, 2012: 299).

However, when global oil prices dropped in the early 1980s, the Nigerian government's difficulty in generating revenues translated into the privatization of social service delivery systems and an increased reliance on individuals fulfilling their social needs privately (Adésinà, 2007, 2012; Ichoku and Fonta, 2006; Odeyemi and Nixon, 2013; Orubuloye and Oni, 1996). At the same time, the shift away from a wider vision of social policy towards the 'social protection paradigm' in Nigeria and globally is tightly linked with the emergence of neoliberalism in the early 1980s (Adésinà, 2011). Neoliberalism, understood by Brenner et al. (2010: 184) as

‘a politically guided intensification of market rule and commodification’, gained prominence throughout the 1970s when a volatile economic situation weakened the legitimacy of Keynesian welfare states (Hemerijck, 2012; Mishra, 1984; Putzel, 2002; Ringen, 2006; Wincott, 2013). The neoliberal agenda included an ‘absolute commitment to the free market at the presumption of the state as a source of both inefficiency and corruption’ (Saad-Filho, 2010: 3–4), cuts in social spending (Standing, 2007) and policies of privatization, market liberalization and deregulation (Jasso-Aguilar and Waitzkin, 2015).

Under pressures from the international financial institutions promoting structural adjustment, many African governments adopted neoliberal policy principles and tightened their welfare programmes (Holmes and Lwanga-Ntale, 2012; Kpessa and Béland, 2013). The concept of universalism suffered, residualism gained ground and responsibility was put on individuals to cater for their own welfare (Bayliss et al., 2016a). Since the early 2000s, ‘social protection’ — a term nowadays often used synonymously with ‘social policy’ (see, e.g., Midgley, 2012) — has appeared as a buzzword in the international development discourse, actively promoted as a global policy to address poverty (Hickey and Seekings, 2017). Such contemporary social protection programmes frequently take the form of income-targeted social assistance schemes, particularly cash transfers (Adésinà, 2015). These have become ‘the primary — and sometimes the only — social protection instrument addressing poverty and vulnerability’ (Barrientos, 2011: 243).

Shifts in health policy making, and the new-fangled promotion of UHC in particular, are emblematic of such changes in the conceptualization of social policy (Birn et al., 2016; Kehr et al., 2023). While in the 1970s, a fairer distribution of power and resources across the globe was seen as an integral part of efforts to improve people’s health, more recent calls for UHC pay less attention to the social determinants of health and emphasize *coverage* with less focus on *how* services are provided (Cueto, 2004; Fischer, 2018; Sanders et al., 2019). Prominently, the World Bank has encouraged the introduction of market principles into healthcare systems, for example via its promotion of user fees in the 1980s and 1990s and, more recently, of public–private partnerships in health (Gorsky and Sirrs, 2023; Mladovsky, 2020; Sridhar et al., 2017; Tichenor et al., 2021). The emergence of dominant private sectors in national healthcare systems is thus linked to the continuous underfunding of public healthcare systems, and advances the fragmentation of service delivery (Fischer, 2018; Koivusalo and Mackintosh, 2005). Public systems are routinely left with limited financial resources and consequently pushed towards concentrating on providing healthcare for only the poorest people within society, while a heterogeneous private sector supplies care of diverse quality (Mackintosh et al., 2016).

While the rhetoric of the World Bank may have changed over time as it now positions itself as a champion of UHC and increased domestic

healthcare financing (see, e.g., WHO and World Bank, 2019; World Bank, 2019), it continues to promote private sector engagement despite evidence that the private sector's profit orientation is often problematic for equitable healthcare provision (Hanson et al., 2008; MacGregor, 2017; Mackintosh et al., 2016; McPake and Hanson, 2016; Mills et al., 2002). For instance, it maintains the position that the private sector is essential to fill the 'financing gap' in realizing the Sustainable Development Goals (SDGs), including SDG 3 on UHC (Dimakou et al., 2021; Doumbia and Lauridsen, 2019). Also, in the midst of the COVID-19 pandemic, the World Bank insisted that its financial support needs to be tied to adjustment policies, notably the creation of private markets in health (Kentikelenis et al., 2020).

While global discourse and practice promoted by international actors markedly influence the form UHC takes within countries, national healthcare systems' reform processes depend as much on localized political struggles, with countries progressing at different paces towards UHC (Fox and Reich, 2015; Greer and Méndez, 2015; McKee et al., 2013). Views on how UHC should be achieved and how it can be operationalized are manifold and are influenced by country-specific socio-economic, cultural, historical and political economy considerations (Reich et al., 2016; Rizvi et al., 2020; Sparkes et al., 2019). Several scholars have put forward theories that help explain practices of UHC, having identified factors that determine the degree of universalism in a country's healthcare system. Such determinants include the maturity of democratization as well as the power of left-wing parties to influence UHC reforms and gather the political support of international organizations for horizontal healthcare system strengthening over single-disease focused programmes (Greer and Méndez, 2015). Lagomarsino and colleagues (2012) further highlight the need for broad domestic support and describe the power of donors, fiscal constraints and operational capacity as crucial factors impacting healthcare sector restructuring. Similarly, McKee et al. (2013) explain cross-country variation in UHC reforms by pointing at differences in availability of economic resources, the political weight of left-labour coalitions, levels of social cohesion, effectiveness of existing institutions and social welfare programmes, as well as the (non-)existence of a 'political window of opportunity'. Others have identified different interests of actors involved, formal and informal political institutions and norms, ideas and ideology as the key determinants for how healthcare system reform processes materialize (Fox and Reich, 2015; Rizvi et al., 2020). Researchers at the United Nations Research Institute for Social Development have specified six enabling factors, which have been shown to facilitate progress towards universalism in healthcare delivery. These are: the degree to which an empowered civil society collaborates with the government; political will as well as institutional capacity to make the necessary financial resources available; democratic mechanisms that facilitate consensus building across a multitude of stakeholders; balance of power between advocates of public versus private provisioning

and financing; the maturity of decentralized service provision systems; and, lastly, a preference for a tax-financed healthcare system over, for example, employment-based contributory insurance systems (UNRISD, 2017).

These elements identified in the literature are helpful in theorizing and explaining Nigeria's progress towards attaining UHC. They provide useful points of reference to guide my examination of the various ways in which different agents, their relations, context-specific structures, prevalent consumption norms and global processes influence Nigeria's UHC reform process (Bayliss and Fine, 2020; Bayliss et al., 2016b; Fine et al., 2018). Before delving into a discussion of the manifold factors which impact Nigeria's capacity to implement UHC, the next section describes how the Nigerian healthcare system, and notably the BHC PF, are expected to operate with the aim of fast-tracking UHC in the country.

THE BHC PF AND ITS ROLE IN NIGERIA'S HEALTH SECTOR REFORM PROCESS

Today, a range of different agents operate within Nigeria's healthcare system and influence how it functions. Most evidently, the government across all three levels, supported by two principal technical agencies — the National Primary Health Care Development Agency (NPHCDA) and the National Health Insurance Scheme (NHIS) — play a leading role in shaping the healthcare system and are mainly responsible for ensuring healthcare delivery. Nevertheless, in reality, private healthcare providers dominate healthcare provision in large parts of the country, catering for the health needs of approximately 60 per cent of the Nigerian population (Alliance for HPSR and WHO, 2017: 17). According to 2018 DHS data, the largest number of Nigerians (46.5 per cent) seek care from private chemists and patent medicine vendors if their children develop a fever, followed by government health centres (18.1 per cent) (NPCN and ICF, 2019).

Privately owned Health Maintenance Organizations (HMOs) are another key feature of the Nigerian healthcare system. HMOs were introduced into Nigeria in the mid-1990s by proponents of the US 'managed care' system (Onoka et al., 2015: 1108). At first, the purpose of HMOs was to supply private health insurance plans to private firms (Eboh et al., 2017). However, when Nigeria's National Health Insurance Scheme⁷ was introduced in 1999, HMOs were included as operators of the scheme to provide insurance plans and manage networks of healthcare providers (Onoka et al., 2016). As Onoka (2014: 75) explains, this development was facilitated by 'the strong participation of HMO enthusiasts with previous exposure to the managed

7. Both the social insurance scheme itself and the agency overseeing its operations are referred to by the same acronym, NHIS.

care system in the United States of America, and lobbyists from the insurance industry', with a majority of stakeholders at the time convinced that the private sector could implement social health insurance more effectively than the public sector. While, today, discontent with HMOs is widespread across Nigeria,⁸ the most recent changes to Nigeria's health insurance system, introduced in 2022 with the passing of the National Health Insurance Authority Act, still allow for the use of HMOs (FMOH, 2022; Wada et al., 2023).

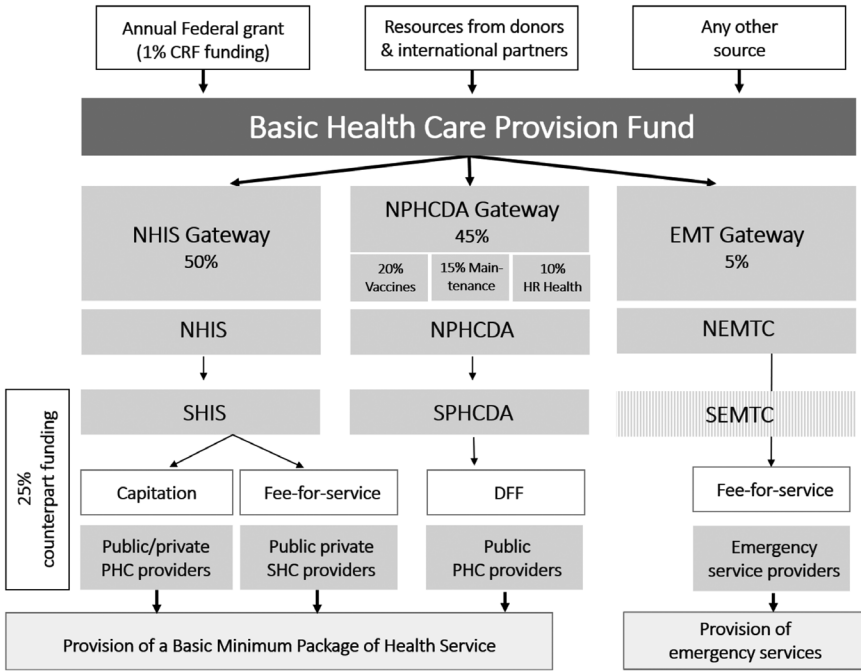
The dominance of the private sector in Nigeria is strongly interlinked with the decades-long underfunding of the public healthcare system. The Basic Health Care Provision Fund was instituted in 2018 to correct this reality and to provide a guaranteed additional funding stream to Nigeria's healthcare system. Since 2020, the 'Guideline for the Administration, Disbursement and Monitoring of the Basic Health Care Provision Fund' (the 2020 Guidelines) has served as the basis for its ongoing implementation (FMOH, 2020). This document outlines the BHCPF's operation via three 'implementation gateways'. Figure 2 illustrates how the BHCPF is expected to operate.

- (1) The BHCPF seeks to broaden access to social health insurance via the 'NHIS implementation gateway'. For this purpose, 50 per cent of the BHCPF's resources are supposed to be channelled via the NHIS to decentralized State Health Insurance Schemes (SHISs). These resources are earmarked for the provision of a Basic Minimum Package of Health Services (BMPHS) to citizens in eligible primary healthcare and secondary healthcare facilities.
- (2) A further 45 per cent of the BHCPF's resources are supposed to support public primary healthcare facilities in their efforts to procure drugs, vaccines and consumables, to maintain their facilities, buy essential equipment, and to invest in staff. These resources are channelled via the National Primary Health Care Insurance Agency and its State-level agencies ('NPHCDA implementation gateway'). The aim here is to ensure that at least one public primary healthcare facility per political ward is functional and can serve as a service delivery point for the BMPHS (NPHCDA, 2018).⁹
- (3) The remaining 5 per cent of BHCPF resources are reserved for emergency medical treatment ('EMT implementation gateway').

8. Interviews: official of the State Primary Health Care Agency Anambra, Awka, 11 March 2019 (Interview 27); owner of a private healthcare facility, Enugu, 7 March 2019 (Interview 19); civil society organization official, Abuja, 20 March 2019 (Interview 36); NHIS official, Abuja, 1 March 2019 (Interview 13).

9. In 2018, 800 out of 9,556 wards in Nigeria were without a primary healthcare facility, and of the 30,000 existing facilities, only 6,000 were functional (NPHCDA, 2018).

Figure 2. Implementation Structure of the BHC PF



Acronyms: CRF = Consolidated Revenue Fund; NHIS = National Health Insurance Scheme; SHIS = State Health Insurance Scheme; NPHCDA = National Primary Health Care Development Agency; SPHCDA = State Primary Health Care Development Agency; EMT = Emergency Medical Treatment; NEMTC = National Emergency Medical Treatment Committee; SEMTC = State Emergency Medical Treatment Committee; HR = Human Resources; DFF = Decentralized Facility Financing; PHC = Primary Health Care; SHC = Secondary Health Care.

Source: Author's illustration

Figure 2 further illustrates that the BHC PF is envisaged as a ‘pooled’ basket fund. The predominant source of funding for the BHC PF is expected to be the Federal Government, which is obliged by law to allocate ‘not less than 1 per cent’ of its public budget to the BHC PF.¹⁰ In addition, Nigeria’s 36 State governments are expected to provide 25 per cent of the total project cost as counterpart funding to match the allocation from the Federal Government as a condition for drawing money from the BHC PF. Donors, too, are encouraged to channel their financial support to Nigeria’s health-care system via the BHC PF. The law further mentions ‘other sources’. These are continuously being explored and possible revenues from taxes on cigarettes and alcohol (Uzochukwu et al., 2015), taxes on refined sugar-based

10. The 2014 National Health Act refers to an annual allocation to the BHC PF of not less than 1 per cent of Nigeria’s Consolidated Revenue Fund (CRF), which combines all revenues raised or received by the Federation.

beverages¹¹ and taxes on mobile phone use¹² are discussed in the literature and the media. The expectation is that all these different revenues are pooled in the BHCPF and then disbursed via a mix of provider-payment mechanisms. As per the 2020 Guidelines, fee-for-service payments, capitation payments as well as direct transfer to primary healthcare facilities (referred to as Decentralized Facility Financing, DFF) are all in use.

THE POLITICAL ECONOMY OF IMPLEMENTING UNIVERSAL HEALTH COVERAGE IN NIGERIA

In this section, I present my empirical investigation of the ongoing efforts in Nigeria to implement the BHCPF. In so doing, I draw attention to the various ways in which a range of controversies between different stakeholders impact on the BHCPF's potential to be a successful catalyst for UHC in Nigeria. I highlight four major areas of contestation which underwrite the lack of success of the BHCPF implementation and shape the form UHC is currently taking in the country. These contestations concern: (1) the BHCPF's funding sources; (2) how resources should be disbursed; (3) the capacity of States in rolling-out social health insurance; and (4) what the basic minimum package of health services should include and who should benefit from it. These areas of contention are the outcome of a complex interplay between different agents operating within Nigeria's federal system, constrained by the country's socio-economic context and influenced by the dominance of neoliberalism and a global push for a certain (narrower) form of UHC. In the following, I highlight selected instances which show how the various agents operating within Nigeria's healthcare system, with different levels of power and interest, affect BHCPF operationalization, often by exerting influence on the text of the implementation guidelines. Table 1 summarizes key changes that have been made to the three versions of the implementation guidelines.

Funding Sources

Strategies at country level to achieve UHC are diverse and, as argued earlier, depend on political processes and a multitude of context-specific factors. How to mobilize resources for service delivery is often a subject of particular debate. In general, while there are several ways of mobilizing resources to pay for healthcare, the wider the pooling of resources and risks

11. See: www.premiumtimesng.com/health/457060-basic-health-care-provision-fund-a-slow-start-to-a-long-journey.html (accessed 9 November 2022).

12. See: www.vanguardngr.com/2018/12/csos-to-fg-introduce-mobile-phone-tax-to-fund-healthcare-in-nigeria/ (accessed 9 November 2022).

Table 1. Summary of Significant Changes across Different Versions of the BHCPF Implementation Guidelines

	2016 Guidelines	2018 Guidelines	2020 Guidelines
Funding sources and disbursement modalities			
Federal Government allocation	Statutory nature not specified	Statutory nature not specified	Statutory nature specified
States' counterpart funding	Encouraged but mention that this condition has been unhelpful in the past	Necessity stipulated for States to allocate counterpart funding	Necessity stipulated for States to allocate counterpart funding
Donor funding	Donor funding mentioned but no further specification	Guidelines stipulate that donor funding should be pooled in the BHCPF	Guidelines allow donors to attach conditions to funding and to support specific States and/or gateways
Provider-payment mechanism	Fee-for-service	Modified fee-for service (a bundled fee is paid retrospectively to pre-selected providers for designated services)	Capitation for primary healthcare delivery (modified fee-for-service for secondary-level healthcare delivery)
Capacity of States to roll-out insurance			
Distribution of BHCPF funding	Guidelines stipulate that all States and the Federal Capital Territory receive an equal share of BHCPF funding (irrespective of land mass, population or disease burden)	Guidelines emphasize the importance of maintaining a 'pro-poor' focus and propose geographical targeting (rural areas with high poverty rates)	Guidelines stipulate that the formula for disbursing funds will be the same for all States for equity and fairness reasons (formula not further specified)
Healthcare services provision			
Enrolment	Service package freely available at point of service without prior enrolment	Enrolment necessary	Enrolment necessary
Cost of Basic Minimum Package of Health Services (BMPHS)	Guidelines highlight the challenging economic climate in Nigeria and the insufficiency of BHCPF funding to provide the BMPHS, costed at 225 Nigerian Naira per capita in 2016	Guidelines stipulate that the BHCPF is designed as a 'low-cost' universal health programme	Guidelines highlight that BHCPF funding is insufficient to finance a comprehensive healthcare package for all Nigerians, costed at 12,000 Naira (capitation rate) to provide the BMPHS in 2020

Source: Based on Chukwuma (2021)

into one unified fund — with contributions no longer being tied to a specific contributor — the more universal the scheme (MacGregor, 2017). The institution of the BHCPF, a pooled basket fund, was thus perceived as an effective way of increasing sustainable public funding for healthcare in Nigeria. In reality, however, different agents' interpretations of how the BHCPF should be funded have influenced the ability of the BHCPF to perform as a solid health-financing mechanism.

Importantly, while it is an obligation by law for the Federal Government to channel 1 per cent of its budget annually to the BHCPF, this has not materialized as planned. Between 2015 and 2017, the Government omitted to allocate any share of its budget to the BHCPF. In 2018, an allocation to the BHCPF only occurred as a result of forceful advocacy by the civil society-led 'Health Sector Reform Coalition'.¹³ Moreover, the first budget transfer to the BHCPF appears to have been intentionally omitted from the list of 'statutory' transfers, which would have bound the government to make this a regular, annual transfer.¹⁴ A major reason for the reluctance to make the allocation to the BHCPF binding seems to relate to the unsuccessful experience of rolling out the 2004 Compulsory Free Universal Education Act. The BHCPF was designed to mirror the funding model of the Universal Basic Education Commission (UBEC), the body in charge of implementing basic education in Nigeria. The UBEC is financed through a 2 per cent annual Federal Government grant. However, State governments, largely characterized by an incapacity to mobilize their own revenues (Gatt and Owen, 2018), have failed to provide counterpart funding — a precondition to receive resources through UBEC. Consequently, a significant proportion of the resources for the education sector continues to lay idle at the Central Bank. This negative experience made the then-Minister of Finance (Ngozi Okonjo-Iweala) reluctant to replicate commitments made to financing the education system, by making a mandatory commitment for the Federal Government to also allocate 2 per cent or more to the healthcare system via the BHCPF.¹⁵

At the same time, the lack of States' engagement with the UBEC incited a generalized debate about whether it was prudent to make the provision of counterpart funding a precondition for States to draw resources from the BHCPF.¹⁶ The 2016 Guidelines left room for interpretation as to whether States have to provide counterpart funding with, notably, the NHIS inclined

13. Interviews: representative of State Primary Health Care Agency Enugu, Enugu, 7 March 2019 (Interview 18); World Bank official, Abuja, 17 March 2019 (Interview 33); representative of the Health Sector Reform Coalition, Abuja, 27 March 2019 (Interview 46).

14. Statutory transfers are backed by law and cannot be denied by the Presidency and the executive government.

15. Interview, representative of the Minister of Health's Office, Abuja, 29 March 2019 (Interview 47).

16. Interview, United Nations official, Abuja, 30 January 2019 (Interview 1).

to show some leniency towards States.¹⁷ However, the 2020 Guidelines now make it explicit that States are required to provide counterpart funding as a precondition to receive BHCPF resources. As a result, concerns that a range of States will not be able to participate in the BHCPF as planned have materialized,¹⁸ illustrating how Nigeria's federal structure, and the failure and (lack of) ability of States to financially contribute to the BHCPF, impacts Nigeria's UHC reform process in practice.

The pooling of donor resources into the BHCPF has also proven to be problematic. This is because the BHCPF originated during a time when donors (notably Gavi, the Vaccine Alliance) were openly challenging the Nigerian government for having misappropriated financial aid.¹⁹ Consequently, many international organizations, at least at the outset, appeared underwhelmed by the idea of having their finances pooled into the BHCPF, as highlighted by a World Bank official: 'I remember speaking to a specific donor ... and they said that there is not a chance in hell that money will go to [the] Government of Nigeria'.²⁰ In response to these concerns, the implementation guidelines were altered to permit donors to specify how they want their financial support to be used, effectively allowing them to circumvent the common BHCPF pool. These concessions appeared necessary as, allegedly, the majority view was that 'donor money is quite important to get things happening. If there is no donor money, nothing is happening'.²¹

Thus, the 2020 Guidelines no longer insist on having donor support to the BHCPF collected in and disbursed via the same common resource pool. This development demonstrates how the balance of power of international versus local forces can impact UHC reform processes. Allowing donors to side-step the common pool and to attach conditions to their funding seems to defeat the purpose of the BHCPF operating as a pooled basket fund. Moreover, international organizations now have leeway to focus on their own priorities under the appearance of contributing to the BHCPF, risking further fragmentation of healthcare delivery in Nigeria.²²

Disbursement Modalities

Another central point of controversy was the modality of disbursing the BHCPF's resources, the provider-payment mechanism. Most importantly,

17. Interviews: academic at the University of Nsukka Nigeria (UNN), Enugu, 28 February 2019 (Interview 12); NHIS official, Enugu, 1 March 2019 (Interview 14).

18. See: <https://authorityngr.com/2023/10/10/minister-to-states-increase-funding-for-health-insurance-agencies-pay-25-counterpart-for-bhcpf/> (accessed 30 November 2023).

19. See: www.gavi.org/news/media-room/reimbursement-misused-amounts-identified-gavi-cash-programme-audit-nigeria (accessed 11 May 2023).

20. Interview, World Bank official, Abuja, 30 January 2019 (Interview 3).

21. Interview, academic at UNN, Enugu, 28 February 2019 (Interview 12).

22. Interview, UNICEF representative, Enugu, 8 March 2019 (Interview 23).

the World Bank's predisposition and authority to impose its view on the provider-payment mechanism caused discontent, especially with the implementing agencies. The World Bank had insisted on the use of a modified fee-for-service payment system, a mechanism that 'incentivizes health workers based on what services they are able to deliver'.²³ Such fee-for-service or performance-based financing (PBF) strategies originate in an ambition to introduce market principles into healthcare sectors, rooted in a belief that competition leads to better performance (Fritsche et al., 2014; Paul et al., 2021). However, to date, there is little evidence that PBF outperforms capitation systems, with the latter being more regularly associated with increased health equity (Hanson et al., 2022; Paul et al., 2018).²⁴ It is noteworthy that in Nigeria an impact evaluation report (commissioned by the World Bank itself to evaluate the Nigeria State Health Investment Project, seen by the World Bank as a blueprint for the BHCPF²⁵) failed to show that the incentive structure yielded any significant results.²⁶

Nevertheless, while Nigeria's implementing agencies were heavily opposed to the World Bank's suggestion of using a PBF mechanism to disburse the BHCPF's resources and positioned themselves in favour of a system of capitation, the modified fee-for-service provider-payment mechanism found its way into the 2018 Guidelines.²⁷ A NHIS official explained the power of the World Bank to influence the BHCPF implementation as follows: 'The World Bank has a lot of overbearing influence in this. Probably because they are bringing money. You know, donors when they bring money ... they bring all the TAs [Technical Assistants] and whatever to assist in the implementation'.²⁸ Many agents with stakes in Nigeria's healthcare sector reform process were therefore apprehensive of the World Bank 'hijacking the

23. Interviews: World Bank official, Abuja, 30 January 2019 (Interview 3); World Bank official, Abuja, 17 March 2019 (Interview 33); NPHCDA official, Abuja, 4 April 2019 (Interview 49).

24. Countries including Thailand, considered a UHC success story, have pursued a capitation payment system for their social insurance schemes (Tangcharoensathien et al., 2019), while other African countries have seen animated debates on whether (and on ways of making) capitation systems work (see, e.g., Atuoye et al., 2016 for Ghana; Obadha et al., 2020 for Kenya).

25. Interview, NPHCDA official, Abuja, 4 April 2019 (Interview 49).

26. Interview, World Bank official, Abuja, 30 January 2019 (Interview 3).

27. The fee-for-service modality was already part of the 2016 Guidelines. However, in the earlier drafts of the 2016 version this was not the case, as highlighted by a NHIS official (Enugu, 1 March 2019, Interview 14), who was part of the initial committee working on the development of the 2016 implementation guidelines.

28. Interview, NHIS official, Enugu, 1 March 2019 (Interview 14). The World Bank committed to support the roll-out of the BHCPF implementation with a US\$ 20 million Global Financing Facility grant. The project, however, was closed in December 2021 with only US\$ 6.2 million disbursed; see: <https://documents1.worldbank.org/curated/en/099520010252232889/pdf/P16396901de4760600bebf07ce76f71307e.pdf> (accessed 5 May 2023).

process²⁹ and exercising undue influence over the implementation of the BHCPF and the NHAct more generally, which was considered ‘a creation of Nigerian people for Nigerian people’.³⁰ During the 2019 annual meeting of the National Council on Health (Nigeria’s highest decision-making organ relating to health), State governments formally raised their concerns and signalled their discomfort with the extent to which international actors had influenced the 2018 Guidelines and the fact that they had not been consulted sufficiently (Ilechukwu, 2019). As a result, the operations of the BHCPF were temporarily halted to rewrite the implementation guidelines, and the revised 2020 Guidelines replaced the fee-for-service mechanism with a capitation system as the primary provider-payment mechanism for the purchase and delivery of primary healthcare.³¹

The role of the World Bank in shaping (and delaying) the implementation of the BHCPF in Nigeria is profound. It illustrates how important global players can impact policy implementation and, consequently, the practice of social policy in an African country. Especially when it comes to introducing PBF mechanisms into healthcare systems, research has shown that government ownership is often lacking (Barnes et al., 2015; Gautier and Ridde, 2017). Besides, the fact that the World Bank positioned itself in favour of a fee-for-service system, despite lack of evidence of its superiority over a capitation system, gives the impression that it was the ideological proclivity of the World Bank that lay behind its push for PBF.³²

Role and Capacity of States to Deliver on the Promise of Social Health Insurance

Another crucial element affecting BHCPF implementation is the division of responsibility between the NHIS as the federal-level agency in charge of social insurance and State Health Insurance Schemes at State level. The BHCPF implementation guidelines accord considerable freedom to States to decide how they wish to implement their social health insurance schemes.³³ Yet, as a consequence of this process of decentralization, States progress at different paces towards UHC, depending on their degree of capacity and their prioritization.³⁴

This, in practice, means three things. First, Nigeria now has 38 different insurance schemes and resource pools (36 State-run health insurance

29. Interview, academic at UNN, Enugu, 28 February 2019 (Interview 12).

30. Interview, NHIS official, Enugu, 1 March 2019 (Interview 13).

31. Secondary-level healthcare providers continue to be reimbursed using a fee-for-service mechanism.

32. Interviews: NPHCDA official, Abuja, 4 April 2019 (Interview 49); academic at UNN, Enugu, 28 February 2019 (Interview 12); NHIS official, Enugu, 1 March 2019 (Interview 14).

33. Interview, representative of Nigeria Health Watch, Abuja, 21 March 2019 (Interview 37).

34. Interview, Clinton Health Initiative official, Abuja, 27 March 2019 (Interview 44).

schemes, one health insurance scheme in Nigeria's Federal Capital Territory and the federal-level NHIS), which are highly dissimilar. Some States even continue to rely on the support of HMOs in administering health insurance. For example, Edo and Lagos States have opted to use HMOs as part of their social health insurance roll-out, as they are seen to have the necessary expertise to conduct critical components of the insurance business process (such as enrolment or claims management).³⁵ Second, because States were given considerable leeway to implement social health insurance to their liking and at their own tempo, some States' interest in the BHCPF appears to be limited.³⁶ Concerns about this are mentioned in the NHIS Strategic Plan 2020–30, which acknowledges the challenging political landscape, highlighting that 'the ideological leaning of the political party in power and electoral cycles' can impact the attainment of UHC (NHIS, 2020: 25). Third, in 2021, the Nigerian government backtracked, to some extent, on the decentralization of social health insurance and elaborated a 'Health Insurance Under One Roof' policy, attempting to harmonize processes and practices of health insurance across Nigeria. A similar objective led to the adoption of the 2022 National Health Insurance Authority Act which, on paper, makes health insurance mandatory.

Overall, there now is a considerable degree of uncertainty about the reality of social health insurance in Nigeria. Nine years after the adoption of the NHAct, the extent to which States will attempt to align their social health insurance schemes with the requirements of the BHCPF, and how this will impact universal access to healthcare in Nigeria, remain to be seen.

Providing Healthcare Services: What, How and to Whom?

The last of our four areas of controversy concerns the actual practice of delivering healthcare as part of the BHCPF roll-out. Who is eligible to receive services? Which healthcare services will Nigerians be able to access? What do Nigerians need to do in order to access healthcare services? And to what extent will Nigerians receive healthcare in spite of the many existing service delivery challenges? The first and second questions are heavily intertwined and relate to two key dimensions of UHC: what part of the population is covered, and which services will be provided? While the 2014 NHAct stipulates that all Nigerian citizens should be able to access healthcare, the 2016 Guidelines were explicit in stating that priority should be given to rural areas. In the 2018 Guidelines, the target group was further specified, stipulating that beneficiaries have to be part of specific groups

35. Interviews: HMO representative, Enugu, 8 March 2019 (Interview 24); HMO representative, Abuja, 18 March 2019 (Interview 34).

36. Interviews: representative of Nigeria Health Watch, Abuja, 21 March 2019 (Interview 37); NHIS official, Enugu, 1 March 2019 (Interview 14).

in targeted regions in order to access healthcare. These are children aged five and younger, pregnant women and all people for malaria treatment, hypertension and diabetes screening within priority rural communities. The 2020 Guidelines, in turn, appear more inclusive, seeking to make selected basic healthcare services accessible to all Nigerians. However, acknowledging the country's socio-economic reality, the guidelines propose to channel resources to rural areas first; to target populations in the lowest wealth bracket; and to prioritize specific areas of concern such as maternal, newborn and child health and non-communicable diseases (FMOH, 2020: 28; 53).

While the list of services which are included as part of the defined package is long, realistically, it is not possible to provide all services to everyone with the resources available. Notably, the inclusion of blood pressure screening and urine analysis were said to have been a political choice to ensure that the text of the 2014 NHAct is respected and that, at least in principle, all Nigerians (and not only women and children) can benefit from the BHCPF.³⁷ Malaria treatment for the entire Nigerian population was added, allegedly, on the initiative of the Federal Minister of Health and the World Bank,³⁸ but the addition of malaria to the BMPHS was met with concern, as providing malaria treatment for an estimated population of 200 million people (with 76 per cent of the population living in high-transmission areas)³⁹ was perceived as too costly. One NHIS employee highlighted that based on their calculations and modelling, the cost of achieving UHC in Nigeria in practice is 'not 55 billion, it goes into trillions'.⁴⁰

As a consequence, the reality of UHC in Nigeria is that not every Nigerian benefits from the BHCPF as there is not enough money available to provide the BMPHS to all Nigerians. Instead, echoing neoliberal principles of selectivity, the beneficiaries of the BHCPF are a targeted segment of the population, in principle consisting of the poorest and most vulnerable people. Targeting options include State-level targeting and making use of the National Social Register, which was set up as part of Nigeria's most recent conditional cash transfer scheme, the National Social Safety Nets Project.⁴¹ Thus, the real-world practice of UHC in Nigeria, namely the choice of policy makers to target beneficiaries on the basis of income, demonstrates that decades of neoliberal policy making have cemented the notion that there is not enough fiscal space to provide healthcare to everyone. The version of UHC in today's Nigeria translates into a limited package of healthcare services reserved for a targeted group — far removed from

37. Interview, World Bank official, Abuja, 17 March 2019 (Interview 33).

38. Interview, NHIS official, Enugu, 1 March 2019 (Interview 14).

39. See Severe Malaria Observatory: www.severemalaria.org/countries/nigeria (accessed 24 May 2023).

40. Interview, NHIS official, Enugu, 1 March 2019 (Interview 13).

41. Follow-up phone call to Interview 36, civil society organization official, London, 8 May 2021.

the conception in the 1970s of comprehensive primary healthcare for all. Rather, the neoliberal 'social protection paradigm' is alive and well, also reflected in the World Bank's US\$ 500 million support to the national cash transfer programme, compared to its stipulated support of US\$ 20 million to the BHCPF.

CONCLUSION

This article has explored how powerplays between different agents, context-specificities such as Nigeria's federal character and a small health-sector budget, as well as changing conceptualizations of the scope of social policy, all influence practices of realizing UHC in Nigeria. In so doing, I have illustrated how global discourses as well as promises of national governments to pursue strategies to provide health for all are not reflected in actual reform processes, oftentimes intentionally and by design. For instance, both the World Bank and the Minister of Finance have directly worked against the successful implementation of universal healthcare in Nigeria by insisting on a less equitable provider-payment mechanism and by advocating for a non-binding lower allocation to the BHCPF. Their influence has been paramount, despite opposition of civil society organizations and implementing agencies which, along the way, have sought to increase healthcare funding and to distribute available resources in a more equitable manner. Perceptions across Nigeria on what form of UHC is possible generally appear to reflect the entrenchment of a narrow view of UHC, limiting pushback against the narrative that healthcare service delivery must be targeted and channelled to individuals most in need.

This relates to the generalized trend towards a narrowing scope of social policy, particularly visible in the area of health (Adésinà, 2015; Lavinás, 2017; Martínez Franzoni and Sánchez-Ancochea, 2016; Mkandawire, 2011). The rise of neoliberalism, accompanied by the intensification of the commercialization and commodification of social services, has had significant implications for the distribution of roles between private and public sectors in health and has impacted practices of universal healthcare provision. Like the variety of positions and views on what social policy is and what functions it needs to fulfil, there are a multitude of perceptions of what universal healthcare (nowadays, universal health coverage) is, what it entails, and how it can and should be attained. Different actors understand and conceptualize universalism differently, and while the goal of UHC 'has risen to the top of the global health agenda, even becoming one of the key pillars of the UN's SDGs ... , [the] UHC cooptation story is illustrative of the fate of many progressive international and global health policy efforts in the context of neoliberal globalization over the past three decades' (Birn et al., 2016: 735). The case of implementing the BHCPF in Nigeria as part and parcel of its UHC reform process appears to confirm that the notion of

comprehensive primary healthcare, previously considered a universal human right, has been replaced by a concept of universal health coverage, which pays less attention to integrated and equitable provisioning modalities.

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