ORIGINAL ARTICLE

The Growth and Development of General Practice Operators in Modern Healthcare Provision in Tivland, Central Nigeria

Abstract
This paper discusses the rise of private healthcare providers, collectively known as general practice operators (GPOs) or commercial providers, in modern healthcare provision in Tivland. This category of modern healthcare provision has 301 healthcare facilities, accounting for 31.987% of the total modern healthcare facilities available in Tivland. Despite the massive contribution of GPOs to the modern healthcare system, very little is known about the rise and development of this arm of healthcare providers in Tivland of central Nigeria. It fills this lacuna by asking: What is the evolution and impact of GPOs in Tivland? Primary and secondary data are used. Primary data include archival documents from the National Archive Kaduna (NAK), Nigeria, and oral interviews, including focus group discussions. Interviews were conducted with GPOs, medical and healthcare practitioners, medical and healthcare Union executives, community leaders, and women in Makurdi, Gboko, Ukum, and Katsina-Ala areas of Tivland from 2016 through 2019. They were qualitatively analyzed through a thematic approach. The rise of GPOs in Tivland was driven by the emergence of qualified indigenous medical professionals, crises in the public healthcare sector, and commercial motives. The government should provide grants and tax incentives to encourage efficiency. Also, to promote professionalism and curtail quackery in GPOS, the government should step up monitoring and supervision to ensure standardization in operation for enhanced healthcare delivery in Tivland, central Nigeria.

Key words: Healthcare, Disease, Tivland, GPOs, Nigeria, Motivation, Humans

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Introduction

The aphorism that "health is wealth" is an incontrovertible one. The socio-economic, cultural, and political developments of any society depend largely on the people's physical and mental well-being (health). Healthcare is intrinsically tied to people's sense of well-being and, thus, occupies a higher order of meaning in people's lives. The Greek Democritus, writing in the 5th century B.C., succinctly captured the importance of health (care) when he said that "without health, nothing is of any use, neither money nor anything else" (Liu, et al, 2002, p. 37). The famous philosopher Descartes wrote, "The preservation of health is … without doubt the first good and the foundation of all the other goods of this life (Keleher and MacDougall, ed, 2016. p. 4). Relating to national economy and development, health has a direct connection with a nation's productivity, as quality health and healthcare provision enhances a healthy population that engages in productive activities with greater productive outputs. Health empowers people to maintain their physical well-being.

Furthermore, health institutions contribute to various aspects of societal development, such as enhancing skills, increasing income, and improving occupational prospects. These benefits extend beyond the immediate locations they serve (Agbali, 2006, p. 76). On the other hand, a nation's poor state of health profoundly impacts the economy, influencing expenses directly through healthcare costs and indirectly via reduced productivity (Liu, et al., 2002, p. 37).

Therefore, due to the centrality of health to human well-being and the society at large, any development that pertains to health, especially healthcare provision, is very important and deserves particular attention in order to tap the benefits that health guarantees the economy and society. Wadge et al, 2017, accurately state that a considerable portion of global healthcare is provided by private entities, encompassing a diverse range of organizations such as large hospital groups and small clinics, as well as formal and informal establishments with both non-profit and for-profit business models. This observation is true about Tivland, where a significant proportion of modern healthcare provision is provided by private individuals either in the form of large hospitals or small clinics, whether as non-profit or for-profit motives. The phenomenal involvement of private individuals as providers of healthcare facilities and services for enhanced healthcare delivery in Tivland has contributed to healthcare delivery, uplifting people's health and boosting the economic productivity of the area. Because of the enormous contributions of general practice operators (GPOs) in modern healthcare provision in Tivland, this paper investigates the rise of GPOs in the modern healthcare system in Tivland and the dynamics that propelled them into healthcare delivery. These trajectories shaped this arm of private healthcare provision and its contribution to the modern healthcare system in Tivland in particular and Benue State in general.

Much works (Schram, 1971; Ityavyar, 1992; Agubosim, 1997) has been done on the modern healthcare system and the varieties of arms or sources of modern healthcare delivery in Nigeria. These works have traced the origin of the modern healthcare system in Nigeria during European activities. Bennett et al, 1997, quoted Ityavyar, 1992, observing that missionaries were responsible for introducing Western medicine. The state under colonial rule established facilities for essential workers, but it was only after independence that state provision of healthcare services became widespread. Schram's, 1971, work covers a period of 500 years from 1460-1960. It discussed the efforts by the European explor-

ers and abolitionists in Nigeria and the entire of West Africa to ensure disease treatment, control, and prevention before established medical work began in Nigeria. It argues that established medical work in Nigeria was started by the missionaries who brought modern medical care to Nigeria. It also discussed the sources of modern healthcare delivery in Nigeria and traced the origins of private medicine practice he referred to as general practice operators (GPOs).

Ityavyar, 1992, examines the origins of healthcare services in Nigeria and focuses on the various sources of healthcare services during the colonial period. This work traced the development of private healthcare provision in Nigeria to the colonial period as a result of the discriminatory policies of the colonialists against Nigerians who were medical professionals, among others. On the other hand, Agubosim, S.C., 1997, narrowed the focus to Warri/Delta Province, Nigeria. It discusses the development of the modern healthcare system in Warri/Delta Province of Nigeria during the colonial period. It dwells on the policies that affected the development and implementation of Western medical practice and the factors influencing the acceptance and rejection of modern treatment in the area. In all these works, very little attention has been paid to Tivland, especially on the development of the modern healthcare system, particularly on the private healthcare system in the area. Only recently, in 2021, Hembe's, 2021, research work on 'A History of Private Healthcare Services in Tivland, 1911-2005' examines modern healthcare services in Tivland with a specific interest in private healthcare services in the area. Hembe discusses the various sources of private modern healthcare provision in Tivland. It considered both the missionaries/voluntary or non-profit agencies and the private individual providers or commercial/for-profit agencies collectively known as general practice operators (GPOs). Despite his efforts, more needs to be done, especially on the rise, development, and contributions of general practice operators in modern healthcare provision in Tivland. This study contributes to the debate on the need for an inclusive approach to primary healthcare delivery in contemporary Nigeria, where the majority of the people who reside in rural areas largely lack healthcare insurance and access to healthcare. In fact, a dearth of literature unpacks how private healthcare providers are responding to healthcare challenges in Tivland of central Nigeria. This study's central argument posits that Group Purchasing Organizations (GPOs) have become vital components in healthcare provision throughout Tivland, central Nigeria. However, their full potential in transforming healthcare delivery remains untapped due to the absence of a coherent, sustainable partnership framework, and an institutional structure that effectively integrates and supports GPOs as essential actors in the overall healthcare system of modern Tivland, Nigeria. The state government should enact laws to provide tax incentives, regular training, and grants to GPOs to enhance their capacity to deliver quality and affordable healthcare services.

Methodology and the Scope of the Study

This paper made use of both primary and secondary sources of historical documentation. The primary sources used in this work include archival documents and extensive oral interviews conducted on the subject matter with some GPOs and some private healthcare facilities in Tivland. Archival documents were collected from the National Archive in Kaduna (NAK), Nigeria. Additionally, oral interviews were conducted with owners of private healthcare facilities. In cases where the original GPO owners were deceased, but their healthcare facilities were still operational, the management of these

facilities, family members, and contemporaries were interviewed to gather relevant information and insights. Others who formed part of this interview included those who attended these GPO's healthcare facilities- the sick and their caregivers. Twelve (12) Focus Group Discussions (FGD) were organized in Makurdi, Gboko, Katsina-Ala, Gwe West, Gwer East, and Zaki-Biam, and the people were interviewed on salient issues concerning the healthcare facilities, their owners, and their contribution to healthcare delivery in their area. Each group, ranging from four (4) to six (6) people, participated in an interview that lasted from one hour and thirty minutes (1:30) to two hours (2hrs). The selection of FGD participants was based on availability, expertise, knowledge, and number of years in such an area. The interviews were conducted mainly in Tiv language and English. The FGDs were recorded and transcribed. However, where fewer than four people were unavailable for focus group discussion, they were interviewed individually across the healthcare facilities visited. Other primary sources included records books, newspapers, and dairies containing useful information, such as daily hospital attendance registers and visitor's books.

On the other hand, secondary sources included published works in books and journals, sources from institutional and private libraries, and the internet. Information derived from these sources was analytically and qualitatively utilized for this work. Collected data were analyzed qualitatively through a thematic approach. The geographical scope of this paper was limited to Tivland of Benue State, located in the Central part of Nigeria in West Africa on the coordinates of latitude 6° 30' and 8° N and longitude 8° to 100 E (Igirgi, A.D., 2007, p.38). The landmass of Tivland covered about 29 300 square kilometers, encompassing 14 Local Government Areas (LGA) of Benue State with over 2 920 481 people. Tivland was selected as the focus of this study due to the substantial number of healthcare facilities owned by private individuals and the noticeable impact these facilities have on the region's modern healthcare system.

Conceptual Clarification and Theoretical Framework

To clarify the concept of General Practice Operators (GPOs) in modern healthcare provision, it is first essential to understand the broader notion of private healthcare provision. Private healthcare provision encompasses non-state medical healthcare services or facilities, including GPOs. Within the realm of private healthcare, GPOs play a significant role as healthcare providers, making it crucial to examine their unique position and contributions in the larger healthcare landscape. These are healthcare services or facilities that are provided and owned by private agencies. The term 'private' means 'non-governmental'. Private services in the healthcare sector are healthcare services organized by private healthcare providers. A healthcare provider is a recognized legal or administrative entity that organizes and produces healthcare services. The term "provider" has at least two meanings: individuals or organizations (Berman, 1999, p. 6). According to Akin, et al, 1985, a "provider" can be both a direct producer of healthcare and a "governance mode" that organizes activities to enable this direct production. Using the governance meaning of the term "provider," private healthcare services are services for improving and maintaining human health that are obtained from the private sector or provided by private agencies and organizations. The Senate of the Federal Republic of Nigeria (2014, p. 28) defines private healthcare services as health establishments that are not owned and controlled by an organ of the state. In line with this view, ownership distinguishes private

healthcare from the rest of the modern healthcare system. Private healthcare services are provided, owned, and controlled by non-state providers. Private healthcare services are classified differently.

General practice operators (GPOs), on the other hand, refer to modern healthcare services or facilities that are provided and operated by individuals either as single persons or combined as a group. Using Donev, Kovacic and Laaser (2013) classification of healthcare services based on ownership, general practice operators (GPOs) are non-governmental healthcare services, facilities, and arrangements set up by individuals to provide healthcare services. Using the profit motive categorization, GPOs are healthcare facilities established by individuals either as commercial healthcare enterprises with the aim of profit maximization or by philanthropists as not-for-profit ventures. The term "for-profit healthcare services or agencies" is often used to describe General Practice Operators (GPOs) as commercial healthcare enterprises established with the aim of profit maximization. However, this labeling can be misleading, as it is largely influenced by the visibility and dominance of profit-driven operators within this category. It is important to recognize that not all GPOs are motivated by profit alone. In light of this, GPOs can also be referred to as "general practice practitioners," reflecting a broader understanding of their role in healthcare provision beyond the scope of profit-making entities. Based on this clarification, adopting the ownership classification of healthcare services, general practice operators (GPOs) are basically classified as private healthcare services at large; this is because they are not provided or owned by the government or state, corporate institutions, or organizations, but by individuals. Against this backdrop, General Practice Operators (GPOs) can be categorized based on their underlying motivations, encompassing for-profit and not-for-profit entities. Some GPOs function as enterprises, transforming healthcare services into commodities that are sold to patients, reflecting a profit-oriented approach. On the other hand, other GPOs deliver healthcare services through a non-profit model.

This paper defines general practice operators (GPOs) as private healthcare services provided and operated by individuals, whether with or without the aim of profit maximization. They are typical like any other private healthcare services; however, the major distinguishing feature from the rest of private healthcare services arrangements is that the GPOs are provided by private individuals operating singly or as a group. This is quite different from other forms of the private healthcare services that are either set up by institutions and organizations such as the missions, non-governmental organizations, and community efforts. The GPOs have had a long history of involvement in healthcare provision in Nigeria since the colonial period. It is this phenomenon of the involvement of private individuals in the provision of modern healthcare services that this paper attempts to look at in the growth and development of general practice operators (GPOs) in Tivland. Facilities or services of particular interest are the hospitals, clinics, healthcare centers, and maternity centers established by the individuals.

This paper is anchored on theoretical assumptions about structural functionalism. Structural functionalism states that society is a system made up of interconnected structures, each of which functions in a specific way to maintain the system as a whole (Orla, et al., 2009, p. 11). It was developed by a 19th-century French sociologist, Emile Durkheim. Structural-functionalism centers around the notion that shared norms and values are crucial for society to operate cohesively as a unified entity (Orla, et al., 2009, p. 11). This

theoretical perspective views society as an organic system whose various components support and maintain one another. Social structures, including roles, norms, and values, are organized based on the functional needs of society, thereby serving a specific purpose in ensuring smooth societal operations. Structural-functionalism draws an analogy between society and the human body, asserting that understanding a particular societal element necessitates examining its relationship with other components and its contribution to the overall maintenance and functioning of the larger society "organism." Just like the human body, an understanding of any part of society should involve an analysis of its relationship to other elements in the society, especially, its contribution towards the maintenance of society (Radcliffe-Brown, 1952, p. 119), and satisfaction of certain basic needs. The society, in the same way an organism survives on the satisfaction of specific basic needs, survives on the satisfaction of particular basic needs and hence requires that such basic needs be met to guarantee its continued existence. In other words, functionalism assumes that the entire system relies on interconnectedness, where each specialized component depends on the contributions of another to fulfill its specific needs and maintain the overall well-being of the system as a whole.

Applying the theory to this discourse emphasizes the health or healthcare sector as an important sector vital for the smooth functioning of any society (including Tivland). Like other sectors that make up society, such as education, politics, transportation, agriculture, manufacturing, religion, and security, which contribute to the smooth operation of society, the health or the healthcare sector is equally vital. The importance of health in the smooth functionality of society is succinctly captured by Democritus, writing in the 5th century B.C. thus: "Without health, nothing is of any use, not money nor anything else (Liu, et al., 2002, p. 37). The famous philosopher Rene Descartes wrote, "The preservation of health is … without doubt the first good, and the foundation of all the other goods of this life" (Keleher, and MacDougall, 2016, p. 4). The socio-economic, cultural, and political developments of any society depend largely on the health of the people. The contributions of the health or healthcare sector, alongside other sectors, in ensuring societal smooth and orderly functioning have been emphasized using the structural functionalist explanation.

Modern Healthcare System and the Rise of General Practice Operators (GPOs) in Tivland

In Tivland, the missionaries made the earliest attempt at modern healthcare provision to the people. The missionary society that first provided modern health treatment in Tivland was the Christian Reformed Church (CRC) - the American branch of Sudan United Mission (SUM). In the early days, the Christian Reformed Church (CRC) was mandated to carry out missionary evangelization in Tivland. During one of their visits to Saai Utu, where they occasionally rested, they introduced modern, Western-style healthcare practices by offering free medical services such as wound dressing and distributing essential medications (Dorward, 1975, p. 215). The CRC later passed on their work to the Dutch Reformed Church Mission (DRCM), which officially took over on April 17, 1911. In the same year, they established a dispensary at Saai known as Rudimentary Dispensary (Dorward, 1975, p. 218). This marked the first attempt at establishing a modern healthcare facility in Tivland. The DRCM was not alone in modern healthcare provision in Tivland at this early period. They were joined in this task by the Roman Catholic Mission, which

came into Tivland in early 1920 for religious evangelization and also provided healthcare services for the treatment of the people. The first modern healthcare facility provided by the Roman Catholic Mission in Tivland was known as Holy Ghost Clinic, and it was located close to the Holy Ghost Parish. The Holy Ghost Clinic was later taken over by the state government and upgraded to a secondary healthcare facility. It was located at the site of the old Federal Medical Centre, Makurdi (Catholic Diocese of Makurdi, 1964). Other early modern healthcare facilities established by the Roman Catholic Mission in the area include the St. Joseph's Primary Health Unit, which was established in 1932. By 1945, the Roman Catholic Mission Maternity Centre, Udei, was established (Manuscript No. NAK/KADMin Health/404, 1945).

With the onset of colonial rule in Tivland, the colonial state also took on the task of modern healthcare provision to cater to the health needs of the European colonial officials and the local population for enhanced productivity, but more importantly, to protect themselves from some infectious diseases endemic to the region. Despite the ability of early British colonial officials in Tivland to treat themselves and other Europeans, they remained vulnerable to re-infection, particularly from contagious diseases carried by the Indigenous population. In Tivland, several infectious diseases posed significant risks to Europeans during the initial stages of colonial rule, including yaws, sleeping sickness, leprosy, tuberculosis, cerebrospinal fever, gonorrhea, smallpox, and helminthic diseases. (Manuscript No. NAK/MAKPROF/1366, 1951). Poor environmental sanitation was another significant contributor to the spread of infectious diseases in the region. Recognizing that the health of British and other European officials in Nigeria, including Tivland, was interconnected with the well-being of the Indigenous population, British colonialists understood that controlling communicable and infectious diseases among their personnel would be challenging unless the local carriers of such diseases were also free from infection. As a matter of policy, the British colonial government was advised to invest in the health of their local or indigenous people if they (British and European officials) were to be free from infectious diseases in the colony. In this wise, based on the colonial health policy, the Colonial State focused initially on disease prevention and control for certain diseases such as smallpox, cerebrospinal fever, relapsing fever, yaws, and other infectious diseases to which the Europeans had yet to build immunity (Hembe, and Abah, 2021, p. 255). Their earliest efforts towards modern healthcare provision were geared towards health campaigns and vaccination or immunization against certain communicable and infectious diseases. Disease prevention and control measures were enforced. These included immunization, advocacy, isolation and quarantining, avoidance of overcrowding or slums, personal hygiene, and environmental sanitation, particularly sewage control to prevent mosquitos' breeding sites and use of wire mesh on residential homes to prevent mosquito entry.

Apart from healthcare provision through ensuring disease prevention and control (preventive health), the Colonial State also began the setting up modern healthcare facilities in Tivland. The first colonial government health facility established in Tivland was the Isolation Hospital Makurdi. The Central Government of the colonial administration established the hospital to control infectious diseases in the Benue Province (Manuscript No. NAK/MAKPROF/1366, 1951). Apart from the Isolation Hospital, the Colonial State also established dispensaries to provide modern healthcare services in Tivland. When the scheme of dispensaries was initially put forward, it was considered that the principal func-

tion of the dispensaries should be to spread the knowledge of health and hygiene among the rural population (Manuscript No. NAK/MAKPROF/1366, 1951). According to Agubosim (1997, p. 87), the scheme of opening dispensaries was a colonial government's health initiative adopted at the Resident's Conference of 1929. The conference endorsed the recommendations for expanding the network of dispensaries and training dispensers and recommending to the Native Authorities a scheduled official launching of the scheme of Native Authority dispensaries for 1930 (Manuscript No. NAK/MAKPROF/MED/64, 1929). On the basis of this recommendation, the central colonial government established special dispensaries for the control and eradication of sleeping sickness preparatory for the start of Native Authority dispensaries. The focus of the Provincial Authority on sleeping sickness in Tivland stemmed from the fact that the British colonialists had declared Benue Province, which included Tivland, as the center of sleeping sickness in Nigeria (Manuscript No. NAK/MAKPROF/MED25Vol II, 1958). The central administration established sleeping Sickness Dispensaries in the following areas in Tivland- Gambe -Ya (Tor Donga), Vandeikya, Shangev South (Ajio), Shangev West, Nyiev (Udei), Ugondo, Mbakor (Wannune) (Manuscript No. NAK/MAKPROF/2780/S.8, 1945). These dispensaries were also to serve as pilot dispensaries preparatory for the takeoff of the scheme by the Native Authorities. While the central colonial administration set up the central authority's dispensaries, the Tiv Native Authority Administrations in the Northern Province established Native Authority Dispensaries to promote rural health in the area. The District Officer in charge of Tiv Division in September 1945 listed six Native Authority Dispensaries established by the Native Authority administration in Tivland in the following locations - Abinsi, Akwara, Gboko, Igbor, Ihugh and Katsina-Ala (Manuscript No. NAK/MAKPROF/2780/S.8, 1945).

The post-colonial state speedily expanded modern healthcare provision in Tivland at the turn of independence. The post-colonial government introduced policies and reforms within the health sector that would promote the health of the people in order to achieve high economic productivity. To achieve her goals, the post-independence state introduced welfarist policies geared towards healthcare provision generally. These included the assumption that the state was responsible for providing healthcare in the country. It assumed the responsibility of healthcare provision to reflect the political structure of the state-federal, state-federal, state-federal, state, and local governments. Therefore, healthcare provision was categorized into primary, secondary, and tertiary levels of care to reflect the three tiers of government. Primary healthcare was under Primary healthcare, which was the local government's responsibility. The secondary healthcare level was under the responsibility of the state government. The tertiary healthcare level, on the other hand, was apex healthcare facilities. This group included specialist hospitals, federal medical centers, and teaching hospitals owned by the national government. These three structures of state healthcare provision were interrelated through a referral system.

These various sources of modern healthcare provision in Tivland provided several components of healthcare delivery ranging from preventive, curative, special services, and health education to social welfare, among others. Records derived from the Health Management Information System of the Benue State Ministry of Health, Makurdi, 2014, show that there are a total of 941 modern healthcare facilities in Tivland (Directorate of Health Planning, 2014, pp. 16-25). Out of this total number of modern healthcare facilities in Tivland, 862 facilities are primary healthcare facilities, 77 are secondary health-

care facilities, and 02 are tertiary healthcare facilities. Regarding ownership of facilities, 515 healthcare facilities are owned by the state (federal, state, and local government), representing 54.729% of total healthcare facilities, whereas 426 healthcare facilities, representing 45.729%, are owned by the private sector. Among the total number of healthcare facilities provided in Tivland, 125 healthcare facilities are owned by the mission (religious groups) or voluntary agencies, accounting for 13.284% of total healthcare facilities in Tivland, whereas 301 healthcare facilities are owned by the general practice operators or private individuals, accounting for 31.987% of total healthcare provision in Tivland.

Table 1: Summary of Modern Healthcare Provision in Tivland Based on Level of Healthcare Facility (Directorate of Health Planning, 2014, pp. 16-25.)

S/No	Primary Care Facilities	Secondary Care Facilities	Tertiary Facilities	Total
1	862	*77*	2	941

The phenomenon of general practice operators in modern healthcare delivery is not peculiar to Tivland alone, as they feature a greater part of healthcare delivery in most areas in the country. The origin of this arm of private healthcare providers in Nigeria is traced back to the colonial period (Schram, 1971, p. 341). According to Schram (1971, p. 341), while most of Nigeria's medical manpower was engaged in the government service, the voluntary hospitals, and industry, a small but not insignificant number were in general practice from a remarkable period. However, wholly independent general practitioners were rare in the early period. This was because the average Nigerian could not afford to pay the fees of private medical care (Schram, 1971, p. 341). In the entire northern region, general practice was not established until 1951 when two medical doctors began practicing. In contrast, Lagos provided a more conducive environment for private practitioners to earn a living, as a larger portion of the population had the financial means to access such services. Outside of Lagos, the Warri and Delta regions witnessed the growth of general practice during the colonial period. In these regions, Dr. F. O. Esiri founded Blissful Maternity and the Esiri Infirmary (hospital) in Warri in the same year (Manuscript No. NAI,MH/Fed/1/1/11841c, 1952). Additionally, Mrs. O. Nelson Williams opened a maternity clinic and nursing home in Warri. At the same time, Mrs. G. E. Adigwe set up a maternity home in Umutu and later expanded to Sapele (Manuscript No. NAI,MH/Fed/1/1/11841c , 1952). In the post-colonial era, various factors led to a significant increase in the number of individuals entering the field of general practice. These factors included economic challenges, the relaxation of stringent entry criteria, and the abolition of the Private Practice Decree No. 5 in 1978, which eased entry into private practice in Nigeria.

Available records of the activities of general practice operators in modern healthcare provision in Tivland show the following persons as the earliest general practice operators (GPOs) in modern healthcare provision in Tivland. They include- Dr. Joshua Atume Adagba, Dr. Pius Y. Ochefu, Mrs Acka Ngumalen, Paul Iorpuu Unongo, Dr. Ameh Matthew Idoko, Dr. Abakpa Benedict Ameh, Dr. Abraham Kohol, Dr. Gbillah Innocent, Dr. Ikparen Myom, Dr. Pevkyaa Yandev, Dr. Lim, Dr. Baki Orhemba, Mr. David Ikereve Adi and Dr. Terungwa Nguher (Hembe, 2019; Gbillah, 2020; Kohol, 2019). Most of these personalities were medical personnel, but a few others were businessmen and philanthropists or social entrepreneurs. They set up modern healthcare facilities of different categories

in different parts of Tivland. For instance, in Makurdi, Dr. Joshua Atume Adagba established the Makurdi Polyclinic in 1983, (Adagba, 2012, p. 34), Dr. Pius Y. Ochefu, established the Hospital of Immaculate Conception in 1984, Mrs. Acka Ngumalen began the View Point Medical Centre, Makurdi, the Madonna Hospital, Makurdi was established by Dr. Ameh Matthew Idoko, the El-Shaddai Specialist Hospital, Kanshio-Makurdi was established in 1991 by Dr. Abakpa Benedict Ameh, Hemko Hospital, Kanshio-Makurdi, established in 1992 by Dr. Abraham Kohol, and the Ushakaa Hospital Makurdi, established in 1994 by Dr. Gbillah Innocent (Hembe, 2021, p. 322). In Gboko, Dr. Ikparen Myom established the Myom Hospital in October 1983 (Ver, 2018), Dr. Pevkyaa Yandev founded the T.B.T Hospital in 1987, Dr. Baki Orhemba, the proprietor of Baki Clinic and Maternity, established in 1996. In Katsina-Ala, Paul Iorpuu Unongo, a politician and businessman, set up the JULADACO Specialist Hospital in 1976, with actual take-off in 1978, and Mr. David Kyereve Adi established the Adi Dispensary in 1981. It was amongst these Tiv and non-Tiv people that the earliest group of general practice operators in modern healthcare delivery in Tivland emerged.

Despite that, general practice operators in modern healthcare delivery in Tivland is an established fact, and a significant proportion of healthcare services in the area is delivered by these set of providers with diverse facilities, including large hospital groups and small clinics, formal and informal in the area, the growth of this group of providers of modern healthcare services (GPOs) in Tivland is given less scholarly interest to examine the forces that resulted to the growth of this arm of healthcare provision in Tivland.

The precursor to the emergence of GPOs in modern healthcare provision in Tivland is traced to the late 1960s when some Tiv indigenes began graduating as medical professionals such as doctors, nurses, and midwives from various educational institutions and organizations across the country (Gyoh, 2018). Nonetheless, this was not accompanied by the establishment of healthcare facilities until the early 1980s. The first Tiv person to qualify as a medical doctor is Dr. Shima Gyoh, in 1966. (Gyoh, 2018). This was followed by Dr. Joshua Atume Adagba, in June, 1969 from the University of Ibadan (Adagba, 2012, p. 14). Another medical doctor with an early medical qualification in Tivland was Myom Ikparen, who graduated from Ahmadu Bello University, Zaria, in the mid-1970s (Ver, 2018). The number of medically qualified people in Tivland kept increasing, and this was not just limited to the Tiv people only, as there were non-Tiv people (among the Igala, Idoma, and Plateau) who also qualified as medical doctors and settled down in Makurdi, the headquarters of the newly created Benue State. Among this category include- Dr. Pius Y. Ochefu, who graduated from the University of Ibadan in 1972; Dr. Ameh Idoko, who graduated from the medical school in 1959 (Ameh, 2018); others were Dr. Igbede, Dr. Adum, Dr. Alexander Fom and Dr. Amali (Ochefu, 2018). These medical doctors added to the number of medical doctors in Tivland. Aside from the medical doctors, other people qualified as nurses, midwives, and theatre attendants. For instance, in 1979, Mrs Ngumalen Acka qualified as a Midwife and later as a Registered Nurse (Adagba, 2012, p. 62). Other medical professionals from other areas were attracted to Tivland (Makurdi) because of the numerous entrepreneurial opportunities in the town (Makurdi) as an emerging urban center and the capital of the newly created Benue State. It was among these medically qualified (Tiv and non-Tiv) professionals, most of whom were employees in government healthcare service, that emerged the first general practice operator to establish a full-fledged hospital facility in Tivland in the person of Dr. Joshua

Atume Adagba, who established the Makurdi Polyclinic in 1983. This was followed by Dr. Ikparen Myom, who established the Myom Hospital, Gboko, later in October 1983. Mrs Ngumalen Acka, a retired nurse, also established the View Point Medical Centre, Makurdi. Among the non-Tiv groups, on the other hand, Dr. Pius Y. Ochefu, in 1984, established the Hospital of Immaculate Conception. Dr. Ameh Idoko established the Madonna Hospital in Makurdi. Whereas Drs Okoye and Abakpa Benedict Ameh established Sandra Hospital Makurdi and El-Shaddai Hospital, Kanshio, respectively.

Other factors that gave impetus to general practice operators in modern healthcare provision in Tivland include the growing perception of poor conditions of the public health sector; this was in relation to not only salaries but also workload, lack of hospital equipment and supplies seen as important for the provision of quality healthcare services (Gilson, Palmer, and Schneider, 2005), the general decline or collapse of public healthcare facilities due to lack of qualified medical personnel, incessant strikes, low remuneration of health workers in the public health sector (Alubo, 1983, pp.185-196; Alubo, 1986, pp. 310-314; Alubo, 1992, p. 45; Iroha, 1984, p. 3; Ogunbekun, Ogunbekun, and Orabaton, 1999, p. 174), noted that the persistent low quality and inadequacy of health services provided in public health facilities made the private health sector an unavoidable choice for healthcare consumers in Nigeria. This preference over private healthcare services by healthcare seekers boosted the drive of many individuals to venture into private healthcare service delivery.

Bureaucratic bottlenecks, including appointment scheduling for patients and designated days for specialty clinics, have created obstacles to accessing healthcare services on demand. Additionally, the inadequate and uneven distribution of public health facilities in certain areas of Tivland has resulted in limited access to modern healthcare services for the local population (Ujoh, and Kwaghsende, 2014, p. 212). Alubo (2010), corroborating this fact noted that entrepreneurial medicine was a "correction," even if unintended, to the lopsided distribution of public medical facilities. The introduction of user-fee-charges, lack of job satisfaction or frustration of workers in the public healthcare sector due to poor remuneration in the public health system, arbitrary retrenchment of workers, and general instability in the public healthcare sector was another contributing factor that propelled general practice operators in modern healthcare delivery in Tivland (Ochefu, 2018).

Furthermore, global action plans have played a pivotal role in promoting and supporting the health sector. For example, the Primary Health Care Convention in Alma-ata in 1978, the Millennium Development Goals (MDGs) 2000, and the World Bank health policy document or blueprint titled Financing Health Services in Developing Countries: An Agenda for Reform (World Bank, 1987) supported private individuals in modern healthcare provision.

Furthermore, some of the general practice operators in healthcare provision in Tivland interviewed pointed to some factors that encouraged their presence in healthcare delivery including:

> *Economic- the need to make a profit and run services, the desire to become bosses and entrepreneurs of health facilities. Personal- the need to make use of modern and high technological innovations in the delivery of healthcare services, the desire to provide health services to humanity, the desire to save lives, reduce pains and sufferings from diseases and ill health, and social reasons such as fame, the desire to provide health services to humanity, the desire to save lives, reduce pains*

and sufferings from diseases and ill health, which was the primary desire or goals of any health provider. Others were the desire to provide community service, especially among health practitioners and philanthropic individuals or groups in society. (Gyoh, 2018; Ochefu, 2018; Ameh, 2018)

These factors were responsible for the rise and growth of the fame of general practice healthcare providers in Tivland.

Table 2: Summary of Modern Healthcare Facilities According to Ownership in Each of the Local Government Areas of Tivland in Benue State (Directorate of Health Planning, 2014, pp. 16-25; Hembe, 2021)

S/No	Location	Public	Private		Total
			Missions/Voluntary Ownership	General Practice Operators (GPOs)	
1	Buruku	*34*	7	13	54
2	Gboko	*35*	12	43	90
3	Guma	*57*	7	8	72
4	Gwer East	*25*	5	8	38
5	Gwer-West	*37*	4	6	47
6	Katsina Ala	*45*	14	58	117
7	Konshisha	*42*	9	20	71
8	Kwande	*45*	6	7	58
9	Logo	*29*	10	15	54
10	Makurdi	*37*	7	62	106
11	Tarka	*26*	6	3	35
12	Ukum	*35*	11	18	64
13	Ushongo	*39*	15	20	74
14	Vandeikya	*29*	12	20	61
	Total	*515 (54.729%)*	125 (13.284%)	301 (31.987%)	941

Table 2 shows the number of health facilities in Tivland based on ownership. As illustrated in the table, the number of health facilities provided by the general practice operators in all the local government areas in Tivland justifies the presence and contribution of general operators in modern healthcare provision, as argued in this paper. The general practice operators' facilities in Tivland are 301, accounting for 31.9% of modern healthcare facilities in Tivland.

Implications of GPOs for Modern Healthcare System in Benue State, Nigeria

The involvement of general practice operators (GPOs) in modern healthcare provision has no doubt has far-reaching implications on healthcare delivery in Benue State. Some of these implications have a direct bearing on patients where they are best served by the GPOs offering high-quality care in an accessible way, but others are directly on the entire health ecosystem where GPOs impact health and health systems through training a new generation of doctors, nurses, and other professionals. Some of the implications are positive to the healthcare system, but others are unhealthy to the entire healthcare system. Although the scope is limited to Tivland of Benue State, the implications of general practice

operators (GPOs) as vital players in modern healthcare architecture transcends Tivland.

One of the major impacts of GPOs on modern healthcare delivery is that they have increased access to modern healthcare services in the area. In healthcare, access is defined as the extent to which patients' financial, organizational, geographical, and cultural barriers are minimized (Gulliford, et al., 2002, p. 19). This set of modern healthcare providers has combined with the public and the voluntary providers and transformed modern healthcare delivery, such as establishing more healthcare facilities to increase access to modern healthcare services in Tivland. The GPOs have provided healthcare facilities such as hospitals, health posts, diagnostic centers, clinics, and dispensaries which have been added to existing facilities provided by the state and other voluntary agencies. Although access to healthcare services is not only measured in terms of the presence or absence of facilities alone, other determinants include the availability of certain services, payment system, income of patients, and number of hospital beds available. However, when the number of facilities and hospital beds available is considered the yardstick, the GPOs have greatly boosted access to modern healthcare provision in the area. It is on record that GPOs facilities provide healthcare services to remote areas in some parts of Tivland where government and voluntary healthcare facilities are unavailable.

Also, the GPOs have stirred improvement in healthcare services provision by engendering inter-sector and intra-sector competition among healthcare providers. Although competition is reported to produce adverse outcomes in some cases, it also has a positive impact on the quality of healthcare services (Dash, and Meredith, 2010, p. 2). The three consistently cited dimensions of healthcare quality are safety, clinical effectiveness, and patient experience. These are testified by users of GPO facilities. This competition could be intra-sector, one seen between healthcare facilities owned by GPOs themselves, and inter-sector, seen between GPO's healthcare facilities and the state and voluntary healthcare facilities, on the other hand. This is mostly the case in a society such as Tivland and Benue State at large, where free healthcare services are abolished, cost-recovery is introduced to commoditized commoditize healthcare services, and people pay for healthcare services they receive. The attempts to provide quality and efficient services by GPOs to attract and retain patronage from health seekers stimulate competition among other healthcare providers within the healthcare delivery system resulting in, resulting in affordable, efficient, or effective healthcare services provision.

Healthcare facilities established by GPOs have contributed to human capital development in the area. This is most especially in the healthcare sector where standard healthcare facilities by GPOs in urban areas like Gboko, Makurdi, and Katsina-Ala and semi-urban areas such as the local government headquarters in Tivland, provide avenues for clinical experiences to various categories of medical professionals such as nurses, community health extension workers, laboratory technicians, and medical doctors to gain practical experience in different aspects of healthcare services. Although this fact of private medical enterprise contributing to the training of health personnel and labor force development has been a subject of controversy among scholars, Alubo (2001) refuted this due to poor equipment and staff. Ogunbekun, Ogunbekun, and Orobaton, (1999), on the other hand, stated that private hospitals continue to serve as training centers for physicians in the General Practice residency. However, in Tivland, where the majority of the population resides in rural areas, this lower cadre of health personnel trained in healthcare facilities established by the GPOs is greatly useful in providing primary healthcare services to the

people in the rural communities in the area.

Furthermore, GPOs in healthcare delivery in Benue State embark on aggressive expansion and establishment of healthcare facilities across the nooks and crannies of the state. This aggressive expansion of existing facilities and establishment of new ones resulted in using poorly constructed structures as health facilities, using lower cadres and mostly unqualified personnel, and obsolete and substandard hospital equipment to cut costs. In some facilities visited, a whole healthcare facility is made up of just three rooms measuring 12 feet by 12 feet, each staffed by two health personnel at the time of the visit and lacking basic hospital equipment. It is important to note that not all GPO-operated healthcare facilities in urban and semi-urban areas of Tivland adhere to the same model. Some of these facilities operate in purpose-built structures equipped with advanced medical technology and employ highly skilled healthcare professionals.

Also, the presence of GPO healthcare facilities in the healthcare delivery system in Benue State further produced negative consequences. Apart from those discussed, which bother on the poor quality of facilities, equipment utilized, and services delivered, some of these GPO's healthcare facilities contribute to frustrating government healthcare policies and strategies. Sometimes, they provide services that are at variance with government policies. At times, the services offered by GPO-operated healthcare facilities may conflict with government policies. Certain services prohibited by the government and not available in public healthcare facilities are performed discreetly within these private establishments due to profit-driven motives. Examples of such services include performing abortions, which are officially prohibited.

Additionally, unethical practices like issuing falsified immunization certificates for mandatory vaccinations have been documented in some GPO facilities. Reports also indicate that certain private medical practitioners have contributed to undermining government efforts to curb the spread of the COVID-19 pandemic in Nigeria. By treating patients who exhibited symptoms of the virus in private hospitals rather than referring them to government-designated healthcare centers, these practitioners jeopardized the efficiency of government initiatives aimed at disease prevention, management, and control.

Another consequence of the profit-driven nature of GPOs is the tendency towards overtreatment of patients to generate additional income. In some instances, conditions that could be effectively treated with simple procedures and medications are subjected to unnecessarily complex treatment plans. Furthermore, surgeries may be performed in cases where less invasive treatments would suffice, leading to increased financial burden on patients. Despite these negative aspects, it is important to recognize the positive contributions that GPOs have made to the overall healthcare system in meeting the diverse healthcare needs of the population. By supplementing public healthcare services and increasing accessibility, GPOs play a vital role in ensuring comprehensive healthcare provision in society.

Conclusion

From the discussion, General Practice Operators (GPOs), which are just an arm of private healthcare provision, have contributed to modern healthcare provision in the Tiv society of Benue State, Nigeria. The Nigerian state's crisis, which emerged due to the failure of successive political leadership to develop the health sector and provide afford-

able healthcare to Nigerians, especially rural dwellers, has spurred the involvement of GPOs in the healthcare sector. They have emerged to fill a vacuum created by a shortage of primary healthcare centers and healthcare officials in different parts of Nigeria. In Benue State, the emergence of this group of modern healthcare providers in Tivland is critical in advancing healthcare to rural and urban folks, especially those not on the national health insurance scheme. GPOs play a vital role in addressing various basic health concerns, including typhoid, malaria, antenatal and postnatal care, pediatric issues, and dermatological treatments. Despite their central role in delivering essential healthcare services, GPOs often face neglect and receive minimal support from both government entities and philanthropic organizations. This lack of assistance hampers their operational efficiency and overall productivity. In an era characterized by pandemics and climate change-induced infectious disease outbreaks, it is crucial for state and non-state actors to extend practical support to GPOs, particularly in rural areas where the majority of Tivland's population resides.

This paper recommends a healthy partnership between all providers of modern healthcare in order to leverage each other's areas of strengths and cover peculiar weaknesses in the delivery of healthcare services to the people. This is because no healthcare delivery system is best as a stand-alone or can function in isolation from others, but only if it works in partnership with other health systems. This means engaging with other providers - government, private, missionary, and other agencies- to help achieve healthcare targets in society. Also, the government should intensify monitoring and supervision of general practice operators, especially in rural villages like Anyim, Logo, Ukum, Naka, and interior villages in Tivland to ensure that GPOs conform to government guidelines as well as primary healthcare practice ethics in the delivery of their services to society. This is important in order to ensure that the do not indulge in unethical health and medical services. The government should provide grants, especially financial and project grants, to GPOs and communities where they operate to enhance efficiency in healthcare delivery, especially with the incessant outbreak of epidemics such as cholera, measles, lassa-fever, and others in rural areas of Tivland and Nigeria in general. A way to enhance monitoring is to support GPOs unions to ensure that they self-regulate themselves with oversight from the Federal and State ministries of health in Benue State. The government should provide tax incentives to GPOs to ensure that they are able to deliver affordable and quality healthcare to the people without necessarily charging exorbitant fees to the majority of the poor in Tivland. In the midst of dilapidate healthcare infrastructures and inadequate funds to provide and finance government primary healthcare across Tivland in Benue State, Nigeria, this study notes the urgent need for the state government to enact laws to provide tax incentives, regular training and grants, and other facilitative measures to GPOs to enhance their capacity to deliver quality and affordable healthcare services.

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Authors' Contribution

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