Discussion Paper for Jigawa Health Purchasing Refinements and Potential Budget Support

January 2013

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The Partnership for Transforming Health Systems Phase Two (PATHS2) is a six year development initiative that aims to ensure Nigeria achieves important health-related Millennium Development Goals.

Funded by UKaid from the DFID, PATHS2 is working in partnership with the Government of Nigeria and other stakeholders, to improve the planning, financing and delivery of sustainable health services for those most in need. In addition to its work at the Federal level, PATHS2 programme is implemented in five states of Enugu, Jigawa, Kano, Kaduna and Lagos. PATHS2 follows the successful PATHS, which was implemented from 2002 to 2008.

PATHS2 is managed by Abt Associates Incorporated USA, in association with Options, Mannion-Daniels, and Axios Foundation.

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Discussion Paper for Jigawa Health Purchasing Refinements and Potential Budget Support

(Also includes questions to initiate dialogue on health purchasing supporting service delivery improvements in Kaduna/Kano/Enugu and at Federal Level)

I. INTRODUCTION

Pro-poor service delivery improvements can't be achieved without better targeting of budget funding to free or highly subsidized MNCH services. Conversely, replication and sustainability will be increased by ensuring that service delivery interventions are designed, developed and implemented directly linked to and consistent with health financing and governance improvements. The purpose of this technical activity is to support federal and state partners to develop relevant questions, gather information, engage in dialogue and develop proposals to refine or improve health purchasing mechanisms contributing to pro-poor service delivery improvements by targeting funding to free or highly subsidized MNCH services

This discussion paper is based upon the three health financing functions of revenue collection, pooling and purchasing. Revenue collection is the source and level of funds, pooling is the accumulation of prepaid revenues on behalf of a population and purchasing is the transfer of pooled funds to providers on behalf of a population.[1] As the focus is health purchasing, the paper is organized by purchasing, followed by health purchaser and other governance issues, pooling and revenue collection. Linkages or relationships between the three health financing functions is a priority throughout.

II. HEALTH PURCHASING

A. What to Purchase?

What to purchase is usually a benefit package or other definition of benefits and services that the population is entitled to receive under a health programme of any type. This discussion paper does not address benefit packages or costing of benefits or services (another PATHS2 activity is working on it) but rather focuses on how to spend existing funding most efficiently and effectively.

A basic assumption is that there is only one comprehensive benefit package although the benefits or services may be purchased using different mechanisms or provider payment systems. In other words, there is not a series of separate or vertical benefits, services or programmes but rather one comprehensive benefit package containing all benefits, services or programmes purchased using appropriate provider payment systems.

[1] WHO/EURO/Joe Kutzin; Health Financing Policy: A Guide for Decision-Makers; 2008

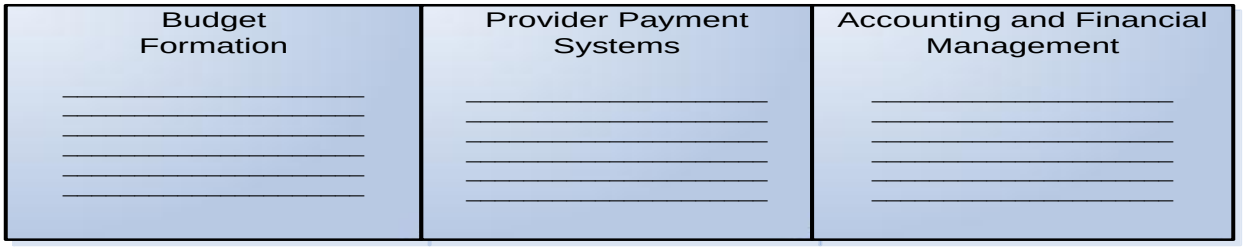
B. How to Purchase?

1. Relationship Between Budget Formation, Provider Payment Systems, Accounting and Financial Management[2]

Although not an academic concept found in the literature, this consultant's practical observation is the health purchasing function can be further divided into ***three health purchasing sub-functions***: budget formation, provider payment systems, and accounting and financial management. Within these three sub-functions, there are two main options for health purchasing differentiated by two parameters, the level of variation across sub-functions and use of line items. The two options are described and illustrated below.

Sub-Functions Not Separated

In this option portrayed in the figure below, the basic mechanism does not vary across the three sub-functions. Not true by definition but often the mechanism is a line-item budget used to form the budget, pay providers and perform accounting and financial management. In general, the Ministry of Finance and Ministry of Health form the total health budget based on line-item budgets for health facilities, pay the health facilities under the same line-item budget provider payment system, and maintain accounting and financial records. The Treasury System usually functions by setting a fixed line item budget for each health facility and then allocating funds according to this fixed line item budget as the country's available cash allows. Line items such as salaries, social taxes, utilities, supplies, food, travel, equipment apply to all three sub-functions.



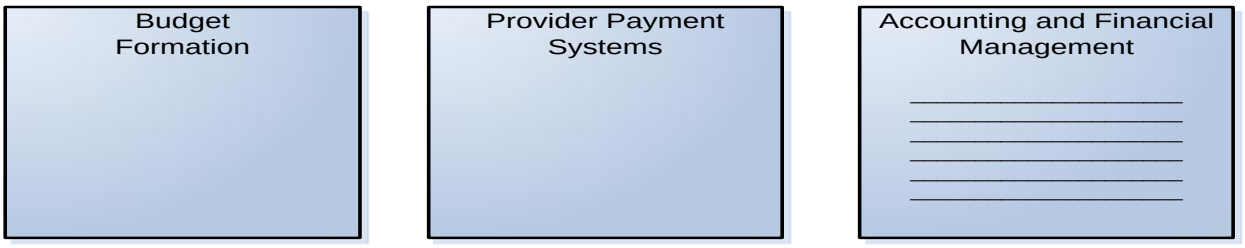
Sub-Functions Separated

In the second option portrayed in the figure below, the basic mechanism varies across the three sub-functions. Methodologies and systems used to form the budget, pay providers and perform accounting and financial management are closely related but different. Budget formation can be performed by setting the total health budget as a percent of total government expenditures, budget standards or normatives, developing and aggregating facility budgets, costing benefits packages, or some combination of these methodologies. Provider payment can be performed by line-item budgets, global budgets, fee-for-service, per capita, case-based or some combination of these systems. Contrary to budget formation

[2] Partnership for Reviving Routine Immunisation in Northern Nigeria: Maternal Newborn and Child Health Initiative (PRRINN-MNCH) two reports entitled "Technical Support for the Funding Flow Mechanism of the Gunduma Health System in Jigawa"

- Background reading included this PRRINN-MNCH report which is good but focuses on PFM and doesn't include health purchasing mechanisms or provider payment systems.

methodologies and provider payment systems, and consistent with international best practice, there is much less variation in methodologies or systems for accounting and financial management as they are governed by accounting standards and standardized financial reports and financial management procedures. Separating the three sub-functions can also include variation across budget line items. Budget formation and provider payment without line items may help achieve objectives related to improving efficiency, determining optimal mix of resources, quality improvement and provider autonomy. There is no line item variation in accounting and financial management as by definition accounting and financial statements portray expenses by line item or chart of accounts.



General Discussion of Options

The two options can be characterized as the convergence of health financing and public finance management (PFM) disciplines. Not separating the three sub-functions tends to be more traditional PFM practice and separation of the three sub-functions is both health financing and PFM-oriented. It's not clear exactly how this dichotomy developed but it's likely due to differences in the natural extension of general business practices by PFM experts and recognition of the unique aspects of health financing by health financing experts. A sampling of the unique aspects of health financing differentiating it from most other businesses or products includes:

- Market condition issues such as asymmetrical information or externalities (not elaborated as paper focuses on finance and payment rather than health economics)
- Insurance function requiring risk pooling, reserves, etc.
- Uncertainty or unpredictability in the type and level of health services and costs:
  - In total due to disasters, epidemics, disease incidence, etc.
  - Across levels of the health system, for example, the health service delivery objective of shifting patient care from hospitals to PHC
  - Facility level inability to prospectively determine how many services or products it should or will produce. Programme level expenditure caps can be more appropriate for health than facility level expenditure caps as they allow health facilities to be paid for the services they provide while also ensuring fiscal controls or budget neutrality at the health programme level.

In addition to the general health financing aspects discussed above, there are also factors specific to each country environment that should be encompassed in health purchasing decisions. What country problems should be addressed? What are the policy objectives and the best instruments available to achieve them? Which provider payment systems provide the desired financial incentives? Is increased provider autonomy or improved provider management an objective and if so how best to achieve it?

2. Key Health Purchasing Objective in Nigeria and Jigawa Experience

Key Health Purchasing Objective in Nigeria

The line-item budget provider payment system currently being used in Nigeria usually works best in a mature health system not undergoing significant reform, with the number, structure, and role of health facilities determined and funding sufficient to pay for all health services defined in the benefit package. In the Nigerian context, one of the main problems is health budget funding is not sufficient and out-of-pocket payments are very high. To address this problem, a key health purchasing objective is targeting payment to services used by individuals rather than to health facilities or buildings. In other words, if the health budget level is not sufficient to pay for all services for all individuals, to make sure the needs of the poor are covered payment should be made for specific populations and prioritized services rather than entire health facilities or buildings. The main factor is the ***definition of the product or unit of service*** – it's not a health facility or building and all services provided within it, it's an individual person and the health services they require. Therefore, the separation of three sub-functions option may be more appropriate and the budget formation methodology different than the provider payment system. In summary, a provider payment system denominated in individual person units of service not health facilities or buildings is required to achieve pro-poor service delivery improvements by enabling targeting of funding to free or highly subsidized MNCH services for the poor.

Importance of Jigawa Experience

Jigawa has developed a mixed model that includes both no separation of the three health purchasing sub-functions (line item budget provider payment system) and separation of the three health purchasing sub-functions (fee-for-service provider payment system). Importantly, the Jigawa experience provides ***evidence that Nigeria's PFM systems are flexible*** enough to improve health purchasing by allowing implementation of new output-based health provider payment systems. This evidence that PFM and health purchasing systems can co-exist, converge or leverage each other's comparative advantages comes from the Jigawa experience in using a fee-for-service provider payment system to pay providers under the Deferral and Exemption (D&E) programme. Consistent with the assumption above, the D&E programme provider payment system does not fund a different or separate benefit package but rather uses a provider payment system containing desired financial incentives to reimburse for a portion of the services contained in the benefit package. These new provider payment systems can help achieve pro-poor service delivery improvements by enabling targeting of funding to free or highly subsidized MNCH services. In addition, the mixed model allows development partner investment in direct budget support as systems already exist to directly target specific priority populations and services.

3. Next Steps in Provider Payment System Design and Funds Flow to Providers[3]

[3] Discussion informed by:

- PATHS2 reports "Public Expenditure Management Review of Kaduna State" in August 2011 and "Jigawa State's Free Maternal and Child Health Programmes: Costing and Program Assessment" in December 2011.
- Workshop with Jigawa state partners in July 2012.

This section focuses on questions related to next generation refinements or improvements and is intended to inform policy dialogue or a workshop to initiate development of these refinements.

Refinements of Existing Provider Payment Systems

As described above, Jigawa has developed and implemented an innovative fee-for-service provider payment system for the D&E portion of its benefits package. It contributes to achieving pro-poor service delivery improvements by targeting funding to free or highly subsidized MNCH services, and also functions within and contributes to improvement of PFM mechanisms.

Questions for information gathering and discussion on how Jigawa could refine the D&E fee-for-service provider payment system:

- How has the Gunduma Health System Board assessed the performance of the D&E fee-for-service provider payment system? Has it performed well and achieved results?
- Should changes in fee calculation methodology be considered? For example, shifting from actual costs to relative weights to help ensure functionality for any total budget amount, ability to prioritize services, desired proportion of payment for specific services, etc.?
- What portion of D&E fee-for-service provider payment goes to PHC, hospitals and other providers? Is there any evidence of shifting funding from PHC to hospitals due to the greater ability of hospitals to generate revenue from procedures and tests? What portion of the funding do you want to go to PHC? Can the provider payment system be refined to better target and improve PHC services?
- How should provider payment systems link? Are there issues with conflicting incentives?
  - Between different provider payment systems or programmes within the overall benefit package? Line item budget, D&E fee-for-service, NHIS/MDG payment systems?
  - Between PHC and hospital payment systems? For example fee-for-service for secondary and per capita for PHC where PHC facilities have incentives to refer under per capita payment and secondary/hospitals have incentives to treat under fee-for-service payment? Could it hamper shifting services to PHC or the MNCH continuum of care and referrals?
- Is there any potential to start bundling the services to reduce supplier induced demand or financial incentives to provide unnecessary services especially lab and diagnostic tests? Bundling meaning combining lab, diagnostic or other tests into an aggregated unit of service for payment.
- Is there potential to enhance drug reimbursement or drug revolving fund payment? Or to enhance linkages with community financing for drugs?
- Is there potential to incorporate a portion of salary payment into the D&E fee-for-service provider payment system to ensure consistent financial incentives or begin unifying payment systems?
- Are any unintended consequences emerging as providers respond to the payment system financial incentives?
- NHIS and MDG Fund:
  - Is NHIS/MDG continuing to fund services?
  - If it does continue, what federal and state institutional roles are appropriate? Role for HMOs? Further discussion required but on the surface it's not clear why private HMOs are needed – they don't seem to be either purchaser or provider,

intermediary role not clear, capacity to enroll clients not clear, and administrative cost and possibly conflict of interest issues arising.
  - How was it decided that State D&E fund secondary and NHIS/MDG fund PHC? Maybe consider the opposite as more PHC Centers, more remote, state has more administrative structure, etc.?
  - Is NHIS for public or formal sectors expected to function in state? If so, what health purchasing and institutional arrangements?

Expanding Provider Payment Systems Improvement

The Jigawa experience is an excellent example of step-by-step implementation of health purchasing improvement. The first step was implementation of a fee-for-service provider payment system under the D&E element of the benefit package. The critical question is whether Jigawa wants to continue this step-by-step health purchasing improvement? If so, the logical next step would be to begin to convert the line item budget payment system to an output-based payment system that enables further progress in targeting payment to individuals thus further realizing pro-poor free or highly subsidized MNCH services.

Questions for information gathering and discussion of if and how Jigawa may want to implement next steps in health purchasing reform:

- Does Jigawa want to develop and implement next steps in health purchasing reform?
- Is it possible to develop a step-by-step approach to converting from budget line item to output-based provider payment systems?
- Can private financing including user fees be better linked to the heath budget provider payment systems?
  - An assumption related to user fees is that they should stay and be managed at the health facility level as experience in other countries is that facility benefit and incentives are lost if they're transferred to the Treasury. Can user fee regulation, standardization be improved? Is specification based on a small number of prospective payment categories to keep it simple for the population and ensure that people know what they need to pay before receiving services?
- How can PATHS2 provide technical assistance to this process?

Improving Provider Funds Flow and Management

In addition to demonstrating that the Nigerian PFM system is flexible enough to allow output-based provider payment systems, the Jigawa experience provides evidence on another critical aspect of health purchasing related to funds flow to providers. Funds flow for the D&E element of the benefits package and its corresponding fee-for-service payment system appears to meet the dual objectives of enabling health purchasing reform including new provider payment systems and ensuring appropriate PFM systems and controls. More documentation is needed but current understanding is that the provider funds flow is transfer of funds from Treasury System to Gunduma Health Systems Board, followed by transfer of funds from Gunduma Health Systems Board to providers, followed by collection of financial reports by Gunduma Health Systems Board and submission to Treasury System.

Questions for documentation of Jigawa funds flow, using the experience to inform other states and determine if further improvements in Jigawa are possible:

- Can the legal basis and exact operational processes and procedures of the Jigawa funds flow from Treasury System to Gunduma Health System Board be documented? Are further improvements possible?

- Can the legal basis and exact operational processes and procedures of the Jigawa funds flow from Gunduma Health System Board to LGAs and health providers be documented? Are further improvements possible?
- Can the legal basis and exact operational processes and procedures of Gunduma Health Systems Board and provider accounting and financial management be documented? Are further improvements possible?
- Can steps be developed and implemented to increase health provider autonomy? How can provider management capacity be improved?

III. HEALTH PURCHASER AND OTHER GOVERNANCE ISSUES

A. Health Purchaser

The health purchaser is the institutional engine driving health purchasing. Its institutional structure, roles and relationships together with systems and human capacity are critical to implementation of health financing improvements. It's closely related to the pooling function as in general the health purchaser administers the pool of funds. The purchasing function is also very closely related to the health purchaser as operates the health purchasing mechanisms and provider payment systems.

Questions:

- What is the legal basis for the health purchaser?
- What are the institutional structure, roles and relationships between the health purchaser, the Ministry of Health, the Ministry of Finance, providers and any other relevant stakeholders?
- What is the department structure of the health purchaser? Are there any desired department structure changes?
- What systems does the health purchaser use and how can they be improved?
- Are improvements to health purchaser processes or operating procedures needed?
- What are the health purchaser human resources? Are any changes or additions desired? Is there a plan to increase human resource capacity or should one be developed?

B. Other Governance Issues

1. Organization and Management of Health System

The type and nature of governance varies by country. A governance issue in Nigeria is fragmentation in the health delivery system due to hospitals reporting to Ministry of Health (MOH) and PHC facilities reporting to Ministry of Local Government Areas (MOLGA). An intervention is needed to reduce this fragmentation and help ensure a seamless health system with good referrals and continuum of care. In addition to health purchasing, Jigawa uses the Gunduma Health System Board to address this issue.

Questions:

- What are the exact details and legal basis for provider reporting relationships?
- Has the effectiveness of the new provider reporting relationships been evaluated? Does it improve service delivery including referrals and continuum of care?
- Are there any unintended consequences of this organization and management of the health system that should be addressed? Does it allow a purchaser/provider split? Is one desired?

2. Relationship Between General Revenue Funding and Payroll Tax or Other Programme Funding

Together the MOF, Treasury, and MOH operate and manage the health budget funded by general revenue. Although more information is needed, current understanding is that social health insurance for public or formal sector workers funded by payroll tax and other programme funding including MDG fund is being developed, operated and managed by the National Health Insurance Scheme (NHIS). International experience shows that the health financing functions of pooling and purchasing do not have to be split or separated by different types of revenue collected for the health system. In other words, general revenue funding and payroll tax do not have to have different health purchasers, pooling arrangements, purchasing arrangements, or benefits packages. All different types of revenue collected can flow into common pooling and purchasing arrangements. As NHIS is still young and developing, now is the time to engage in policy dialogue on whether Nigeria wants one common or two separate health financing systems in the future. Nigeria's path to universal coverage should also be encompassed in this dialogue as the nature of the path and probability of attaining universal coverage may vary by the one common or two separate health financing systems decision.

Questions:

- How does the NHIS system work at the federal level? What is the legal basis and operating processes and procedures? Is it possible to engage in dialogue with NHIS on one common or two separate health financing systems?
- How does the NHIS system work for all programmes at the state level? What is the relationship between federal (including federally contracted) institutions and state institutions? What is the funds flow? What are the operating and management systems?

3. Increasing Provider Autonomy

Health provider performance and management is an issue in Nigeria related to both service delivery and general finance and management. This health systems strengthening topic encompasses broad health strategy and plans including topics such as separating purchaser and provider or centralizing finance and decentralizing management, and also detailed strategies and plans to improve individual health provider management capacity.

Questions:

- What is the current juridical status of public health providers? Are there other juridical options?
- Is increasing health provider autonomy a policy objective being considered? Have any plans been developed?
- Are there federal or state level plans to improve provider management? If so, can these be linked to health purchasing improvements giving providers more responsibility and accountability for financial management?

4. Private Sector

Private sector development is a means not an end. The objective is to optimize provision of high quality pro-poor services using a mix of public and private provision and financing appropriate to each country or environment. In addition, private provision and private financing are not the same thing and should be differentiated in the process of developing policy objectives and deciding on the best instruments or tools to attain them. Jigawa currently has limited private provision and private financing beyond population out-of-pocket

payment. Jigawa could function at extremes by either ignoring the private sector completely or by delegating substantial functions to it. However, the best public-private strategy for Jigawa may be to improve public provision, financing and management to improve quality and obtain efficiency gains to extend pro-poor free MNCH services, and then enhance or fill gaps with private provision and/or financing. In other words, take more of a middle ground approach that prioritizes improving the relationship between public and private service provision and financing.

Questions:

- What role does private service provision play in Jigawa now? What role do you want it to play? What percentage of health providers are private?
- What role does private financing play in Jigawa now? What role do you want it to play? Legally and operationally, can public funds be allocated to private providers through the D&E fee-for-service system?
- Can programmes or activities be implemented to enhance the relationships and synergies between public and private payment in the drug revolving fund?

IV. Pooling

One of the most critical aspects of health financing is the relationship between pooling and purchasing.
Obviously pooling is needed to obtain improvements in equity and financial risk protection. However, it's also hard to obtain efficiency gains and improve access and quality without good pooling arrangements even though health purchasing mechanisms are flexible with many instruments and tools that can be used to overcome pooling deficiencies in the short-term. The consultant's understanding is that Nigeria in general and Jigawa Gunduma Health System in particular have relatively good pooling arrangements largely due to the high proportion of the health budget that comes from federal funding (in general less pooling fragmentation when source of funds is federal rather than LGA level). Nevertheless, given the critical relationship between pooling and purchasing and desire to avoid barriers or obstacles, investing in assessing and improving pooling arrangements may pay high returns or dividends in the future.

Questions:

- What are the current pooling arrangements?
- How are funds pooled from federal, state and LGA sources?
- Is population per capita funding from federal and state sources equal across LGAs?
- Are resource allocation formulas used to equalize funding or should they be used?
- Can steps be developed and implemented to improve pooling arrangements?

V. Revenue Collection

This assessment, refinement and improvement process is focused on health purchasing particularly increasing efficiency and getting more for the money. The health financing function of revenue collection is not the primary emphasis but it is important to both the source and level of funding available and the relationship to pooling and purchasing.

The assessment process is intended to be quick, practical and not require extensive analysis or research. However, it would be valuable to framing the Jigawa story, improving national resource allocation and contributing to health purchasing improvements in other states to have answers to the following questions:

- What is the total Jigawa state health budget in absolute terms and % of total state expenditures (preferably 2010, 2011 and 2012)?

- What is the % of budget funding from all different geographic levels and types of programs? Specifically:
  - What % from federal, state, LGA resources (if possible linked to the type of revenue, where it is collected and how it moves across geographic levels)?
  - What % from different health programs (or is it all just general allocation to health)?
  - Again, 3 years of 2010, 2011, and 2012 would be optimal but if data collection is difficult then 2011 (assuming 2012 numbers are still difficult to access). The purpose is less having exact numbers and more understanding how system and process works to help develop small improvements.

VI. Budget Support

Assuming development partners investing in budget support want to target their funding to specific populations (e.g. poor) or specific services (e.g. MNCH), they also require provider payment systems that pay for individual units of service rather than entire health facilities or buildings.

More development is needed but a proposal for development partner budget support for Jigawa is outlined below (it could be adapted to other states but a pre-condition is implementation of provider payment systems targeting specific populations and services):

- Purchasing:
  - Benefits – part of the overall benefits package but can be earmarked or targeted to specific populations and services
  - Budget formation – incorporated into the general budget formation process but probably will have a separate line in the budget
  - Provider payment system – an output-based provider payment system (could use current D&E fee-for-service provider payment system or another system) targeting funding to specific priority services and populations
  - Operating systems and processes – funding incorporated into current operating systems and processes although could have a separate designation in the billing process.
  - Accounting and financial reporting – funding incorporated into current accounting and financial reporting systems and procedures although separate designation in the billing process could enable production of supplementary reports for development partner budget support.
  - Financial management and internal controls – funding incorporated into current systems but development partner budget support could be used to initiate improvements in financial management and internal controls for all health funding.
- Pooling – not a separate pool of funds but included in current pooling arrangements
- Revenue collection – flows into the Treasury System and financial reports like other funding

General Health Purchasing Questions

For Health Purchasing Improvement Dialogue in Kaduna, Kano, Enugu States and at Federal Level

Nigerian states have different environments and Kaduna, Kano and Enugu states will not implement the exact same health purchasing improvements as Jigawa state. However, as discussed above it is likely that Kaduna, Kano and Enugu states will need to make payment for specific populations and prioritized services rather than entire health facilities or buildings

in order to achieve pro-poor service delivery improvements by targeting funding to free or highly subsidized MNCH services. The questions below are intended to gather information or serve as a guide to initiate this process.

1. **Free or Subsidized MNCH Programmes**
   - Do free or subsidized MNCH programmes exist in Kaduna, Kano or Enugu? If not, do the states want to develop them? If so, what are they and are they working? What step-by-step improvements can be made to make them work better?
   - Does NHIS have any current role or plans in Kaduna, Kano or Enugu? Health insurance for public or formal sector workers, MDG, other?

2. **Health Budget Formation Process**
   - Who does what? Provider, LGA, SMOH, SMOF, Treasury, etc.?
   - What methodology is used to form the budget?
   - Total ceiling set and flexibility to allocate?
   - Normatives or standards to create budget?
   - Historical?
   - By line-item?
   - Other?
   - What standard mechanisms are used? Is there a standard chart of accounts or economic classification system? What line items?
   - How is it formatted and included in the state budget? By budget or accounting line item, by programme, other?
   - What's in it? For example, is PHC only salaries or other expenses too?

3. **Provider Payment System for Health Budget Funds**
   - What type of provider payment systems? Line item budgets, global budgets, per capita, case-based, fee schedule?
   - Is there potential to step-by-step develop and implement new provider payment systems?
   - Fixed costs – how are they included in the provider payment system and paid? Same as other budget line items? Are there arrears? What % on average are fixed costs like utilities?
   - Variable costs – how are they included in the provider payment system and paid? What line items? Supplies, drugs, food, travel? Is there any funds at all? Is a possible first step finding ways to increase payment for direct patient care to enhance service delivery? Any ideas on how to do this?
     - Can payment for drug revolving fund be improved? How can public and private payments for drugs be better linked?
   - How do provider payment systems for PHC and hospitals relate to each other? Are there conflicting financial incentives?
   - Should new provider payment systems be developed using actual costs or relative weights?

4. **Labor and Salaries**
   - Can salary payment be changed to enhance financial incentives to improve service delivery? Can salaries be incorporated into new provider payment systems or otherwise linked to healht services provided to individuals to enhance financial incentives to improve service delivery?
   - Labor classification and salary or wage scales – what system is being used? Can it be improved? Who makes human resource decisions? Do health providers have autonomy to hire and fire?

5. **Funds Flow for Health Budget Funds**
   - What is the legal basis for funds flow? What are the operational processes and procedures?
   - How do funds flow to the health purchaser? From Treasury System, SMOF, SMOH, LGA, etc.?
   - How do funds flow to the health providers? Do providers have bank accounts or Treasury System accounts?
   - Who signs? How many steps to receive funding?

6. **Accounting and Financial Management**
   - How does the accounting system work?
   - What financial management systems and processes are in place?

7. **Health Purchaser**
   - Who is the health purchaser? If no health purchaser beyond MOH, MOF, Treasury currently exists, is the establishment of a health purchaser being considered?
   - What is the legal and operational basis for the current health purchaser?

8. **Other Governance Issues**
   - Organization and management of health system – is a policy or mechanism in place in Kaduna, Kano and Enugu to address the fragmentation in the health delivery system due to hospitals reporting to Ministry of Health (MOH) and PHC facilities reporting to Ministry of Local Government Areas (MOLGA)? Are roles for the State PHC Development Agency or an entity like the Gunduma Health Systems Board envisioned?
   - The consultant was surprised to read in the PATHS2 August 2011 report entitled "Public Expenditure Management Review of Kaduna State" that PHC facilities don't have their own budget and are completely encompassed into LGAs. Should PHC facilities have and be responsible for their own budget?
   - Relationship between types of public funding – how do Kaduna, Kano and Enugu envision the relationship between general revenue, payroll tax and other programme funding?
   - Increasing public provider autonomy – should provider autonomy be increased?
   - Private sector – what is the relationship between public and private provision and financing? Can it be improved?

9. **Pooling**
   - What are the current pooling arrangements?
   - How are funds pooled from federal, state and LGA sources?
   - Is population per capita funding from federal and state sources equal across LGAs?
   - Are resource allocation formulas used to equalize funding or should they be used?
   - Can steps be developed and implemented to improve pooling arrangements?

10. **Revenue Collection**
    - What is the total Kaduna, Kano and Enugu state health budget in absolute terms and % of total state expenditures (preferably 2010, 2011 and 2012)?
    - What is the % of budget funding from all different geographic levels and types of programs? Specifically:
      - What % from federal, state, LGA resources (if possible linked to the type of revenue, where it is collected and how it moves across geographic levels)?

- What % from different health programs (or is it all just general allocation to health)?
- Again, 3 years of 2010, 2011, and 2012 would be optimal but if data collection is difficult then 2011 (assuming 2012 numbers are still difficult to access). The purpose is less having exact numbers and more understanding how system and process works to help develop small improvements.

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