Jigawa State Free MCH Programme Health Purchasing Results

FEBRUARY 2014

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SECTION ONE: INTRODUCTION

Significant pro-poor maternal and child health service delivery improvements cannot be achieved without better targeting of health budget funding to free or highly subsidized maternal and child health services. Strategic or active health purchasing can drive service delivery improvements, help make free maternal and child health programmes work, create efficiency gains and increase value for money. Output-based provider payment systems can be used to target budget funding at poor and vulnerable populations and the health services they need the most. Health purchasing is at the core of the relationship between health systems strengthening and service delivery and its contribution to removing health systems barriers can help enable Jigawa State use its own resources more efficiently and effectively and improve the planning, financing and delivery of sustainable and replicable pro-poor priority health services.

The successful Jigawa State Free Maternal and Child Health Programme (FMCHP) health purchasing experience has produced results and provided evidence and lessons learned for both the federal level and other Nigerian states. The purpose of this report is to document Jigawa FMCHP results and propose next steps to continue refining the programme, expanding the programme and enriching health systems strengthening contributing to improved service delivery and increased financial risk protection for poor populations. It should be noted that indicators were established and analysis done retrospectively.

I. Jigawa State FMCHP Health Purchasing Results

A. Legal and Policy Framework

With PATHS2 support, Jigawa has improved general health sector policy, planning and budgeting. The State Strategic Health Development Plan (SSHDP) provides the policy and planning framework for the health sector and feeds into yearly plans and priorities. A Medium-Term Sector Strategy (MTSS) is used as a mechanism to link planning and budgeting. Budget execution is improving as health begins to be seen as a better investment due to improved policies, planning and budgeting. In essence, the Government has increased confidence in the quality of the product and value of health. In addition, improvements in public finance management (PFM) systems enable better cash request and management of funding by the health system which also tends to increase budget execution. Improved expenditure tracking strengthens the feedback loop to planning and budgeting. Finally, increased citizen demand, advocacy and monitoring for a more transparent and improved process also contributes to improvements in policy, planning and budgeting. Improvements in this governance and financing foundation set the stage for strengthening health purchasing better targeting health budget funds to priority services and populations.

A strong legal and policy framework is required to improve and expand FMCHP. Periodic or irregular investment in free MCH services for poor populations cannot substitute for the long-term commitment required to strengthen health system functions and improve service delivery. Existence of a legal and policy framework helps institutionalize the programme and guard against the uncertainty of short-term discretionary investments. More predictable investment and improved operations contributes to a more sustainable and replicable programme.

1. Indicator #1: Legal and policy framework exists for FMCHP health purchasing.

This indicator has been partially achieved. The FMCHP is explicitly included in the State Health Sector Development Plan. The FMCHP is included in the Medium-Term Sector Strategy (MTSS) and in the state budget where it has a formal and separate line item in the budget rather than Government discretionary spending. In health financing policy, increasing funding for the FMCHP is a priority for Jigawa State. In addition, Government authorities recognize the fragmentation of funding and its potential negative consequences on equity and efficiency. Their intent is to help ensure that all funding is consistent with their policies, strategies and operating mechanisms.

Notwithstanding the status of health policy and planning described above, SMOH assessment is that health purchasing for FMCHP and other health financing policies and plans require a stronger legal base to ensure current operating procedures are maintained and also establish the legal authority to make additional health financing improvements. A health financing policy bill should be drafted, approved by House of Assembly and signed by Governor to solidify the health financing legal base in Jigawa State. It should include general health financing policy, commitment of Jigawa State to FMCHP and the programme technical foundation, additional budget formation and funds flow improvements to further shift to programme budgeting and output-based provider payment, sustainability of Drug Revolving Fund (DRF), roles and relationships of public and private financing (who funds what in what proportion and how operational systems and procedures work), relationship between national and state programmes, and the pooling of funds issue described below.

B. Health Purchaser Institutional Arrangements, Governance and Health Financing Functions

Functioning health purchaser institutional arrangements, governance and optimal relationships between health financing functions contribute to meeting health purchasing pre-conditions, implementing FMCHP by targeting health budget funding to MCH services and poor populations and achieving sustainable and replicable pro-poor services. The three basic health financing functions are 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] Pooling of health funds is critical to equity and equal financial risk protection for the entire population of Jigawa State. In addition, there is a strong relationship between pooling of funds and health purchasing, as pooling can either enable or hamper health purchasing mechanisms contributing to efficiency gains, transparency and high quality health services for the population.

Health purchasing is the most continuous and complex of the three health financing functions of revenue collection, pooling and health purchasing. There is no magic bullet or perfect health purchasing mechanism or provider payment system and the aim is selecting the option best matching objectives and state environment. International experience has shown that a number of barriers can hamper health purchasing improvements and the impact is often so substantial that removing these barriers become pre-conditions to the implementation of health purchasing improvements. Health purchasing pre-conditions vary by country environment but based on international experience generally include establishment of a health purchaser, pooling of funds, harmonization of health financing and public finance management systems to enable output-based provider payment systems, and resolution of any other country-specific governance issues.

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

a. Health Purchaser Institutional Arrangements

A health purchaser administers pooling and purchasing arrangements for FMCHP and other health sector programmes and also contributes to improving governance in the health sector. A number of health purchaser institutional structure options exist and institutional arrangements may vary across states in Nigeria.

2. Indicator #2: Health purchaser established with organizational structure and capacity

This indicator has been achieved. The Jigawa State Ministry of Health (SMOH) is responsible for overall health policy. SMOH/Admin and Finance Department serves as the health purchaser but contracts out many health purchasing functions to the Gunduma Health Systems Board (GHSB) which reports to the SMOH. The board of GHSB has oversight functions and consists of board chairman, representatives of SMOH, SMOLG, MOF and Office of Head of Civil Service, and Local Government Area (LGA) representative for the 27 LGAs in Jigawa State. SMOH contracts GHSB to operate financing and health purchasing systems and manage/coordinate service delivery provision.

Roles and relationships between SMOH and GHSB are clear and who does what is stated in regulatory documents and operating procedures. In addition, there are clear roles for GHSB affiliated structures called Gunduma Health System Councils. There are nine Councils with functions including funds flow to health facilities, managing service provision and monitoring and evaluation (M&E). GHSB has an organizational chart, engages in ongoing organizational development and has sufficient human resources capacity to perform its functions and operate programmes.

Possible Next Steps:

- Continue to increase health purchaser capacity through ongoing SMOH and GHSB organizational and human resources development.
- Consider enhancing capacity of SMOH/Admin and Finance Department to increase their involvement in design of provider payment systems operated by GHSB, improve oversight, coordination and monitoring of all health purchasing mechanisms, and continue to solidify separation of SMOH and GHSB functions.

b. Significant Governance Issue

The type and nature of governance varies by country. A significant governance issue in Nigeria is fragmentation in the health delivery system due to hospitals reporting to State Ministry of Health (SMOH) and PHC facilities reporting to Local Government Areas (LGAs) who in turn report to State Ministry of Local Government (SMOLG). An intervention is needed to reduce this fragmentation and help ensure a seamless health system with good referrals and continuum of care.

3. Indicator #3: Improve PHC center and hospital coordination and continuum of care

This indicator has been achieved. Reform of the health sector and health delivery system has occurred. SMOH and SMOLG have delegated management of service provision to GHSB and the 9 Gunduma Councils manage the health service delivery system. Thus GHSB is Jigawa State's mechanism to help ensure better PHC and hospital coordination and continuum of care.

c. Pooling of Funds

Approximately 40% of funding for LGA health facilities is state level funding for payment of personnel costs and 60% LGA level funding for other costs.

4. Indicator #4: State and LGA funds are pooled to enable FMCHP and equitable health services

This indicator has not been achieved. Hospital funding is pooled by definition as is state funds and state responsibility. State and LGA funds for PHC are not pooled at state level. As LGA level funding varies, there is not equity or equal financial risk protection for the entire population of Jigawa State. Improving pooling of funds is a priority for the health financing policy bill discussed above. Pooling of funds could be improved by pooling state and LGA level funds in GHSB or by other mechanisms ensuring equal per capita health funding for PHC across LGAs in Jigawa State. Per SMOH and GHSB, lack of pooling of funds is the most significant barrier to expansion of FMCHP to PHC facilities. Coordination between national and state programmes at LGA level could also be improved to increase equity and efficiency. Finally, it appears that could be significant private individual or entity investment in the health sector including in the public health sector and pooling of funds should include mechanisms to incorporate these private funds.

d. Health Purchasing and Relationship to Public Finance Management

Health purchasing is at the intersection of health financing and public finance management (PFM) which includes budget formation, provider payment systems, health purchaser operating systems and capacity, funds flow, accounting, financial reporting and internal controls.

Other important health purchasing relationships include relationship to management and relationship between public and private financing. There are significant overlaps between health purchasing and health management at both the purchaser and provider level. It will be hard for Jigawa to get on the road to universal coverage without a vision of how public and private funding relate to each other and health purchasing for public health budget can help clarify the role of public financing which in turn clarifies the role and creates space for private financing.

There are two elements of health purchasing, “what” to purchase and “how” to purchase it. 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. How to purchase is the mechanisms used to pay health facilities for providing health services and is commonly called provider payment systems and contracting.

Key Health Purchasing Objective in Nigeria

Why is improving health purchasing for health budget funds needed to target free MCH services to the poor? Current health budget purchasing mechanisms or provider payment systems generally allocate funds to infrastructure including staff and building costs and these funds may or may not be disproportionately targeted at either MNCH services or the poor. Shifting to output-based provider payment systems allows government health budgets to be explicitly and directly targeted at MCH services and the poor. In essence, people matter more as providers are paid to deliver services to them.

In addition to linking with pooling arrangements to improve equity and financial risk protection, output-based provider payment systems have another major advantage – they support improvements in efficiency and transparency. They are directly related to

improvements in governance, stewardship and management as they provide financial incentives for providers to manage better and allocate resources more efficiently. Transparency is improved as the rates paid for services are public information such that health providers know the amount they should be paid for the services they deliver.

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 Nigeria, one of the main problems is that 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 priority services are delivered and 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.

5. Indicator #5: FMCHP covers priority services and poor populations

This indicator has been achieved. FMCHP priority services are covered and the services that are provided are itemized. It is clear who FMCHP covers including poor and vulnerable populations.

6. Indicator #6: PFM Mechanisms Allow Output-Based Provider Payment Systems for FMCHP

This indicator has been achieved as output-based provider payment systems are being implemented for FMCHP. Budget formation processes allow output-based provider payment systems as there is a line item in the budget for FMCHP. In addition, funds flow processes to GHSB and providers allow output-based provider payment systems. Jigawa receives money from federation account monthly with salary payments as a priority. FMCHP is part of a standing order and money is transferred from Treasury to GHSB account.

Importance of Jigawa Experience

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 or fee schedule provider payment system to pay providers under the FMCHP. The fee schedule and other output-based 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, it can contribute to the step-by-step development of unified pooling and purchasing arrangements that both link all Nigerian funding or programmes and enable development partner investment in direct budget support as systems already exist to directly target specific priority populations and services. Over time, the fee-for-service or fee schedule payment system could be refined to mitigate internationally recognized consequences including supplier-induced demand. However, the SMOH and GHSB took a good and practical first health purchasing step to achieve FMCHP objectives including increasing utilization of priority services.

C. FMCHP Facilities

FMCHP implementation started in selected health facilities. The selection of the initial facilities can help establish the programme, improve service delivery and access for poor

populations, produce results, and increase the probability of programme expansion and sustainability. Criteria or factors such as number, mix of type of facility, coordination with service delivery investments, and involvement of many LGAs can contribute to establishment and expansion of the FMCHP.

7. Indicator #7: Appropriate selection of initial FMCHP health facilities

This indicator has been achieved. Jigawa used the following criteria to initiate and refine selection of health facilities for FMCP participation:

- Type of health facilities: FMCHP initially covered hospitals as they are state facilities with an easy mechanism to pool funds. After it was demonstrated that LGA funds can be pooled then PHC centers were included.
- Location or distribution of health facilities: it was planned that health facilities participating in FMCHP would be distributed around the state and include all LGAs to initiate programme implementation and facilitate developing experience and lessons learned contributing to expansion of FMCHP.
- Services available in health facilities: when GHSB and FMCHP started, PHC centers did not have the capacity to deliver prioritized services. The Jigawa State Service Delivery Strategy (SDS) supports introduction of essential service packages through four components: infrastructure (rooms, light, security, etc.), basic equipment/commodities, required HR number and mix, and service charter for facility (statement of what services provide). PHC capacity for service delivery is increasing and beginning to demonstrate the link between health financing and service delivery.
- Included in MNCH service delivery clusters -- improved coordination and continuum of care is directly related to the service delivery cluster model being implemented to improve MNCH services. In the nine Gunduma Health System Councils, there is a cluster of PHC centers under each hospital providing different levels of emergency obstetric care. MNCH cluster facilities are disproportionately included in FMCHP.

The total number of health facilities in Jigawa State is 629 including:

- 12 general hospitals that are also comprehensive obstetric emergency centers (CEOCs)
- 1 specialty hospital
- 2 sub-specialty referral hospitals for psychiatry and TB/leprosy
- 24 PHC centers
- 590 other health facilities including health centers, health posts, health clinics and dispensaries.

The total number of FMCHP health facilities in FMCHP is 22 – 12 hospitals (CEOCs) and 10 PHC centers. Out of 27 LGAs, 18 or two-thirds have one or more facilities under FMCHP which contributes to increasing ownership and developing experiences and lessons learned in all LGAs. Cluster model hospitals/CEOCs are all covered by FMCHP ensuring a comprehensive and direct link to the Jigawa Service Delivery Strategy and cluster model. Jigawa State intent is to expand to the remaining PHC centers and possibly also to other types of health facilities.

D. FMCHP Budget and Provider Payment System Implementation

The proportion of the total state health budget contained in the FMCHP is important as it reflects the scope of and commitment to the programme. Many of the nuts and bolts of FMCHP health purchasing are contained in the design and operation of the provider payment system. Better targeting health budget funding to priority services and poor populations to help make FMCHP work generally requires shifting from input-based line item budget payment system to an output-based provider payment system. In other words, it's

hard to match health budget funding to FMCHP priority services and poor populations through FMCHP without using output-based payment.

8. Indicator #8: Proportion of state budget in FMCHP and budget execution

This indicator has been partially achieved. The Jigawa State FMCHP started in 2009 and in 2010 a separate budget line item was created. The FMCHP budget and percent increase, and proportion of total budget and percent increase are contained in the following table:

Year	FMCHP Budget	% Increase Budget	Budget Proportion	% Inc. Proportion
2010	140 million N.		2.3%	
2011	176 million N.	26%	2.8%	22%
2012	280 million N.	59%	2.8%	0%
2013	300 million N.	7%	3.0%	7%

Jigawa State commitment to FMCHP has been excellent as demonstrated through budget execution. Not only has budget execution been 100% but in some years budget execution has been more than the budgeted amount. SMOH/GHSB have made requests for additional funds and these requests have been granted, either through allocating additional funds or reallocating Jigawa NHIS/MDG programme share. For example, in 2010 256 million N. was expended against an initial budget of 140 million N., and in 2011 195 million N. was expended against an initial budget of 176 million N.

The combination of Jigawa State FMCHP budget increases and budget execution show real commitment to the programme. However, the FMCHP budget still represents a small proportion of the total Jigawa State health budget and more budget increases or allocation of existing budget to programme are needed. In addition, it may be time to begin the process of shifting more of the budget to programmes to fully realize programme budgeting and increase the proportion of the health budget where active and strategic health purchasing targets or matches health budget funds to priority services and populations.

Possible Next Steps:

- Assess, recommend and implement any further improvements in budget formation for the FMNCHP.
- Dialogue on further increases in FMCHP budget and development of phases to fully realize programme budgeting with corresponding active and strategic health purchasing mechanisms. Per discussion with SMOH and SMOF, a possible next step is inclusion of some overheads into the FMCHP. Including salaries into FMCHP was discussed and could be a long-term step in improving health purchasing but is not possible now.

9. Indicator #9: Implementation of output-based provider payment systems

This indicator has been partially achieved. The provider payment system selected by Jigawa for the FMCHP is fee-for-service through a fee schedule which functions by GHSB paying a fee for each covered MCH service for each eligible beneficiary. SMOH and GHSB may not have had a wide range of options for how to start output-based payment. In addition, unbundled payment for each service provides an incentive to increase utilization consistent with service delivery objectives. However, international experience shows that over time issues with supplier-induced demand and cost containment will likely arise such that the fee-for-service payment system should evolve to a provider payment system with more bundling or hard caps for budget neutrality. In other words, a key to health purchasing is refinement and continuous improvement of provider payment systems.

The Jigawa FMCHP fee schedule matches priority services and populations. Targeted population has been incorporated since the start of FMCHP in 2009 and a refinement in 2013 better matched the fee schedule to priority services. The fee schedule varies by type of facility as it matches their service charter. Drugs are priced centrally and the State Sustainable Drug Supply Committee decides on the mark-up which varies across administrative levels and type of entity. Health facilities use the mark-up for administrative costs, managing drug supply issues such as expiration, exemption schemes and other legitimate expenses. Before 2013, the system tracked expenses by beneficiary and after 2013 also by type of expense (e.g. drugs, lab tests). There is a standard format for bills portraying how many people were served and how much charge for services with supporting information documented at the facility level.

GHSB has already initiated refinement of FMCHP provider payment systems. They started with fee-for-service where each health facility used an approved process to establish their own fees and are refining this system to a more regulated fee schedule with standard categories and fees across health facilities. While not yet bundling or establishing hard caps for budget neutrality, this refinement is a good improvement step that should provide some incentives to increase efficiency and improve management of purchasing and provision of services.

Possible Next Steps:

- Continue development of longer-term vision and strategy for health financing/purchasing implementation sequencing. One example is to pool state and LGA funds, expand FMCHP or other priority programmes to PHC level, pay PHC facilities a capitated rate payment system to incentivize preventive services and shift or share risk between purchaser and provider, and add results-based financing (RBF) or pay-for-performance (P4P) on top of capitated rate to stimulate provider performance. In the shorter-term, a vision or strategy is bundle service delivery and commodities into payment system for priority services and populations (e.g. for PHC-sensitive conditions to reduce hospitalizations).
- Finalize and implement standard or uniform FMCHP fee schedule to reduce variation and enhance incentives to increase efficiency
- Consider converting from the current fee schedule based on absolute prices to one based on relative weights to allow better matching of payment commitments to available funding and enhance financial incentives for priority services.
- Consider bundling of some FMCHP services to reduce potential unintended consequences of fee-for-service payment system, increase efficiency, obtain value for money, and stimulate health providers to implement service delivery improvements. A more bundled service delivery example could be 4 ANC visits. It could be the first step in gradual movement towards output-based provider payment system (e.g. capitated rate, case-based hospital payment system).
- Begin to develop implementation strategy and sequencing to gradually shift budget formation and provider payment from the state consolidated health budget to programmes such as the free MNCH programme allowing further targeting of limited budget funding to priority services and poor populations. Per discussion, a first could be incorporating overheads into the FMCHP.
- Further develop proposals for development partner budget support for the FMCHP. The FMCHP is well suited for budget support as the mechanisms are in place to target funding to priority services and populations. In addition, as FMCHP already uses output-based payment, results-based financing (RBF) could be added on top rather than established as a separate, vertical mechanism.

E. FMCHP Operating Procedures, Information Systems and Management

Strategic purchasing of free MCH services and targeting health budget funds to priority services and poor populations requires operating procedures and information systems. Existence of these procedures and systems provides evidence of the commitment and operating capacity required to make the FMCHP work. Operating procedures, information systems and management improvements are needed at both the system or health purchaser level and the provider level. Management improvements are crucial to operation of the FMCHP, increasing health system efficiency and improving service delivery.

Avoiding duplication or overlapping information systems by developing a unified health information system including data exchange standards is also a priority. A unified system can feed information into a number of objectives including operating the FMCHP and other health programmes, improving service delivery and management, collecting and compiling health statistics, and enhancing monitoring and evaluation. For example, vertical programmes that operate separate information systems can contribute to duplication, increased costs and fragmented policy and M&E. Jigawa is one of 5 states that have subscribed to web-enabled DHIS2 which further increases productivity and efficiency, provides data for decision-making, and supports and improves information systems in rural facilities.

10. Indicator #10: Functioning FMCHP operating procedures, information systems, financial management systems and management processes

This indicator has been achieved. Operating procedures including guidelines are functioning at health purchaser and provider level. A service coding system exists and is incorporated into service form. FMCHP Invoices or bills are submitted by providers and processed by GHSB. The billing system could be further linked to the general health information system to help develop a unified information system. Invoices are used both to bill and for beneficiary statistics. Financial management and internal control systems are functioning. A standard chart of accounts for accounting and financial management is used (Nigeria is changing to International Public Accounting System (IPAS)).

Review committees of experts review facility invoices and quality assurance (QA) system determines whether services provided such as lab tests or operating theater were necessary. GHSB plans to review and upgrade the QA system including incorporating service delivery/clinical practice standards.

Possible Next Steps:

- Develop plans to continue to enhance operating procedures, information systems and management processes.
- Support GHSB to review and upgrade their QA system including define and determine roles for quality assurance vs. quality improvement (e.g. supportive supervision).

F. FMCHP Communication and Advocacy

There are a variety of general factors and system barriers mitigating against optimal uptake of health services including poverty, financial access, cultural practices related to health services, and service delivery quality. Low population knowledge about FMCHP also contributes to low utilization of health services. It also results in little recognition of the extent of current government investment and limited advocacy by the population to increase future investment in health. Improving communication about FMCHP to providers and the population should result in increased population knowledge and involvement and improved service utilization and health outcomes. Advocacy and evidence will contribute to SMOH

refinement of health policies and provide Government and State Ministry of Finance (SMOF) justification for increased investment in the health sector.

11. Indicator #11: FMCHP better communicated to providers and population and advocacy increased

This indicator has been partially achieved. FMCHP has been communicated to the population through media coverage including radio programmes and community engagement processes including focus group discussions. CSOs are involved in community voice and accountability activities and also advocate for FMCHP including through CSO MNCH partners which is a coalition of CSOs advocating for MNCH. FMCHP has been communicated to all providers including programme materials with operating guidelines. FMCHP is discussed in all policy forums and includes ongoing communication consisting of SMOH updates in all government meetings, yearly reports and annual planning processes. However, enhancing advocacy and promoting FMCHP at all levels could help produce a variety of positive results including increasing budget and expanding FMCHP, removing system barriers to implementation, more responsive provider service delivery and more aware communities and active population involvement in their own health.

Possible Next Steps:

- Develop an expanded FMCHP communication and advocacy strategy and implement at policy-maker, provider and population levels to increase knowledge, ownership and active participation.

G. FMCHP Monitoring and Evaluation

Monitoring and evaluation (M&E) of the FMCHP is critical to refining implementation, demonstrating results and creating a feedback loop to policy dialogue, planning and budgeting. In addition, building and institutionalizing systems and capacity for FMCHP M&E will improve systems and increase capacity for M&E of other health programmes.

12. Indicator #12: Improve systems and build capacity for FMCHP M&E

This indicator has been achieved. A SSHDP M&E framework exists and encompasses all state health plans and activities including FMCHP. Specific FMCHP monitoring indicators and processes are in place and used. FMCHP expenditures are tracked and used for both financial management and budget development. Health Data Consultative Committee coordinates information and meets quarterly to review HMIS data quality, strengthening linkages to FMCHP M&E could be considered. Reports are disseminated on FMCHP results. In summary, while M&E can always be improved, Jigawa State has systems and processes in place to monitor and continuously refine FMCHP.

H. Relationships and Synergies with Other Health System Functions

The close relationship between FMCHP health financing/purchasing and the leadership/governance health system function is documented above. This section describes relationships and synergies between FMCHP health financing/purchasing and other health system functions including human resources and drug supply management.

13. Indicator #13: FMCHP contributes to strengthening drug supply management, replacing population out-of-pocket payments for drugs with pre-paid funding and increasing drug revolving fund (DRF) sustainability

This indicator has been partially achieved. It is clear there is a correlation between FMCHP health purchasing and improvements in drug supply management. However, further analysis is needed to determine the exact relationship or to demonstrate causation. Drug

supply management institutional strengthening for key institutions such as Central Medical Store (CMS) has involved improving policies, guidelines, plans and operating mechanisms. Jigawa CMS procured drugs worth 587million Naira from August 2012 to July 2013, signifying maturity of its internal systems, processes and infrastructure, as well as growth in its own resources. Drug purchases by health facilities also increased over the same period, with the total value of commodities procured by facilities from CMS increasing to 582million Naira from 202million Naira in 2009, an increase of 188%. This signifies that logistics and DRF systems have matured to meet the growing demand but also a correlation to FMCHP purchasing that provides funding and financial access for key drugs required by patients. More analysis including a household survey is required to verify that FMCHP is gradually replacing population out-of-pocket payments for drugs. In summary, linking FMCHP purchasing including payment for drugs, and drug supply management improvements including DRF creates synergies between both interventions and is an example of good governance and strategic health purchasing.

Possible Next Steps:

- Further assess drug supply management including drug revolving funds (DRF) to determine if additional small health purchasing improvements to increase sustainability are possible in the context of the Jigawa system.
- Further assess relationship FMCHP purchasing and population out-of-pocket payment for drugs and refine or align as necessary to ensure that payment for drugs within FMCHP is replacing population out-of-pocket payment for drugs and increasing financial access for poor and vulnerable populations.

14. Indicator #14: Improve number, type and mix of human resources in FMCHP health facilities

This indicator has been partially achieved. It is clear there is a correlation between FMCHP health purchasing and improvements in the number, type and mix of human resources in health facilities. Within the context of the Human Resources for Health (HRH) policy framework, over 1500 different cadres of health workers have been recruited specifically to address one of the major challenges to health in Jigawa. This improvement is due to many factors including the political will of Jigawa State Government to improve health services but FMCHP health purchasing contributes to appropriate placement and motivation to ensure that additional human resources are providing priority services to poor populations.

I. Direct Service Delivery and Utilization Impact

There is a direct relationship between health systems strengthening including FMCHP health purchasing and improving service delivery. Although international experience has shown that the interventions and results detailed above strengthen the health system, it is critical to produce and document improvements in service delivery outputs and health outcomes. Ultimately, FMCHP purchasing will be assessed by its impact on service delivery outcomes as well as improving financial risk protection for poor and vulnerable populations.

15. Indicator #15: FMCHP health purchasing contributes to service delivery outputs and outcomes

DFID/PATHS2 MNCH outcome level indicators in Jigawa State are shown in the table below:

Indicator Name	Baseline	2013	% Increase
% of pregnant women making at least 4 ANC visits	7.5% (17,768)	13.3% (325,525)	77%
Proportion of births attended by skilled birth attendants	5.1% (3,917)	12.2% (25,994)	139%
Proportion of birth taking place in a public health facility	4.5% (8,529)	11.8% (25,073)	162%
Number of midwives per 10,000 population	.2	.7	250%

This indicator has been partially achieved. MNCH outcome level indicators all show great improvement although the results shouldn't be overstated as low baselines amplify the percentage increases. It is clear there is a correlation between FMCHP health purchasing and improvements in service delivery outputs and outcomes. The overlap between FMCHP facilities and MNCH cluster model facilities and strong relationship to facility involvement in MNCH service delivery improvements described above contributes to this conclusion that they are correlated. However, more analysis and disaggregation of data is required to demonstrate causation.

Achieving sustainable and replicable service delivery results requires linking, integrating, or creating synergies between investments in health systems strengthening including health financing, service delivery, and active and involved population and community. As FMCHP is still in its infancy and programme expansion is planned, it is expected that FMCHP purchasing will continue to contribute to service delivery results in the future.

J. Financial Access Impact

Comparable to service delivery, the interventions and results detailed above have been shown internationally to increase financial risk protection for poor and vulnerable populations. However, it is necessary to document outcome level results in increasing financial risk protection to demonstrate that the interventions are being implemented successfully and in a way that produces results in the unique Jigawa State environment.

16. Indicator #16: FMCHP health purchasing contributes to financial risk protection improvements

This indicator has been partially achieved. Per above description of FMCHP beneficiaries and provider payment systems, it is clear that FMCHP purchasing better targets funds to serving poor and vulnerable populations. SMOH and GHSB are developing creative ways to ensure that eligible beneficiaries are not paying for services they should receive for free. For example, a number is publicized that beneficiaries can use to send a text directly to the Governor if they are erroneously charged for services. An evaluation including a household survey of out-of-pocket payments will help definitively determine impact, including documenting the extent of out-of-pocket payment reduction due to FMCHP and DRF, and also inform further FMCHP refinements and expansion.

II. Conclusions

1. Demonstrating Health Systems Strengthening and Service Delivery Linkages

The Jigawa health purchasing results document FMCHP success and provide evidence on the importance of health purchasing as a direct link between health systems strengthening and service delivery improvements. Health purchasing helps bring free MCH programmes to life by better targeting of health budget funds to priority services and poor populations. Improved health policy, SHCDP, improved yearly planning, MTSS linking plan and budget, increasing budget execution and improving expenditure tracking established a foundation for health financing/purchasing to build upon. Strong linkages to other health system functions including drug supply management and human resources magnifies the impact on improvements in service delivery and financial risk protection. Service delivery and financial risk protection results document FMCHP success and provide information to refine current implementation, advocate for the programme, and implement step-by-step expansion or scale-up plans.

2. Importance and Generalizability of Jigawa Health Purchasing Experience

Results of FMCHP health purchasing interventions implemented in Jigawa state are very powerful because they are suited to the state environment and provide evidence that health purchasing pre-conditions can be met in Nigeria. Health purchasing pre-conditions vary by country environment but based on international experience generally include establishment of a health purchaser, pooling of funds, harmonization of health financing and public finance management systems to enable output-based provider payment systems, and resolution of any other country-specific governance issues. In Jigawa state, the GHSB functions as health purchaser (SMOH and SMOF also have purchasing functions) and LGA funds are pooled at state level at least to the extent of enabling unified payment rates. Jigawa state found a way to manage the Nigerian health governance issue of fragmentation in the health delivery system due to different reporting relationships of PHC facilities (SMOLG) and hospitals (SMOH) through GHSB coordination improving the continuum of care.

Jigawa State purchasing of free MCH services through a fee-for-service or fee schedule provider payment system verifies that the Nigerian public finance management systems and processes are flexible enough to enable health purchasing improvements better targeting health budget funds to priority services and poor populations. In other words, implementation of these health purchasing reforms supports the conclusion that there are ***minimal systemic barriers*** to the harmonization of health financing and public finance management required to initiate active health purchasing of pro-poor MCH services. This evidence that the Nigerian public finance management system is flexible enough to allow output-based provider payment systems opens the door to other states and the federal level to further improve health purchasing, link all health programmes and payment systems (input-based budget and all output-based provider payment systems including results-based financing), enhance the relationship between public and private financing, and improve federal and state coordination of policies and programmes including National Health Insurance Scheme.

State level strategies and plans will vary as they adapt to each state environment but accomplishing the core tasks of reducing fragmentation in health delivery system governance and management, establishing a health purchaser, and introducing health purchasing and provider payment system improvements to better target health budget funds to pro-poor MCH services should be possible in each state given the Jigawa experience. The documentation and dissemination of institutional arrangements and operating mechanisms can contribute to each state developing their own active health purchasing for pro-poor MNCH services.

3. Relationship between Public and Private Financing

It will be hard for Nigeria to get on the road to universal coverage without an overarching health financing policy and strategy including a clear vision of how public and private funding relate to each other now and in the future. Without this vision, unintended consequences impacting equity and financial risk protection for poor and vulnerable populations may occur including government abdicating responsibility for health budget funding, limited focus on efficiency gains to effectively extend coverage, and introduction of private financing mechanisms that could undermine or fragment pooling in the future. Implementation sequencing is critical, in particular whether the first step is to extend publicly funding benefits and coverage as far as possible and then align private financing around it, or whether the first step is development of private financing mechanisms with the expectation they will either solve the problem of high out-of-pocket expenditures for poor and vulnerable populations or leverage change in public financing mechanisms.

In summary, if stewardship and governance in Nigeria focuses on a productive public and private financing relationship rather than isolated public sector health programmes or private sector products, it will likely contribute to a vision for the road to universal health coverage. If public programme budget funding is better targeted to priority services and poor populations, it could allow gradual development of a publicly-funded basic benefit package for all Nigerians, formal population copayments along with exemptions for priority services and poor populations, and creation of space for private financing to develop and complement public financing. For example, community-based health insurance could fund copayments in state health programmes or private health insurance could fund uncovered benefits.

4. Relationship between Federal National Health Insurance Scheme and State Health Programmes

The story of the relationship between Jigawa State FMCHP and NHIS/MDG programme is complex and can provide some lessons learned on the relationship between national and state programmes and improving pooling and purchasing arrangements. Particularly important is ensuring that national programmes use state structures and systems to the maximum extent possible to reduce administrative costs and fragmentation, increase efficiency and financial risk protection, enhance service delivery and increase sustainability.

Jigawa State health purchasing results can contribute to enhancing policy dialogue on general health policy and the relationship between health purchasing in National Health Insurance Scheme and state health programmes. Dialogue could include exploring options for establishing health purchasers at state level and also establishing unified pooling and purchasing arrangements for different sources of funding. Health purchaser institutional arrangements and harmonization of funding streams are critical to replication and sustainability of service delivery improvements, making free MNCH programmes work and the road to universal coverage.

Possible Next Steps:

- Engage in policy dialogue with NHIS on how the Jigawa State active health purchasing experience can provide lessons learned to incorporate into NHIS MDG programme and civil servant health insurance.

5. Relationship to SWAp Development

The health sector governance, finance and management mechanisms and processes discussed throughout this paper provide the foundation for sector-wide approach (SWAp). This foundation can be further enhanced by joint plans, coordination mechanisms and M&E framework. In addition, if donors provide budget support in a SWAp, the funding can be added on top of existing FMCHP purchasing mechanisms including provider payment systems, information systems and operating procedures and processes. In summary, Jigawa State is well prepared to develop and implement a SWAp.

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 Department for International Development, 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, the PATHS2 programme is implemented in the five states of Enugu, Jigawa, Kaduna, Kano, and Lagos. PATHS2 follows the successful PATHS programme, which was implemented from 2002 to 2008.

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