

Basic Health Care Provision Fund Project Implementation: An Assessment of a Selected Technical Skill among Mid-level Managers of a Performance-based Financing Scheme in Southwest Nigeria

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Abstract

Introduction: Knowledge and skills in quantitative/numerical disciplines are some of the essential skills necessary for sustainable and successful administration and management in financing health care. It is not clear whether the personnel across relevant establishments in the health sector of Nigeria have the requisite capacity to implement and manage a performance-based financing project. This survey assessed the availability of certain technical skills among selected mid-level managers in charge of the implementation of the Basic Health Care Provision Fund Project (BHCPFP). **Materials and Methods:** Data were collected with the aid of a self-administered questionnaire developed from a review of the project document. A total population of mid-level managers from all the respective ministries was studied across the six states in Southwest Nigeria. Data collection was conducted between February and June 2019. Data analysis was done using SPSS version 22. Frequency tables were generated and charts were constructed. **Results:** A total of 234 eligible participants were studied. Those who had formal training in quantitative/numerical-based skills such as accounting-related courses were about one-third, 77 (32.8%) and those who had acquired formal training in insurance-related disciplines were 91 (38.7%). A little above one-third, 66 (28.2%) had a form of on-the-job health insurance training. **Conclusions:** This study showed that mid-level managers had poor quantitative-related skills necessary for administrative and technical roles for implementation of BHCPFP. Mid-level managers should be trained and re-trained on those administrative and technical skills for better implementation of BHCPFP.

Keywords: Basic health care, mid-level managers, Nigeria, performance-based financing

INTRODUCTION

Nigeria with a population of about 180 million people is the most populous African country. The country is made up of six geo-political zones: Northcentral, Northeast, Northwest, Southeast, South-south, and Southwest. Each of these zones is made up of varying numbers of states, the majority of the population living on less than two dollars a day.^[1,2] Nigeria has three tier levels of health care; primary, secondary, and tertiary. The primary level is the first level of entry to the health system, it is also the most patronized of the three levels. Unfortunately, it has the lowest standard of care.^[2] The private health sector contributes substantially to health care delivery in Nigeria, however, its potentials have not been optimally harnessed by the public health system.^[3]

Although population health indices have shown progressive improvement in the last decade, however, various sources of information have shown poor health outcomes in the country, and poorer than the obtainable average in the Sub-saharan African (SSA) Region. Of these, infant, child, and maternal

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health indices are among the worst affected. Globally, the maternal mortality rate in Nigeria is the highest, infant and child mortality rates remained high compared to some of the more resource-constrained West African countries. A similar pattern is observed in child immunization coverage and skilled birth attendance in health care facilities. The adolescent birth rate and total fertility rate in the country are much higher than the average for the SSA region.^[1-4] This may corroborate the low uptake of contraceptives in the country. The gravity of poor health outcomes varies across different socioecological groups and between rural and urban areas. Those who are in the lowest socioeconomic groups as well as rural dwellers in the country are the worst affected.^[2,3]

Factors that contribute to the poor health outcomes in Nigeria are many. Major among these, is the grossly low investment in the health sector by the government.^[3] Furthermore, access to and utilization of available health services is inequitable. This is partly due to inadequacy in the number, spread of and quality of services in the available health care facilities.

One of the efforts to addressing the poor population health status in Nigeria is the introduction of the Basic Health Care Provision Fund (BHCPF) in 2018 and implementation in 2019. The BHCPF is a performance-based financing method designed to strengthen the PHC system for service delivery through more funding among other approaches. It purchases high-impact maternal and child health services through accredited public and private providers. Through decentralized financing facility, it also meets the operating costs of public providers to improve their service quality. PHC facilities in rural areas are prioritized to ensure improved equity of access to health care for the poor. Direct beneficiaries of the Project are pregnant women, children under 5 years and adolescents. Funding of the BHCPF Project (BHCPFP) was secured through a 20 million United States dollars (\$20 million) Global Financing Facility grant. Ministries of health and relevant agencies at the federal, state levels and the local governments' departments of health are involved in the project. The project implementation is structured to be streamlined into existing government structures at the federal, state, and local government levels through the respective ministries and departments. Technical assistance and coordination support are provided through the Project Implementation Units at the National Health Insurance Scheme and the National Primary Health Care Development Agency to the respective States' health insurance and primary health care development agencies. The respective state agencies coordinate the project implementation at the level of PHC facilities. Their roles include setting standards for implementation, which includes provider accreditation and enrolment. To ensure accountability in the project, certain measures were built into the project. These involve the verification of the quantity and quality of care provided, provider payments, and monitoring as well as verification and Ex-post verification of the fee for service and the direct facility financing of public health facilities among others.^[3,5] The project was designed to be implemented in

three phases; Phase I was designed to be implemented in three selected states in the country for a period that spans between 2018 and 2022. Phase II was tailored on a geographical expansion of the project to additional 33 states and the Federal Capital Territory, while Phase III was to expand the benefit package in the project to include more cost-effective health care services between 2022 and 2030. The last phase was designed to enable the project to accommodate all other population groups in addition to the beneficiaries in the previous two phases. It was expected that the health system strengthening would be accomplished as a result of the scaling up of the health system infrastructure incorporated in the project.

Formal and on-the-job-trainings on quantitative disciplines, account, and financial management as well as trainings directly related to the BHCPF are strategies to build up the capacity of personnel involved in the BHCPFP. An assessment of exposure to these trainings is a proxy to measure the capacity of mid-level managers involved in the implementation of the project. Currently, the capacity of these managers to manage the project is not known. Therefore, this survey aimed to assess the capacity of mid-level managers at the federal, state ministries of health and relevant agencies to carry out accountability processes outlined for the implementation of this project. Findings will assist in the design of appropriate strategies to correcting deficits so identified if any.

MATERIALS AND METHODS

Ethics

Ethical approval for this study was obtained from the Ondo State Health Research Ethics Committee (OSHREC), with Protocol Number OSHREC/20/02/2019/106. Informed oral consent was also obtained from individuals study participants before data collection.

Study design

This is a descriptive cross-sectional study conducted among mid-level managers in the BHCPFP of Nigeria.

Selection and description of participants

Stakeholders eligible for the interview were all the 275 technical personnel of the National Primary Health Care Development Agency, National Health Insurance Scheme, State Primary Health Care Development Agency and the State Supported Health Insurance Agencies in each of these establishments in all the six states of the southwest region of Nigeria. All the personnel in each of these establishments were eligible for the study and were purposively selected. Respondents' bio-data including previous training exposure to financing health care, awareness of the BHCPFP, and training in any aspect of the project were assessed. All consenting technical personnel in each of these establishments across all the states were eligible for the interview.

Technical information

Using a short, self-administered questionnaire developed from a review of the BHCPFP document, a survey on the level of

preparedness of stakeholders involved in the BHCPFP across the six states in the Southwest geo-political zone of Nigeria, namely; Ekiti, Lagos, Ogun, Ondo, Oyo, and Osun was conducted. Data collection started in the first week of February 2019 and was completed in the second week of June 2019. Eligible study participants across all the agencies were 275 in the six states of the southwest region of Nigeria. Personnel distribution and response across all the establishments in each of the states is as follows; Ekiti (24 vs. 21), Lagos (83 vs. 79), Ogun (19 vs. 17), Ondo (24 vs. 20), Osun (33 vs. 32), and Oyo (92 vs. 87). These were used as the sampling frame in each state. In a particular state where health insurance was not yet established (Ekiti State was about to commence, while Ondo did not have as of the time of the data collection), only the three other establishments were visited for data collection. However, 256 were interviewed (93.1% response rate, the non-response included those out of the office on assignments and those who declined to participate). In the end, 234 technical personnel were studied.

Statistics

Descriptive analysis of the data collected was done using IBM SPSS Statistics for Windows, version 22 (IBM Corp., Armonk, N.Y., USA). A frequency table was generated. Charts describing variables of interest in the study were constructed.

RESULTS

The majority of the respondents were within the young to middle age group $\geq 20-49$ years, 187 (79.8%), males were more than females 125 (53.4%) versus 109 (46.6%). Respondents with a background training in account and related courses were about a third, 77 (32.8%) compared with those who had training backgrounds in other courses. In like manner, respondents who claimed to have acquired formal training in actuarial science 91 (38.7%) and those who have ever had any on-the-job training in health insurance or actuarial science 66 (28.5%) were much less, compared to their respective counterparts. About half, 121 (51.8%) of the respondents have ever heard about the BHCPF, and none have had any training on it [Table 1 and Figures 1-5].

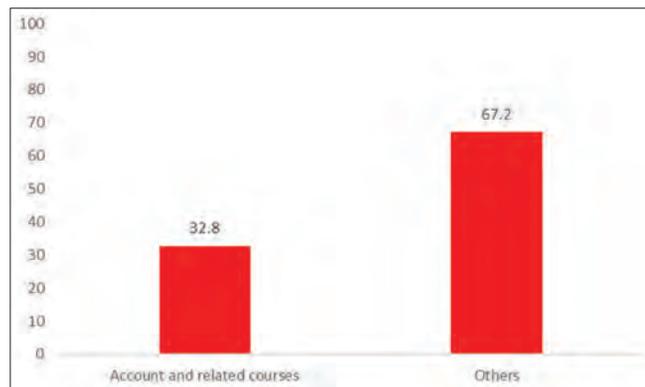


Figure 1: Percentage distribution of educational qualifications in quantitative disciplines

DISCUSSION

This survey revealed some gaps and the likely inadequacies with fund management skills or experience among relevant personnel. This is evident by the low proportion of those who had formal training in quantitative or accounting-related fields as well as the low number of those who claimed to have ever had exposure to on-the-job, workplace training in actuarial science and or health insurance. The quality of technical and administrative competencies of human resource employees of an organization is akin to the ability of that organization to achieve its set goals. In the same continuum, the degree to which set goals are achieved could be used as a proxy to calibrate its level of performance. Evidence from previous research works globally indicates a strong relationship between formal and on-the-job, workplace pieces of training, and human resources capacity development, it reiterates the role of human resources training as it enhances organizational performance.^[6-10]

Previous studies conducted on health care financing in some low- to middle-income countries of Zambia, Ghana, and Thailand,^[11] have shown that internal capacity constraints with regards to fund management skills especially, efficient purchasing and paying for health care services are factors of sub-optimal performance or collapse of financing health care mechanisms in such countries. Weak capacities especially with regards to funding management have been reported in previous works in Nigeria and similar other countries.^[5,12] In separate studies by Mills and Bennet, Walker and Gilson as well as in another study conducted by Chuma and *et al.*, weak managerial and technical capacities regarding fund management have been cited as some of the main causes of poor implementation and execution of health intervention

Table 1: Sociodemographic characteristics of respondents

Characteristics	Frequency (n=234), n (%)
Age	
<20	1 (0.4)
20-29	33 (14.1)
30-39	104 (44.4)
40-49	49 (20.9)
≥ 50	21 (9.0)
No response	26 (11.1)
Mean age (years)	37.1 \pm 8.3
Sex	
Male	125 (53.4)
Female	109 (46.6)
Education level	
University degree	194 (82.0)
Diploma	33 (14.1)
No response	7 (3.9)
Marital status	
Married	189 (80.8)
Others	45 (19.2)

Others: Single, widow/widower, separated

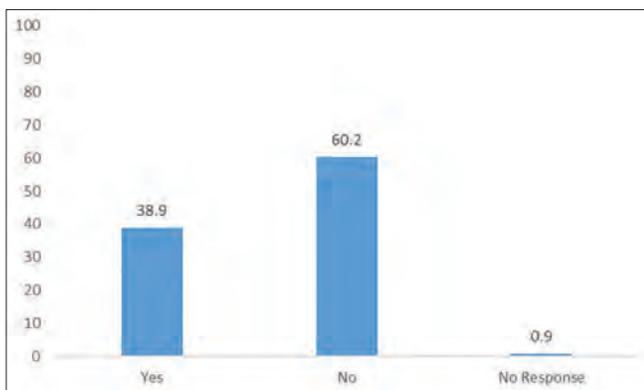


Figure 2: Formal training in actuarial science/health insurance

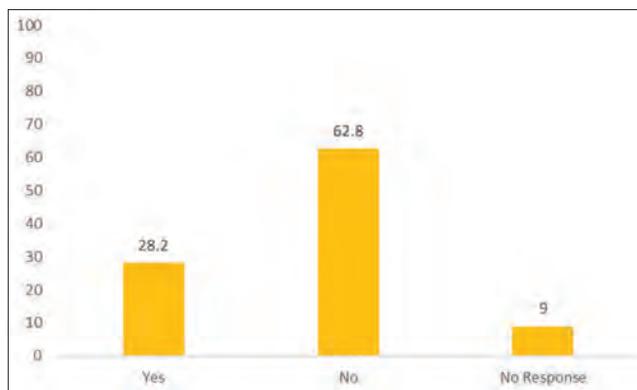


Figure 3: On the job training in actuarial science/health insurance/fund management in health care sector

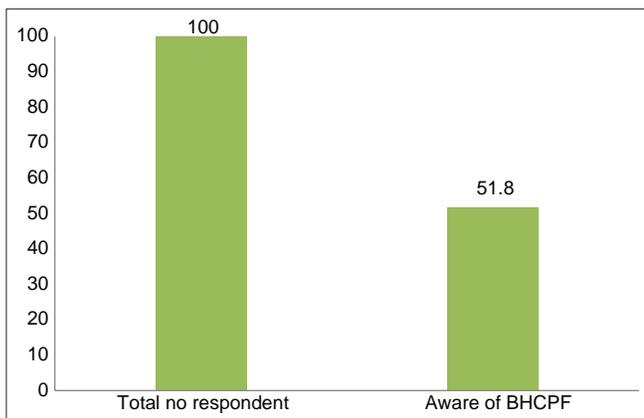


Figure 4: Awareness about the Basic Health Care Provision Fund Project

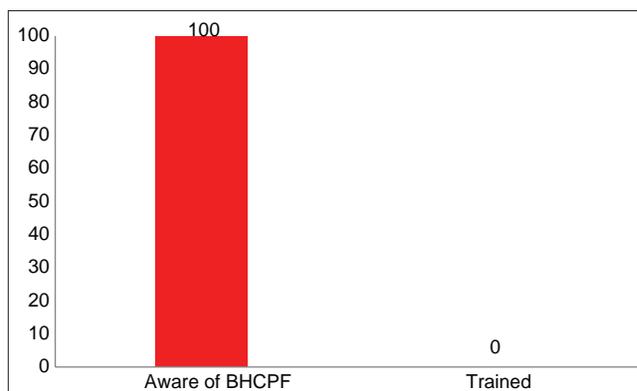


Figure 5: Training on the Basic Health Care Provision Fund Project

projects and as barriers to achieving beneficial health policies.^[11-13] Deficiencies in the technical and managerial capacities of human “drivers” of projects are hindrances to effective project implementation.^[11,12,14]

Regarding some thematic areas of the project such as technical skills in purchasing health care services, verification of claims, and payment of such are essential to BHCPFP implementation. This study showed that training in any thematic area of the project has not taken place, especially among mid-level managers. It is important to note that the specified role of this personnel is to provide training, monitoring, and supervision to the operational (facility) level health care workers at the implementing health care facilities. In the absence of the ability of the mid-level managers to perform their assigned roles, implementing the project at the facility level will be associated with diverse inadequacies. It is noteworthy that the majority of the study participants were within the young age group that is more open to learning new skills.^[15,16] This is a factor that could be used as an advantage for training purposes. In as much as delayed implementation is a setback, it however could allow the opportunity to organize needed training for the personnel involved before implementation.

Research works have shown that exploring the route of a heuristic approach to policy implementation demands clearly

defined and widely understood goals.^[13] A disconnect between policy formulation which is perceived as explicitly political and policy implementation, which consists of the administrative and technical components of the heuristic continuum, is one of the major causes of failure of health policy implementation especially when the implementation component is neglected.^[17] An adequate level of preparedness assessed by ample knowledge and requisite technical and managerial skills is necessary for project implementation. Studies have indicated that awareness and good knowledge of the content of a policy document are associated with personnel implementing a policy and doing so as expected.^[18] Logically, awareness of an issue precedes knowledge of it. In the same vein, a high level of awareness and knowledge among those responsible for implementation is the “link bridge” between policy formulation and policy implementation. It also serves as a precursor for effective and sustainable project implementation. Thus, in the absence of awareness, the knowledge gap about the particular policy is obvious, which makes it almost impossible for the content of the policy issue to be executed as planned.

More recent works by Allison *et al.* as well as by Weatherson *et al.* in the implementation of beneficial health-related projects in the province of Ontario and British Columbia respectively in Canada averred that awareness, adequate knowledge of the policy content and objectives, coupled with necessary

skills acquired through training were directly associated with effective policy implementation.^[18,19] Besides, awareness of a health service program has been shown to increase the utilization of services among potential beneficiaries.^[20,21]

This study revealed that only about half of the study participants were aware of the project. This should be of concern to the strategic policymakers regarding this project. It should also be addressed as a matter of priority before project implementation.

With the current level of awareness of the project among the study participants, and take them as a subset of the larger public, it is logical to suggest that the level of awareness of the project among the general public will be much lower. A lower level of awareness of the project and its benefits will most likely result in low uptake of the services.^[21] Evidence has shown that enormous material and financial resources in addition to human personnel are required for project implementation activities.^[22,23] Poor uptake of the benefits of this project will amount to an enormous waste of scarce resources that could have been deployed for use in other social sectors.

Implementation of the project was scheduled to commence in the year 2018, however, it was not launched until 2019.^[24] For a project that has a timeline with scheduled reporting intervals especially with a global financial corporation as the World Bank, late commencement is a setback and efforts should be made to expedite implementation activities without compromising quality.^[25]

CONCLUSIONS

It is important that mid-level managers who play important role in the implementation of the BHCPFP are well acquainted with the policy document. In addition to this, the acquisition of requisite technical skills as is available in quantitative disciplines needed to manage the funding of health interventions is essential. Appropriate formal and informal trainings and re-training programs in quantitative skills related to funds management are recommended.^[26] This study was self-funded by authors by, thus, the study was limited to the six states in the Southwest geo-political zone of Nigeria. We accept this as a limitation. To a large extent, the study findings may be representative of the situation concerning the BHCPFP in other zones of Nigeria. The expansion of this study to other geo-political zones in Nigeria is recommended.

Limitations to study

This study was limited to the Southwest region as a result of limited funding.

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Conflicts of interest

There are no conflicts of interest.

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