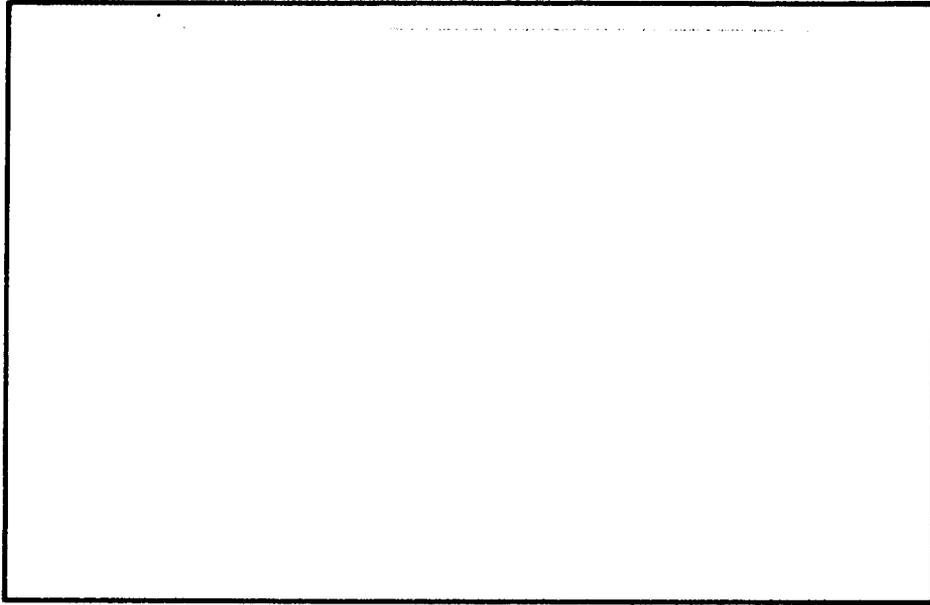


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ISA 52745



PRITECH

Technologies for Primary Health Care

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PD-AACW-584
MAN = 52745

CCCD PROJECT
FINANCIAL PLANNING AND MANAGEMENT
NIGERIA

A Report Prepared By PRITECH Consultants:
PETER BERMAN
ANNEMARIE WOUTERS

During The Period:
FEBRUARY 22 - MARCH 26, 1987

TECHNOLOGIES FOR PRIMARY HEALTH CARE (PRITECH) PROJECT
Supported By The:
U.S. Agency For International Development
AID/DPE-5927-C-00-3083-00

AUTHORIZATION:
AID/S&T/HEA:
ASSGN. NO: DC-271

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I. INTRODUCTION

This trip report is a synopsis of the activities of The Johns Hopkins University (JHU) team, Drs. Peter Berman and Annemarie Wouters, for their trip to Nigeria between February 22-March 26, 1987, for the financial planning and management component of the CCCD Project. Briefly, the overall objectives of this component are:

1. to assist the states in a comprehensive analysis of their health sector financial situation to implement health programs,
2. to identify strategies and constraints concern in the financial sustainability of health programs,
3. to develop and evaluate innovative approaches to solving financial planning and management problems,
4. to disseminate results and experiences to all states.

II. PURPOSE OF VISIT

This was the first trip to Nigeria for the team managing the financial planning and management project within the CCCD Project. The purpose of the trip was to develop a work plan and schedule of activities for the project. With the assistance of the Directorate of National Health Planning, the JHU team was to select focus states for the first phase of project activities and to identify a federal counterpart who would be responsible for coordinating and managing the project at the federal level. Preliminary visits were to be made to the focus states to assess their interest in the

project, review the draft of the work plan and schedule of activities, and identify a counterpart within the State Ministry of Health to coordinate and manage project activities.

III. TRIP ITINERARY

The first week of the trip was spent in Lagos meeting with the CCCD Technical Officer, John Nelson; the AID Director, Keys McManus; and officials of UNICEF and in the Ministry of Health in the Directorate of National Health Planning (DNHP) and Directorate of Public Health. A full list of the individuals contacted during the trip is appended to this report. Lengthy discussions were held with Dr. A.B. Sulaiman, the Director of National Health Planning, to draft the work plan. At this time, he suggested Lagos and Niger as the focus states. Also, he proposed that the team observe the state planning workshop held in Bauchi and Kaduna during the week of March 2-6.

The team attended the workshops in Bauchi on March 2 and in Kaduna from March 3-5. Upon its return to Lagos on March 6, the team met again with Dr. Sulaiman to review the experience at the workshops. At this time he identified Mrs. Charity Ibeawuchi from the Directorate of National Health Planning as the federal counterpart for the project and provided the team with official letters of introduction to the Ministries of Health in the Lagos and Niger States.



Although Mrs. Ibeawuchi was unavailable to work with the team during the week of March 9-13, the members were advised by other officials in DNHP to go ahead with the preliminary visit to the Lagos State Ministry of Health. On March 7, Drs. Berman and Wouters met with both the Commissioner and the Permanent Secretary. The Permanent Secretary identified Dr. Oluwole (Planning Officer -- Medical Statistics Unit) as the project counterpart. They were also invited to observe a three day LGA planning workshop.

Since Dr. Berman's schedule limited him to a three week stay in Nigeria, he left Nigeria on March 13. Dr. Wouters remained an additional two weeks to meet with Mrs. Ibeawuchi and to travel with her to Minna, Niger State. They met with the Commissioner and Permanent Secretary of the Niger Ministry of Health from March 18-20 to discuss the work plan and a general schedule of activities. Dr. H.M. Gambo, the principal medical officer, was identified as the counterpart for the project. It was also decided to draft a list of data requirements which would be collected by the state before the next visit by the JHU team.

During the last week of the trip, Mrs. Ibeawuchi and Dr. Wouters met again with the State counterpart in Lagos, Dr. Oluwole, to review the draft of project activities. As in Niger State, a list of data was drafted which state personnel would collect before the next JHU trip to Nigeria. Before leaving the country, meetings were held with John Nelson and Debbie Blum to review progress to date. Dr. Sulaiman was unavailable for a final meeting; however, a letter was left with his secretary summarizing the progress made by the team.

IV. ACCOMPLISHMENTS

The principal accomplishments of the trip were preparation of the work plan and timetable for the overall 18 month project and specifically for the financial situation analysis (FSA), the first major project activity. Both documents are appended to this report. The main activities include:

<u>Activity</u>	<u>Approximate Dates</u>
1. Preliminary visit to develop workplan and identity states	Feb. 22-March 27, 1987
2. Financial situation analysis (FSA)	Sept.-Oct. 1987
3. Prepare state pilot project proposals	Nov.-Dec. 1987
4. State project implementation	Jan.-Feb. 1988
5. Workshops: FSA Program budgeting	June 1988
6. Monitor/follow-up state projects	June 1988
7. Evaluate state projects Initiate FSA in two new states	Sept. 1988
8. Financial situation analysis	Nov.-Dec. 1988

Each of the project activities is explained in more detail in the appendices. FSA, the first major activity of the project, is briefly reviewed here. Its general objective is to provide state planners with a practical, up-to-date portrait of the current financing of the public health sector and identify critical gaps in the financing and planning of key public health sector programs. In addition, the process of doing the exercise should broaden state planners' awareness of the options available to them to improve

health care financing, as well as highlight which strategies may be most promising in the future.

Specific objectives of the FSA include:

1. Describe the organization of health sector financial planning and management at the state and LGA level, and review the existing state and LGA plans;
2. Estimate the financial value of money and material inputs to the public health sector in the state from all revenue sources;
3. Estimate the size and composition of all health sector budget centers (for both budgeted and actual expended amounts) in the state in terms of total value, capital and recurrent components, and, as far as possible, specific health programs;
4. Estimate the total and average cost of a few key public health programs of particular importance to the states such as EPI, ORT, leading to approximations of program budgeting;
5. Describe links between sources of revenue, budget allocations and disbursement of funds to implementing the facilities;
6. Prepare an FSA report with state planners based on 1-5 above, for review at a workshop for state and LGA senior staff;
7. Develop proposals for follow-up activities to the financial situation analysis based on the results of the workshop.

A wide range of activities is possible for the pilot projects which follow the FSA. Some may deal with well-defined, primarily short-run exercises in operations research or budgeting techniques. However, experiments in areas such as cost-recovery, decentralization of financial and management responsibilities, and reallocations between and within program budgets will necessarily be long-term activities over the life of the CCCD Project and will require additional data collection before they can be designed and implemented. For example, since the financial situation analysis in September 1987 will focus on the public health sector, it is likely that follow-up activities in Spring 1988 will be required to examine the size and nature of the private sector as well as household preferences for public versus private sector health services. In sum, the nature of the pilot project activities should be defined rather broadly to cope with the wide range of problems and possible solutions brought out during the financial situation analysis.

V. CONCLUSION

During the trip the team was able to accomplish all of the tasks initially proposed for the trip. Focus states were chosen. Counterparts at the federal and state levels were identified. A workplan for the scope and schedule of activities was drafted. It is important to recognize, however, that the workplan is necessarily vague since the specific issues, problems and potential solution areas in financial planning and management can only be

identified during the financial situation analysis. Basic data collection, review and discussion of the data is a prerequisite to determine the final course of action for this project component.

APPENDIX I: LIST OF CONTACTS

Federal Government

1. Dr. Kolawole - Primary Health Care Unit
2. Dr. Kayode - Special Assistant to the Minister of Health

Directorate of National Health Planning (Ikoyi)

1. Dr. A.B. Sulaiman - Director, (W): 684491, (H): 617323
 2. Mrs. Charity Ibeawuchi - Federal counterpart CCCD/FPM - 684063
 3. Richard Olaniyan - Coordinate state planning workshops
 4. Tony Isama
 5. Dr. Labiran
 6. Dr. Adelaja
- Federal representatives to State workshops

Directorate of Public Health (Onikan)

1. Dr. Smith - Director of Public Health
2. Dr. Sorungbe - Head of Epidemiology Unit
3. Dr. Odunsi - Chief of EPI Programs
4. Dr. Ewoigbokhan - Project Officer EPI, Niger State
5. Mrs. Henshaw - Director Health Education

CCCD Staff

1. John Nelso - CCCD Technical (H): 682440
2. Jason Weisfeld - CCCD/Kaduna, U.S. Consulate Kaduna
3-201070
UNICEF Kaduna - 210535
3. Dr. Isaac Egboja - PRITECH resident ORT Advisor, Onikan
4. Paul Litchfield - UNICEF/Bauchi

UNICEF

1. Mr. Idris - Chief of Health Section
2. David Bassioni - Primary health care
3. Alan Brody - EPI/ORT
4. Dr. Magan - EPI Officer
5. Mr. Bala - UNICEF/Kaduna
6. Dr. Alexa Malyavin - Project Officer

CCCD Consultants

1. Sandy Buffington - CDC, Training
2. Annie Boyt - CDC, Training
3. Carol Kozi - HEALTHCOM
4. Ab Gratima - HEALTHCOM
5. Mark Rasmusen - HEALTHCOM Director
6. Robert Hornik - HEALTHCOM (Annenberg School of Communication)
7. Michael Fry - PRITECH, ORS Supply Management
8. Debbie Blum - PRITECH

World Bank 616196, 616044
 Plot 1309A, Karimu Kotun St.,
 Victoria Island (near Eko Hotel)

1. Mrs. Khadijat Mojidi - PHN Specialist/Lagos
2. David Radel - PHN/Washington
3. Mead Over - PHN/Washington

World Bank Consultants

1. Robert Lermonth - Planning Assistance, Planning Workshop
2. Mr. Bellamini - Planning Workshop
3. Eleanor English - Data Collection, Sector Work
4. Prince Frank Akenzua - Data Collection, Sector Work, 832937
5. Dr. Kanagarantan "KK" - retired, former boss of Radel

Lagos State

1. Dr. Adekunle Desalu - Honorable Commissioner MOH
2. Dr. J.T. Somoye - Permanent Secretary MOH (01-964061)
3. Dr. Oluwole - Planning Officer, Medical Statistics Unit
- Old Secretariat Block 7
- Oba Akinjobi Street (opposite Police College),
Ikeja
4. Mr. Dada - Finance Officer MOH
5. Dr. (Mrs.) A.L. Tilley Gyado - Medical Officer of Health,
Shomolu
6. Dr. MYI Salami - Medical Officer, Lagos Mainland

Niger State

1. Dr. Inua - Honorable Commissioner
2. Dr. Susan Saba - Permanent Secretary 3-222427
3. Dr. H.M. Gambo - Principal Medical Officer 222779
4. Abdullah Etsu - Planning Officer
5. Mr. Mahmoud - State Ministry of Finance and Planning
6. Dr. Jonathan Jiya - Director SHMB
7. Dr. Halilu - Chief Medical Services SHMB
8. Mr. Bada M. Olukun - Project Coordinator UNICEF/Minna
9. Dr. Y.M. Sahittu - Project Manager, Water and Sanitation, UNICEF

Niger State (continued)

10. Hans Bumberger - Rural Hospital Consortium , Voest-Alpine/Minna, P.O. Box 10040 (223724, 223696)
11. Wolfgang Neuwirth - Rural Hospital Consortium, Voest-Alpine/Austria

Lagos University

Business Administration

1. Dr. J.O. Oni - Health Management Course Proposal
2. Dr. O. Akintola - Bello - Department of Finance

Economics Department

1. Prof. F.A. Alaluku - Chairman
2. Dr. R. Ubogu
3. Dr. O. Odufalu

Political Science

1. Dr. H.O.O. Coker

NISER (Nigerian Institute for Socio-Economic Research) - Ibadan

1. Dr. Moloye - Department of Economics

University of Ibadan

1. Dr. Ohiorhenuan - Department of Social Science/NIGER

Ford Foundation

1. Lilian Trager - 682469

Other

Guest House - 680813 Ikoyi
Eko Hotel - 615000 Victoria Island
U.S. Embassy - 610050
USAID - Keys McManus - Director
Larry Eicher - Assistant Director
Pat Nelson - Administrative Assistant
Becky Thompson - Embassy Administration
- Thesis - Lagos State Family Planning

APPENDIX II: CCCD FINANCIAL PLANNING AND MANAGEMENT

SCHEDULE OF ACTIVITIES AND PERSONNEL INPUT

1987

Activity	Personnel Input	Location	Dates	Team Members (# weeks)
1. Preliminary Visit: Identify states Develop workplan	2.00 pm	Nigeria	Feb. 22- Mar. 27	PB, AW (3) (5)
2. Financial Situation Analysis (FSA)				
- Preparation	1.50 pm	JHU	August	AW, SG, WR, IS, OC (2) (1) (1) (1) (1)
- Nigeria	4.00 pm	Nigeria	Aug. 31- Oct. 9	AW, SG, WR (6) (6) (4)
3. State Project Proposals				
- Preparation	0.75 pm	JHU	November	AW, WR, (2) (1)
- Nigeria	1.75 pm	Nigeria	Nov. 29- Dec. 18	AW, WR, PB (3) (3) (1)
TOTAL	10.00 pm			8 trips

By Person:

PB: 1.00 pm 2 trips P. Berman
 AW: 4.50 pm 2 trips A. Wouters
 SG: 1.75 pm 1 trip S. Goings
 WR: 2.25 pm 2 trips W. Reinke
 IS: 0.25 pm 0 trips I. Sirageldin
 OC: 0.25 pm 0 trips Outside Consultant (possibly Marty Makinen - MM)

May 21, 1987

1988

Activity	Personnel Input	Location	Dates	Team Members (# weeks)
4. State Projects Implementation				
- Preparation	1.25 pm	JHU	January	AW, SG, WR, IS, OC (1) (1) (1) (1) (1)
- Nigeria	1.50 pm	Nigeria	Jan. 30- Feb. 19	AW, SG (3) (3)
5. Workshops				
- Preparation	0.75 pm	JHU	May	AW, SG, WR, (1) (1) (1)
- Nigeria (FSA, Program Budgeting, Operations Research)	1.75 pm	Nigeria	May 30- June 11	AW, SG, WR, PB (2) (2) (2) (1)
6. Monitor/Follow-up State Projects	1.00 pm	Nigeria	June 11- June 18	AW, SG, WR, PB (1) (1) (1) (1)
7. Evaluate State Projects, Initiate FSA in 2 New States				
- Preparation	0.75 pm	JHU	August	AW, WR, IS (1) (1) (1)
- Nigeria	2.25 pm	Nigeria	Aug. 29- Sept. 18	AW, SG, WR (3) (3) (3)
8. Financial Situation Analysis				
- Preparation	0.50 pm	JHU	November	AW, WR (1) (1)
- Nigeria	2.25 pm	Nigeria	Nov. 28- Dec. 18	AW, SG, WR (3) (3) (3)
TOTAL		12.00 pm		12 trips

By Person:

AW: 4.00 pm 4 trips A. Wouters
 SG: 3.50 pm 4 trips S. Goings
 WR: 3.25 pm 3 trips W. Reinke
 PB: 0.50 pm 1 trip P. Berman
 IS: 0.50 pm 0 trips I. Sirageldin
 OC: 0.25 pm 0 trips Outside Consultant (possibly Marty Makinen - MM)

May 21, 1987

Schedule of Activities

Activity	1987																				1988			
	August (week)				September (week)				October (week)				November (week)				December (week)				January (week)			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
2. Financial Situation Analysis																								
- Preparation--JHU																								
- Nigeria																								
3. State Project Proposals																								
- Preparation--JHU																								
- Nigeria																								
4. State Project Implementation																								
- Preparation--JHU																								

1988

Activity	February (week)				March (week)				April (week)				May (week)				June (week)				July (week)			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
--Nigeria	_____																							
5. Workshops																								
- Preparation--JHU																								
- Nigeria																								
Financial Situation																								
Analysis, Program																								
Budgeting, Operations																								
Research																								
6. Monitor/Evaluate State Projects--Nigeria																								

Activity	1988																				1989			
	August (week)				September (week)				October (week)				November (week)				December (week)				January (week)			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
7. Evaluate State Projects Initiate Financial Situation Analysis in 2 New States																								
- Preparation--JHU				—																				
- Nigeria					—	—	—	—																
8. Financial Situation Analysis																								
- Preparation--JHU															—	—								
- Nigeria																	—	—	—	—				

DRAFT
P. Berman
A. Wouters
March 12, 1987

WORK PLAN FOR THE FINANCIAL PLANNING AND MANAGEMENT COMPONENT OF THE CCCD PROJECT

Introduction and Justification

This document presents an initial work plan for the financial planning and management (FPM) component of the Combatting Childhood Communicable Diseases (CCCD) Project in Nigeria. The Government of Nigeria has embarked upon a set of ambitious public health programs, including the CCCD-assisted EPI, ORT, and malaria control activities. These programs have been initiated despite the serious financial constraints faced by the public sector since the early 1980s.

The CCCD Country Assessment done in preparation for the project expressed concern about the capacity of the public sector to sustain these new programs. Recurrent cost budgets have been substantially reduced in recent years, leaving few resources for operating expenses. Capital budgets have also been cut, suggesting that replacement of equipment and vehicles, such as those required for EPI, may be difficult. While special allocations from state and LGA governments have provided essential interim support for key programs, it is unclear to what extent these can be relied upon in the future.

The FPM component has been formulated to focus some CCCD resources on increasing understanding of these issues and developing strategies for financial sustainability of health programs. A basic premise of this activity is that the financing of some key public health programs cannot be isolated from the overall financing issues of the public health sector. Thus, the activities described below will touch on a wide range of financing issues, although the ultimate objective is to strengthen the capacity of states and LGAs to plan, finance, and manage priority programs, including those supported through CCCD.

Objectives

The overall objective of this component is to strengthen state and local government area (LGA) capacity financially to sustain key public health programs. Within this goal, the following specific objectives are proposed:

1. To provide state and LGA planners with a practical portrait of the revenues, budgets, costs, and estimated financial needs of the public health sector in general, and specific maternal and child health programs in particular;
2. To identify and implement interventions which: (A) reduce costs and increase productivity in existing programs to make program goals more affordable and (B) generate new sources of funds to support public health programs;
3. To improve the skills of state and LGA planners in financial planning and management and to disseminate knowledge and skills gained in focus states to other states in the federation.

Outline of Project Activities

Three sets of activities are proposed for this project, corresponding to the three specific objectives above. These are:

- o In-depth financial situation analyses (FSA) at state and LGA level
- o Development, implementation, and evaluation of project experiments to improve service efficiency and to generate funds as identified from the FSA
- o Training courses and workshops for state and LGA planners to improve skills and disseminate project results for implementation in other areas.

The FPM component will have two phases. In Phase I, covering approximately the first two years of the project, these activities will be initiated in two states representing two of Nigeria's four zones. In Phase II, an additional two states will be selected representing the other two zones. Each activity is described in more detail in the following sections.

Financial Situation Analysis

The health sector financial situation analysis is proposed as an initial step towards strengthening state and LGA financial planning and management. The exercise will provide state and LGA planners with a practical up-to-date portrait of current financing of the public health sector. It will also identify critical gaps in financing and planning of programs and provide cost estimates to facilitate program budgeting and financial planning. A detailed protocol for this activity is given in Appendix I.

The first step in the FSA is to develop estimates of the total resources available to the public health sector in the states. This will be done in two parts. In part one, the financial value of all revenue in terms of its sources will be estimated. For example, state programs are supported by funds from the statutory allocation, direct grants from the FMOH, and by funds generated by state and LGA taxation. In part two, resources will be described in terms of their location in health sector budgets. For example, the State Ministry of Health (SMOH), the State Health Management Board (SHMB), and LGA Health Departments each have budgets, which may be funded from a variety of revenue sources. This type of analysis has already been done successfully in the preparation of the Ogun State Health Plan and we have adopted some of these approaches in our protocol for FSA.

The next step in the FSA is to estimate the total costs and utilization of specific health programs and facilities, such as primary curative care, EPI, MCH, etc. This may only be possible to a limited extent from available data, and will require some data collection in LGAs. It will be important to distinguish capital costs from recurrent costs, and within recurrent costs to identify personnel, expendables, transport, and supervision and support inputs.

These data on revenue sources, budgets, program costs and output should be linked as far as possible to identify which funds are ultimately supporting which programs. Also, this will help identify funding gaps for specific programs.

The data on program costs and utilization will support program budgetting, linking output targets to future budget requirements. It may be difficult to achieve ideal results with available data, but the attempt will be enlightening for state and LGA planners.

Based on these materials, a FSA report will be prepared for the state. This report will highlight key issues in financing overall and specifically in the support of public health programs. This report will be reviewed by state and LGA planners and decision makers in a two-day workshop in each state. An important objective of this workshop will be to identify strategies for solving some of the problems and propose field experiments, operational research (OR), and studies to test solutions.

Development, Implementation, and Evaluation of Project Experiments

Strategies for addressing the problems identified in the FSA will focus mainly on improving the efficiency of program implementation and generating new sources of revenue to support programs. These strategies will be translated into project

proposals for funding through operational research, project studies, and technical assistance. These proposals will be forwarded to the CPOD implementation team in the FMOH.

Thus, this second set of activities will consist of proposal development, implementation of projects, and their evaluation. The specific content of these proposals must await the results of the FSA and be determined by the state and LGA governments concerned.

Training Courses and Workshops

The FPM component seeks to improve the skills of state and LGA planners and to disseminate successful innovations to other states. At this time, one can envisage several workshops and training activities likely to be implemented.

The FSA will have a strong training component. A working group will be formed at the state level and substantial outside consultant time will be devoted to collaborating with this group. The state workshops to review the FSA results will also provide an opportunity for technical review and discussion of financing strategies for the states.

If the FSA proves relatively straightforward and useful, we would propose a 3 day workshop for the other states. Officers from the FSA states would present the methodology and results of the initial exercise. Ideally, guidelines can be prepared for other states and they would be able to do a similar FSA on their own. The results of such analyses for a large number of states would be useful for both state and national planning.

Program budgetting is getting increasing attention from the Federal ministry as a planning tool. The FSA results will provide the material for developing a methodology for costing and program budgetting for EPI and other programs. This could also be developed into a topic for a workshop for state EPI managers, to enable them to use these techniques for budget preparation. Following such a workshop, states could undertake their own program budgetting exercises based on their own data.

Following completion of the first set of operational research studies and financing experiments, an additional workshop to present OR methodology and results should be considered.

At the end of Phase II, zonal workshops should also be planned to disseminate results from component activities in all four states and to develop a plan for extending these activities to the other states.

Other topics for training and workshops need to be discussed with the Federal ministry and CCCD project personnel as interests and need arise.

Institutional Links

All activities under the FPM component will be done primarily by staff of the state ministries of health in collaboration with selected LGAs in each state. Technical and possibly some financial support will be provided by FMOH and CCCD, the latter through consultants from Johns Hopkins and local institutions.

The FMOH base for this activity is the the Directorate of National Health Planning and Research. The directorate has identified a counterpart at the federal level to coordinate component activities at all levels of government.

Each state included in this component will identify a local counterpart, preferably a senior planning officer to assist in making contacts with various state agencies and to coordinate the state working group. Other state counterparts may be identified as needed. Formal contacts will be needed with the state ministries of finance and planning, local government areas, and the health management board.

As required, local consultants and data assistants may be hired. As far as possible, this will be done within each state in collaboration with state counterparts.

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P. Berman
A. Wouters
March 12, 1987

Appendix I
DRAFT PROTOCOL FOR STATE-LEVEL HEALTH SECTOR
FINANCIAL SITUATION ANALYSIS

Introduction and Conceptual Framework

The first activity proposed for the financial planning and management component of CCCD in collaborating with focus states is a health sector financial situation analysis (FSA). This draft protocol outlines some of the concepts supporting this approach, details some of the data requirements, and suggests how the results of the FSA can be used.

The primary concern of this component of CCCD is to improve government capacity to assure financial support for public health interventions to reduce child morbidity and mortality during and after the project is completed. However, financing of health programs is a problem for the whole public health sector -- not just a few programs. For example, recent analysis in Ogun State show that 98 percent of all recurrent costs in health went to salary support in 1984, leaving little for the other inputs required for health services. Since this problem affects all programs, dealing with the financing of some programs must begin with an assessment of the financial situation of the state public health sector overall.

Financial planning should be based on measuring and comparing two basic components: the financial resources needed for implementing desired programs and the financial resources available for supporting these programs. Both of these items include both present and future finances. A primary and critical problem in financial planning for health in Nigeria is the simple lack of information on the magnitude of both of these quantities: needs and resources. This is true for specific programs, like EPI, and for the sector as a whole.

If there is no gap between finances needed and available, or if available funds exceed those needed, lack of financial resources is not a problem. In such cases, financial planning consists mainly in assuring that funds are available at the right time and in the right form, or in figuring out how to spend excess funds or how to reduce the amount of money available.

The main problem in Nigeria today is not excess finances but rather inadequate funds to support key programs. In other words, there is a financing gap. Financial planning should first identify the size of that gap currently and into the future. There are then a limited set of options for what can be done to deal with the gap. These fall into three categories: generation

of new funds to support health programs; reallocation of existing funds amongst health programs, i.e. reducing some programs to eliminate the gap; and improving the efficiency of program operations to reduce costs, thereby reducing the gap.

All of these options can be translated into a wide range of specific strategies and interventions for government. They all have positive and negative aspects which must be carefully weighed in selecting strategies. The proposed FSA seeks to assist state planners to estimate financial needs, resources, and gaps and to identify promising strategies for improving the financing of their programs.

The overall problem described above is daunting, especially given the lack of adequate data on program costs (which affect financial needs) and resources available to state health programs. The financing of the public sector in Nigeria is complicated. Federal, state, and local governments all raise and spend funds separately, with programs coordinated by a variety of formal and informal mechanisms. We have tried to develop a framework for organizing these different parts to help with a more coherent analysis.

One can identify three inter-related components of public health sector financing in Nigeria. We have called these revenue centers, budget centers, and activity centers. Because of its federal system, the relationships amongst these three aspects are particularly complex in Nigeria. This has made thorough analysis of health sector financing and program costs difficult.

Revenue centers are the sources of financial and material inputs to the public health sector. This includes such items as the federal statutory allocations to state and LGA treasuries; state tax-generated revenue; and users fees where they exist. Knowing the magnitude and composition of resources from different revenue centers provides insight into the relative role of federal, state, and LGA governments and households in health care financing.

While resources originate in revenue centers, they are spent on health programs from budget centers. For example, the State Ministries of Health, the State Health Management Boards, and LGA Health Departments each have clearly demarcated budgets for health. These budgets may be funded from a variety of revenue centers and include a variety of line items which support specific programs as well as general administration and back-up services. Analysis of budget centers identifies which agencies control expenditures on programs and provides some information on how these resources are allocated.

Budget centers expend resources through activity centers, which implement the actual health programs or provide the support services. For example, EPI is implemented by hospitals and peripheral health facilities which are distinct operational units. These units may be owned by federal, state, or LGA

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governments, but they may receive resources from a variety of budget centers. Similarly, the Epidemiological Unit in the State Ministry of Health contributes to EPI implementation, but mainly through support services. In addition, not all resources are earmarked for specific programs. For example, personnel may not be assigned to only one program, but rather work in a particular facility on several programs. This is true at the facility level as well as for state administrative staff.

For the purpose of financial planning, what is required is program budgeting: that is, estimation of the financial resources needed for each program at desired levels of activity. This is often done using a model of program operations, as in the national costing of EPI. However, this approach is made more realistic when combined with cost studies of the actual program at the activity centers, linking real resources with the programs they serve under field conditions. An added benefit of analysis at the level of activity centers is data on the real allocation of resources and the information needed for assessing program efficiency.

Figure 1 presents a schematic diagram showing most of the revenue, budget, and activity centers typical of Nigeria's public health system. We have included some connecting lines as examples indicating the flow of resources from revenue to activities. In fact, the network of flows linking these centers is much more complicated than we have shown.

Objectives of the FSA

Drawing on this framework, we propose that states do a FSA to identify as best they can the resources available to them and at least some of their priority financial needs related to programs. The overall objective is to provide state planners with a practical, up-to-date portrait of the current financing of the public health sector and identify critical gaps in the financing and planning of key public sector programs. In addition, the process of doing this exercise should broaden state planners awareness of the options available to them to improve health care financing as well as highlight which strategies may be most promising to pursue.

Specific objectives of the FSA include:

1. To describe the organization of health sector financial planning and management at the state and LGA level and to review the existing state and LGA plans;
2. To estimate the financial value of money and material inputs to the public health sector in the state from all revenue centers;

3. To estimate the size and composition of all health sector budget centers (for both budgetted and actually expended amounts) in the state in terms of total value, capital and recurrent components, and, as far as possible, specific health programs;
4. To estimate the total and average costs of a few key public health programs of particular importance to states such as EPI, communicable disease control programs, maternal and child health, etc., leading to approximations of program budgetting;
5. To describe links between revenue, budget, and activity centers for these specific programs;
6. To prepare an FSA report with state planners based on (1) through (5) above, for review at a workshop in the state for senior state and LGA staff;
7. To develop proposals for improvements to financial planning as well as for experimental projects to improve the financing of key programs, based on the results of the workshop.

Data Requirements

Much of the detail of the data needed for the FSA must be determined from what is available in the states and the specific interests of state and LGA planners. We have developed some examples here of the types of data needed and their presentation.

Data requirements for FSA can be divided into three parts: contextual information, revenue and budget analysis, and program cost and utilization analysis. First, a variety of background data on the social, economic, and demographic characteristics and health sector physical resources should be assembled. Most of this information will simply be collated from what is available from state statistical reports and available surveys and studies. Table 1 provides a list of the kinds of data that could be assembled.

The second part focuses on the revenues and budgets available to the public health sector. Table 2 presents a summary table showing revenue centers as the rows (listed on the left) and different sectors of government activity related to health as the columns. Our main interest is in the rightmost column of "Totals" for each revenue center (to show the relative magnitude of the different sources of revenue) and the column "Health" to show the total resources available for the sector and their approximate distribution amongst the various sources. The "other" category as a revenue center might include such things income from a drug revolving fund, special user fees, etc. If possible,

it would be helpful to assemble these data for several recent years, to show trends in resource availability. Separate accounts may be required for state and LGA revenues.

A next step in this analysis is shown in Table 3. The revenues described in Table 2 are allocated to different budget centers, as shown in the leftmost column of Table 3. The budget centers consist of annually budgetted amounts for capital and recurrent budgets. The amounts finally spent are often different from those budgetted, and are perhaps more significant for financial planning. For the LGA level budget centers, estimates might be obtained from a few sample LGAs and extrapolated to the state as a whole. Again, it would be useful to obtain breakdowns from several previous years.

Table 4 draws again on data from budget centers, although our main concern is with actual expenditures that can be attributed to specific health programs. The actual health programs should be chosen collaboratively with the states. Not all expenditures will be directly attributable to a specific health program. These expenditures should be totalled under "Unattributable Expenditures". We have little doubt that this will account for a large part if not a majority of spending. But it will still be useful to see what part of spending can be attributed to specific programs and to see what is initially judged as "unattributable".

These three tables summarize much information that will have been derived from more detailed sub-analyses. We have not tried to append all the component tables that may need to be developed to arrive at these final outputs.

The program cost and utilization analysis -- part three of the data requirements -- will be drawn mainly from the level of activity centers. Specifically, we envisage sampling about three LGAs in a state for a detailed assessment of program costs and utilization. Again, the programs to be analysed should be worked out with state counterparts. Coming from CCCD, we would certainly suggest breaking out the costs of at least EPI and possibly other communicable disease control programs. Table 5 presents an example of a summary table for program costs. Completing this table will probably require a cost analysis of individual health facilities in the sample LGAs, including allocation of staff time across health programs. We have developed some feasible methods for doing this in other countries, which can hopefully be adapted to Nigerian conditions.

Table 6 presents a summary table of data on program outputs or utilization to be collected from the sample LGAs. Again, this will probably require data collection at individual facilities. The overall utilization of health facilities for each health program will be examined. Utilization of private and public facilities for each type of service should be assessed as far as is possible in the field.

Results

We expect to develop a FSA state report from these data. At the least, this report will show the resources available to the health sector in the state, the role of different agencies and levels of government in spending those resources, some indications of resource allocation across health programs in current budgets, some indicative program budgetting for certain key programs, and estimates of financial needs for those programs from state and LGA budgets compared with current spending levels. This report will be prepared collaboratively with state counterparts.

The report should be presented to senior state and LGA officials at a 1-2 days workshop held at the state capital. The report and presentation will focus attention on specific financing needs of the state and LGAs. The discussion should address how to set priorities amongst those needs and potential strategies for meeting them.

Institutional Links and Timing

The FSA will be done initially in two states. The exercise should be based at the State Ministry of Health and coordinated with selected LGAs in the state. The SMOH will appoint a team of three staff, with one of them as team leader. They should include the SMOH senior planning officer.

A counterpart from the Federal Ministry of Health, Directorate of National Health Planning and Research will also be assigned to participate in this activity. Technical support will come from the FMOH and the CCCD consultants from Johns Hopkins University.

At the state level, formal contacts will be needed with the State Ministry of Finance and Planning, the State Ministry of Local Government, and the State Health Management Board. These groups could also be invited to participate fully in this exercise.

Within each state, three LGAs will be selected for detailed assessment of program costs and utilization. A senior health officer involved in planning from each LGA should be identified as a collaborator.

Local consultants and data assistants will also be sought as required. As far as possible, this should be done within each state in collaboration with state counterparts.

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The FSA is planned to be initiated during the summer months of 1987, possibly June - July. It may be continued into the Fall if additional time is needed. Final workshops in each state should be held by July, 1987 if the exercise can be completed, but no later than December, 1987.

Figure 1

CONCEPTUAL FRAMEWORK: Revenue, Expenditure, Budget Centers

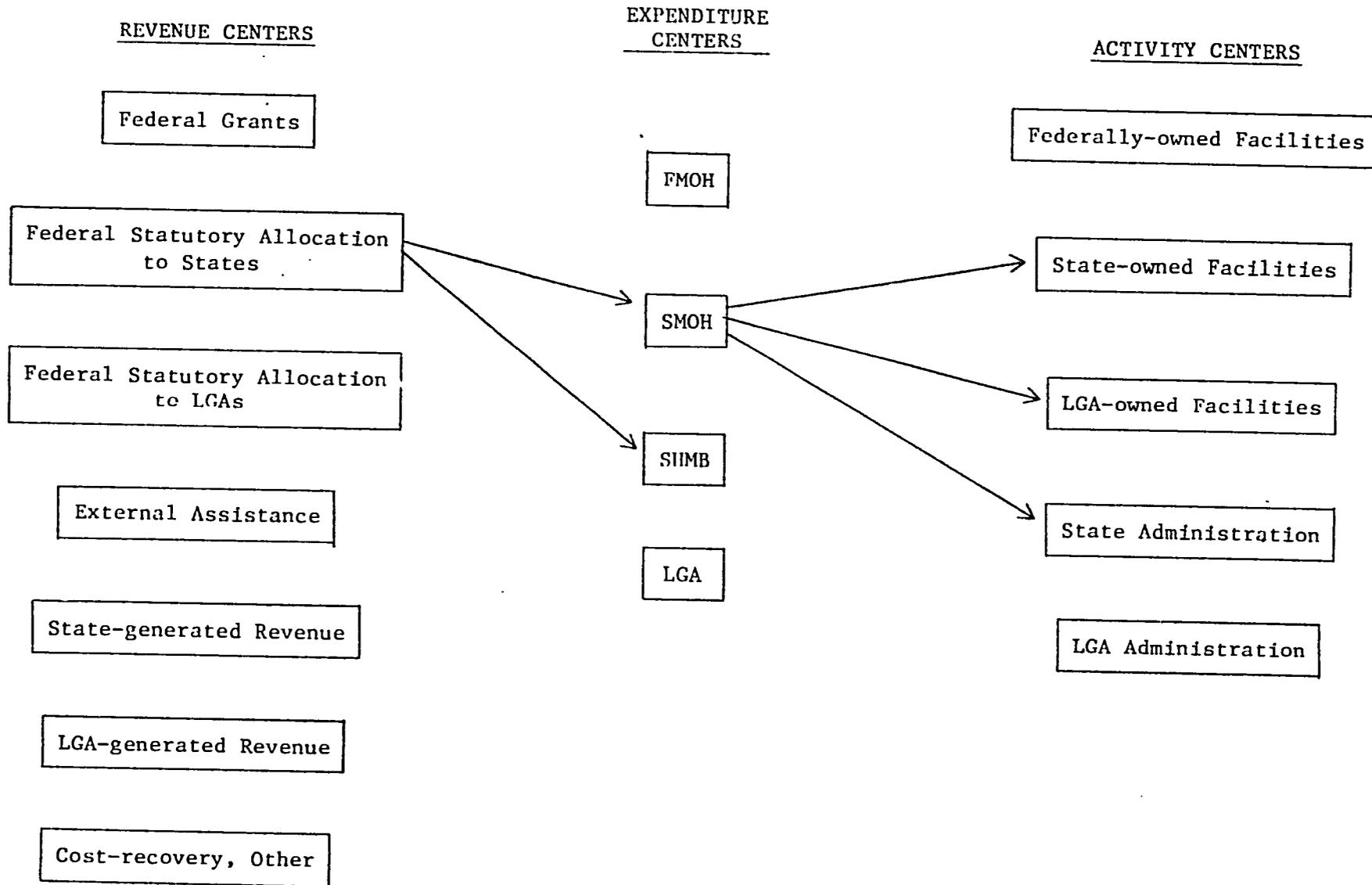


Table 1

SUGGESTED BACKGROUND DATA

- Population estimates by LGA, age, sex, urban/rural
- Health facilities by LGA, type, ownership
- Health personnel by LGA, place of posting, employer
- Map of state with main health facilities
- State coverage data for MCH, EPI, key disease control programs (from facility reports)
- Diagnosis rates from facility reports
- Estimation of total facility utilization by hospitals, health centers, dispensaries for curative services (from available reports)
- Existing socio-economic, household expenditure and household health care utilization survey data/reports and copies of survey instruments
- State economic data: occupations, main products, income distribution
- Relative fees and drug costs at different facilities/outlets
- Institutional framework for health planning
- Previous planning exercises

Table 2

SOURCES OF PUBLIC HEALTH SECTOR REVENUES BY SECTOR*

Sources of Revenue	Health Sector		Non-health Sector	
	(estimated)	(actual)	(estimated)	(actual)
<u>State Level</u>				
Federal-tied grants				
Federal statutory allocation to state				
State-generated revenue				
Others**				
<u>LGA Level</u>				
Federal-tied grants				
Federal statutory allocation to LGA				
LGA-generated revenue				
Others**				

*actual revenues for 1985, 1986, projected for 1987
 **give details

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Table 3

TOTAL FINANCIAL RESOURCES FOR PUBLIC HEALTH SECTOR IN THE STATE*

BUDGET SOURCES	CAPITAL		RECURRENT	
	<u>Approved</u> Estimate	<u>Actual</u> Expenditure	<u>Approved</u> Estimate	<u>Actual</u> Expenditure
FMOH grants to states				
FMOH aid-in-kind to states				
External Aid to states				
SMOH				
SHMB				
LGAs**				
Cost-recovery				
Other sources				
TOTALS				

*To be completed for 1984, 1985, 1986

Table 4

EXPENDITURES ATTRIBUTABLE TO SPECIFIC HEALTH PROGRAMS* BY SOURCE OF BUDGET**

BUDGET SOURCES***	EPI		ORT		MCH		FP		Others		Unattributable Expenditures	TOTAL
	D	I	D	I	D	I	D	I	D	I		
FMOH Grants												
FMOH aid-in-kind												
External aid												
SMOH												
SHMB												
LGAs												
Cost-recovery												
Other												
TOTALS												

*Program categories to be determined by states

**To be completed for 1986

***D = Directly attributable, I = Indirectly attributable (methodology in appendix)

1/2

Table 5

ESTIMATES OF TOTAL COSTS OF SPECIFIC PRIMARY CARE PROGRAMS*

COST COMPONENTS	PROGRAMS					
	EPI	ORT	MCH	FP	Others	TOTAL
<u>Capital**</u>						
Buildings & land						
Vehicles						
Equipment						
<u>Recurrent</u>						
Personnel (direct)						
Supplies						
Operation/Maintenance						
Support Costs						
TOTAL						

*From sample of up to 3 LGAs in state

**Annualized replacement cost of capital

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Table 6

HEALTH PROGRAM UTILIZATION IN SELECTED LGAs--1986

Type of Facility	EPI	ORT	MCH	FP	Other
<u>Public</u>					
Hospital					
Basic Health Center					
Community Health Center					
Dispensary					
Other					
<u>Private (if possible)</u>					
Clinics					
Maternity					
Other					
TOTALS					
Estimated Target Population					
Rate					