Kaduna State Free MCH Programme Health Purchasing Implementation Workshop Report May 2013

May 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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I. INTRODUCTION

Despite good programme design and the clear commitment of Kaduna State government authorities, some problems or barriers are hampering optimal implementation of the Kaduna State Free MCH Programme. Government authorities have identified lack of ownership of the programme as one of the major problems or barriers. Active health purchasing targeting health budget funding to priority services and poor populations can increase ownership at all levels of the system. An often unrecognized or underappreciated benefit of health purchasing including output-based provider payment systems is that the process of shifting from funding health infrastructure to funding targeted services and populations can help shift the perception of all stakeholders on the nature of health programmes and their role in the health system. Brightly illuminating and promoting the services and populations covered by the Free MCH programme personalizes the system and could increase: 1.) government understanding of the benefits of the programme; 2.) health provider understanding that their payment is directly related to providing high quality priority services to specific individuals; and 3.) population understanding of their health care-related responsibilities, what services are provided by the government and what services require private payment thus opening the door for a productive role for private financing.

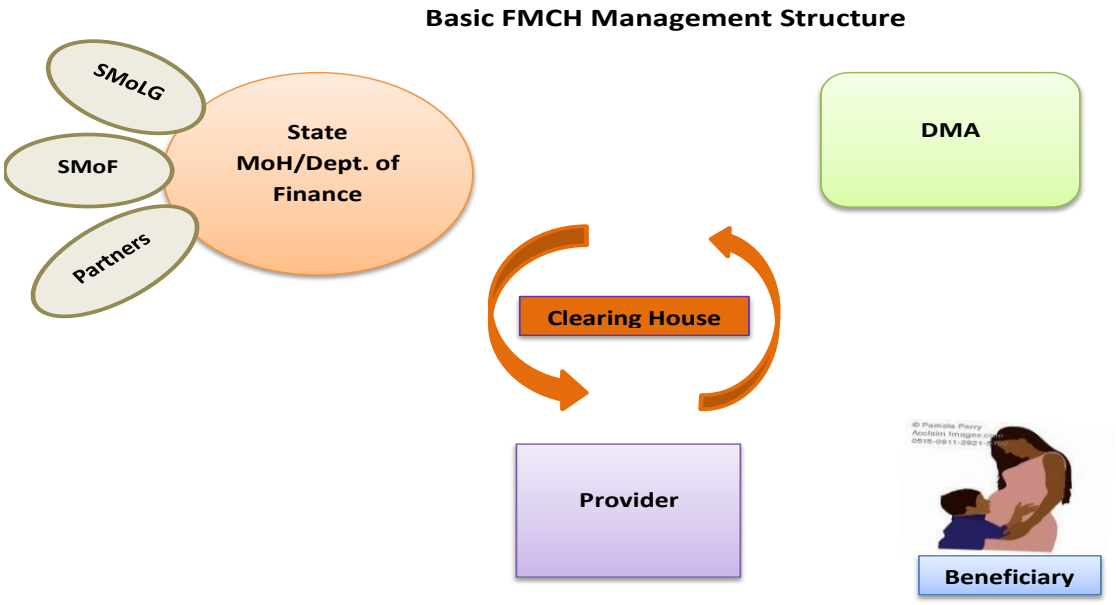
A variety of government ministries and agencies have health purchasing roles in Kaduna State including State Ministry of Health (SMOH), State Ministry of Finance (SMOF), State Ministry of Local Government (SMOLG), and Drug Management Agency (DMA). Although the advantages of having one institution serve as health purchaser to coordinate roles and operate systems is recognized, Kaduna State does not have a health purchaser performing all functions now and it is unlikely that one will be established in the near future. Instead, Kaduna State government authorities have developed a creative and innovative idea which is establishment of a "virtual" health purchaser or information Clearinghouse through unification and expansion of existing information and operating systems.[1] Their recognition that operating and information systems and processes serve as the foundation or core of active health purchasing is an excellent example of implementation sequencing enabling further step-by-step development of the health system and improvement in the Free MNCH Programme.

The first Kaduna State Free MCH Programme health purchasing workshop focused on defining problems and developing a strategy to solve or mitigate the problems and improve programme implementation. The second workshop focused on concrete implementation details to define the role of the Clearinghouse and allow Free MCH Programme improvements to progress rapidly. The purpose of this paper is to document ongoing dialogue and implementation decisions regarding Kaduna State Free MCH Programme health purchasing and the information Clearinghouse supporting improvements.

II. CLEARINGHOUSE CONCEPT AND GENERAL ROLES AND RELATIONSHIPS

There are parallels between the Kaduna State Free MCH Programme Clearinghouse or unified and shared information system concept and other modern information technology including the internet. It's not bricks and mortar or owned by an entity but rather an information system with a multitude of users functioning under shared rules or guidelines. The chart below shows the major stakeholders and their relationship to the Clearinghouse.

[1] Unpublished paper; Increasing Sustainability of Pro-Poor Service Delivery Improvements: Kaduna State Next Steps in Health Purchasing for Free MCH Programme; Sheila O'Dougherty



The following sections provide details on the role of the Clearinghouse and planned improvements to Free MCH Programme information and funds flow, information systems, and provider payment systems.

III. FREE MCH PROGRAMME INFORMATION AND FUNDS FLOW OPTIONS AND RELATIONSHIP TO THE CLEARINGHOUSE

The key to Free MCH Programme active health purchasing is how health facilities are paid for health services provided to programme beneficiaries. Dialogue on roles and relationships and information and funds flow resulted in the development of two options described below. In general, Option A consists of Free MCH Programme payment to the DMA for the cost of drugs and payment to health facilities for fixed costs of operating the facility (called subventions). Option B consists of Free MCH Programme payment to the providers for all costs of treating programme beneficiaries including drugs.

Model A

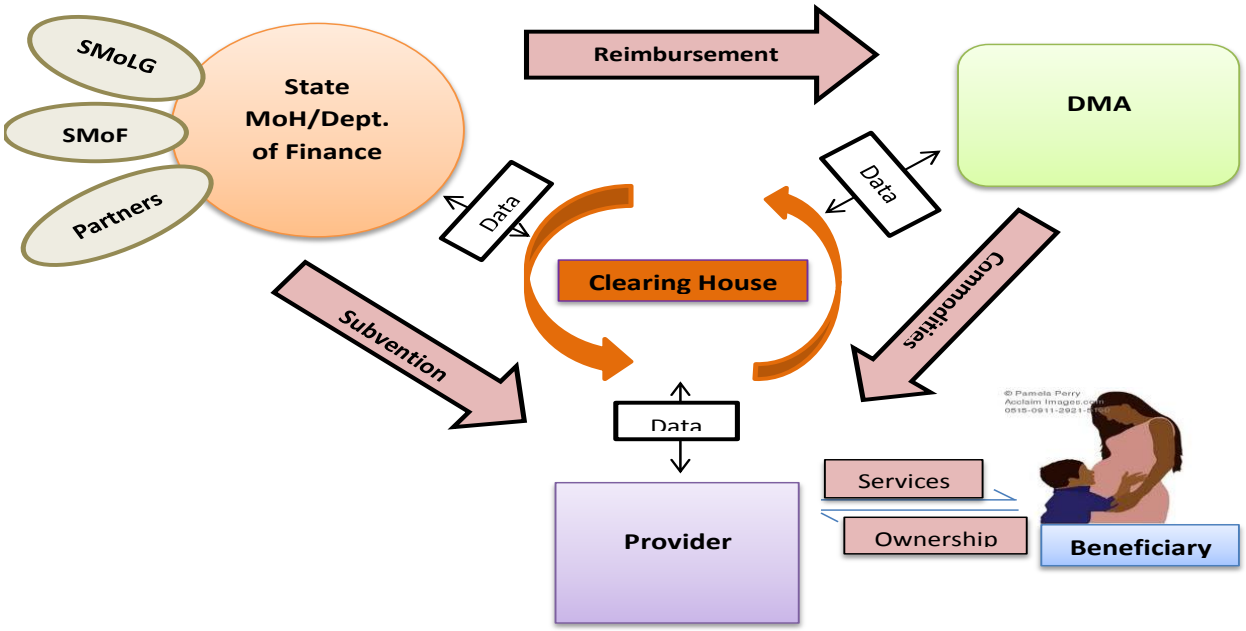
- **The Provider**:
  - The provider provides free MCH services to the beneficiaries.
  - The provider prepares individual service vouchers in triplicate, gives a copy to the beneficiary, forwards a copy to the DMA through the Clearinghouse and retains a copy.
  - The provider also prepares a database of all beneficiaries and services detailing their bio-data, diagnosis and treatment received. The database is uploaded to the Clearinghouse monthly.

- **The DMA:**
  - The DMA processes the service vouchers received from the providers, aggregates the service vouchers to an invoice, then invoices the SMOH/Finance Department through the Clearinghouse for drug reimbursement.

- The DMA replenishes the providers' stock of drugs based on service vouchers received.

➢ **The SMOH/Finance Department:**
- The SMOH/Finance Department reviews the invoice from the DMA received through the Clearinghouse and releases funds for drugs supplied by the DMA.
- The SMOH/Finance Department reviews the service data received from the provider through the Clearinghouse, determines the subvention due to the providers and releases the subvention accordingly (see provider payment system section for discussion of subventions).

FMCH Management Structure – Model A



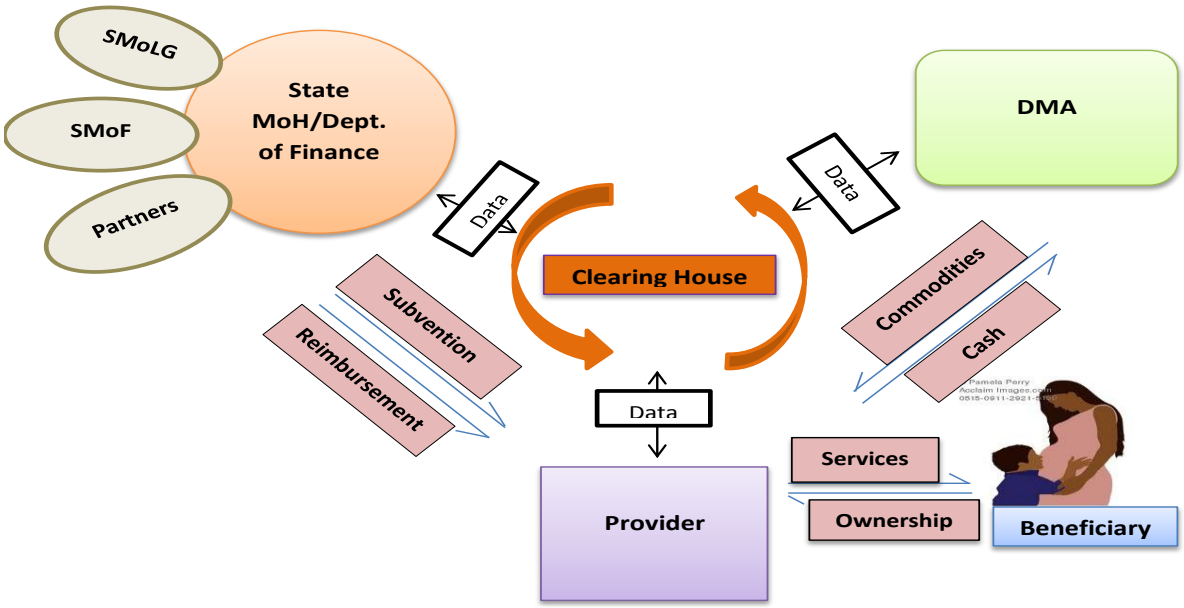
Model B

➢ **The Provider:**
- The provider provides free MCH services to the beneficiaries.
- The provider prepares service vouchers in triplicate, gives a copy to the beneficiary, forwards a copy to the Clearinghouse and retains a copy. The provider also prepares an aggregate database of beneficiaries detailing their bio-data, diagnosis and treatment received. The database is shared with the Clearinghouse monthly.
- The provider prepares an invoice based on the service vouchers and forwards it to the SMOH/Finance Department through the Clearinghouse.
- The provider prepares drug order forms for the DMA

➢ **The DMA:**
- The DMA supplies commodities to the providers on cash and carry basis based on drug order forms.
- The DMA provides information on providers that procure drugs from the agency. This is to ensure that the providers are not procuring drugs from other sources.

- **The SMOH/Finance Department:**
  - The SMOH/Finance Department reviews data and invoice received from the provider through the Clearinghouse and makes payment decision.
  - The SMOH/Finance Department releases payment to reimburse the provider for the direct costs incurred in providing free MCH health services.
  - The SMOH/Finance Department also releases the monthly subvention to providers to cover indirect costs and make up for revenue loss due to free services.

FMCH Management Structure – Model B



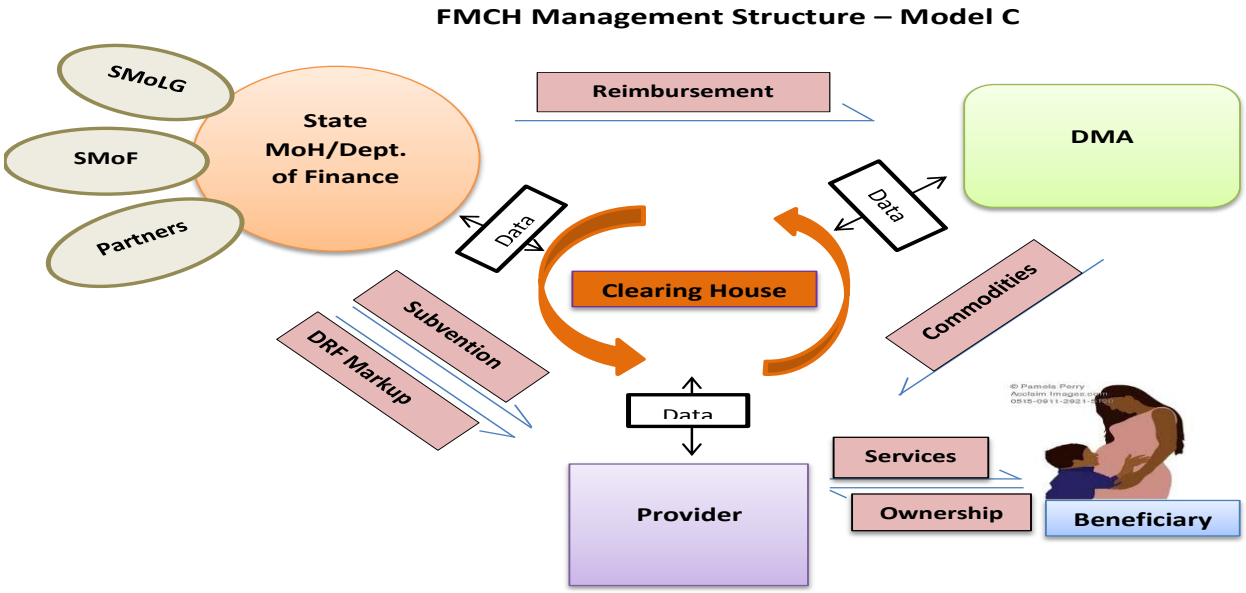
The merits and demerits of Options A and B are discussed in the following table.

Merits and Demerits of Options A and B

	Model A	Model B
Merits	• Reduced risk of financial mismanagement as minimizes cash flow. • Providers are more likely to procure commodities from the DMA. • Payment for commodities is made in bulk to the DMA. Therefore, financial transaction is more efficient at the level of the DMA.	• The model is more output-based and oriented to people and services. • Greater transparency and separation of functions reduces financial risk. • The model strengthens DRF as mark-up management is more feasible. • The model is based on cash and carry. Therefore, it confirms with the modus operandi of the DMA
Demerits	• Also has risk of financial mismanagement as less transparency, separation of functions. • No arrangement for remittance of DRF mark-ups to the providers • The voucher system doesn't conform with the cash and carry modus operandi of the DMA. • The DMA lacks the capacity to manage huge vouchers from the providers.	• The risk of financial mismanagement at provider level is higher as cash flows directly to the provider. • Providers are less likely to procure commodities from the DMA.

Kaduna State stakeholder dialogue resulted in a preference for Option B. This preference is consistent with the overall strategy of mitigating the major identified problem of lack of Free MCH Programme ownership by active health purchasing better targeting budget funds to the priority services provided to beneficiaries.

Further dialogue resulted in operating procedures to the mitigate demerits or disadvantages of Option B. To reduce cash flow risk, it was agreed that the portion of the provider invoice for all free MCH services allocated to drugs can be paid to or established as a credit in the DMA which providers would drawdown when they purchased drugs at the DMA. This cash or funds flow adjustment would also mitigate the risk of providers purchasing lower quality or higher cost drugs outside of the DMA.



A. Concrete Funds Flow Implementation Steps

Following the selection of the Free MCH Programme funds flow option, Kaduna State stakeholder dialogue turned to practical and concrete operational implementation steps. It was decided that there should be no barriers to moving forward if health providers or facilities already have a bank account. If health facilities have a bank account demonstrating that they are already being paid directly and have appropriate public finance management systems, procedures and controls, then they can be paid directly following Clearinghouse production of required information and SMOH Finance Department authorization of payment. All hospitals and approximately 40%-50% of PHC centers currently have a bank account allowing Free MCH Programme funds flow of payment for services to programme beneficiaries.

For PHC centers that do not have a bank account, this funds flow is not currently a viable option. Plans were developed including the following steps:

- In the short-term, LGA representative would serve as an intermediary to provide management support to PHC centers without a bank account including receiving payment for services to Free MCH Programme beneficiaries, distribution of payment and required financing reporting.

- In the mid- to longer-term, PHC centers can begin to go through the procedures required to obtain a bank account.

It is not planned that LGA representatives would serve as permanent intermediaries. The process of obtaining a bank account is viewed as an implementation step in Free MCH Programme health purchasing and service delivery improvement as it will provide an incentive for the remaining 50%-60% of PHC centers to improve their general and financial management, a process which is likely to spill over into improved capacity to manage and improve health service delivery.

B. Clearinghouse Status, Operational Guidelines and Costs

The Clearinghouse would not be a separate legal entity but rather a group of legal entities agreeing to share unified information systems to improve performance in accomplishing their own responsibilities. Kaduna State stakeholders agreed that a Memorandum of Understanding (MOU) could be developed between Clearinghouse users (SMOH, SMOF, SMOLG, DMA, providers) outlining the rights and responsibilities of all parties and the rules or guidelines governing use of the Clearinghouse unified and shared information systems.

The Clearinghouse would not be financed outside of the administrative costs allocated from users for operation of the unified or shared information systems. Specification of administrative roles and administrative costs could also be included in the MOU governing use of the Clearinghouse. Examples of administrative costs include:

- Provider level staff completing tasks such as enrolling beneficiaries, completing service delivery vouchers, developing invoices, and completing drug order forms. Minimal additional effort should be necessary as most of the information is already required for health statistics and financial reporting. Use of the Clearinghouse should increase administrative efficiency and productivity and also provide better data for decision-making driving management and policy improvements.
- DMA staff completing drug supply management tasks.
- SMOH/Finance Department staff completing tasks such as budgeting, authorizing expenditures, financial reporting, internal controls and financial analysis.
- Office supplies, paper, computer supplies and computers in approved budgets.

C. Clearinghouse Unified and Shared Information Systems

A key element of the Free MCH Programme health purchasing and Clearinghouse strategy is to gradually shift from manual to automated systems to improve operations, efficiency, service delivery quality and monitoring and evaluation. This transition can be accomplished gradually and the Clearinghouse can start with the current mix of manual and automated information systems. The Clearinghouse consists of eight interrelated information systems as described below.

1. Standard Reference Coding and Databases

A core building block of the Clearinghouse unified and shared information system is standard reference coding and databases including beneficiary identification number (ID), provider code, clinical coding system (e.g. ICD-10), drug coding system and financial chart of accounts or coding system. Most of these reference codes are already in place but a priority in Clearinghouse development should be solidifying them and automating them. An important part of the process will be developing and implementing procedures to assure patient confidentiality.

2. Beneficiary Enrollment Database

Criteria already exist for the identification of beneficiaries -- women for the term of their pregnancy plus six weeks and children from birth up to five years old. Over time, the beneficiary enrollment database should include all those eligible, not just those accessing services over a particular time period. However in the initial implementation phase, beneficiaries will be enrolled when they first access services at a health facility. Beneficiary enrollment steps include:

- Complete manual or automated beneficiary enrollment when eligible women and children first access services.
- Provide beneficiaries with a Free MCH Programme enrollment card. The card and any accompanying materials should clearly identify the Free MCH Programme and the rights and responsibilities of the beneficiaries. The beneficiary card is also part of the advocacy campaign to ensure the population is aware of and understands the health benefits being provided by the Government.
- Enter or upload the beneficiary bio-data information into the beneficiary enrollment database in the Clearinghouse information systems with the unique ID that can be used to access or reference patient service or medical records over time to help improve service delivery.

3. Provider Service Voucher or Records

The provider service vouchers are a record of the services provided to each patient. They are completed at the time of service with a copy to the patient and entry into the provider service or medical records that are also entered or uploaded into the Clearinghouse information systems. The service or medical records feed into both clinical or health statistics information systems and financial information systems for invoicing and financial reporting.

4. Provider Drug Order System

If service delivery or treatment requires drugs, then the required drugs are entered into the drug order system. The drug orders are aggregated and entered or uploaded into the Clearinghouse to be accessed by the DMA to fill provider drug orders. The patient is either given the drugs at the time of their visit or informed when they can pick up their drugs.

5. DMA Drug Supply Management Systems

The DMA uses the Clearinghouse to operate both drug supply management systems and financial systems. Drug supply management includes aggregating orders from providers, procuring drugs and managing drug inventory. Financial systems include maintaining and reconciling provider accounts and generating financial reports as necessary for SMOH/Finance Department.

6. Provider Invoice

Based on published Free MCH Programme payment rates, providers convert service delivery vouchers to invoices billing the SMOH/Finance Department for services provided to programme beneficiaries. These invoices are entered or uploaded into the Clearinghouse information systems.

7. SMOH/Finance Department Authorization, Payment and Financial Reporting Systems

The SMOH/Finance Department uses the Clearinghouse to receive invoices, authorize payment and release payment to providers for services provided to Free MCH programme beneficiaries. Service vouchers are also accessed through the Clearinghouse to justify invoices and calculate subventions (see provider payment section). Any payments for DMA services outside of the direct cost of drugs can also be authorized and payment released using information accessed through the Clearinghouse. SMOH/Finance Department also performs a multitude of budgeting, financial reporting and financial analysis functions some of which may use data contained in the Clearinghouse information systems.

8. Other Stakeholders Systems and Linkages

As needed, Clearinghouse information will be made available to SMOF, SMOLG and other SMOH Departments to perform their responsibilities including budget planning, allocating funds to the Free MCH Programme, service delivery quality assurance, health statistics and monitoring and evaluation.

i. Type of Free MCH Programme Costs and Provider Payment Systems

The ultimate goal of the Free MCH Programme is to prioritize and improve delivery of MCH services and reduce the out-of-pocket payment or user fees of poor and vulnerable programme beneficiaries.

Costs of the Free MCH Programme can generally be categorized into two main types: 1) direct or variable costs required for each individual patient (e.g. drugs, lab test supplies); and 2) indirect or fixed costs required to operate the health facility where the patient receives services. To replace the patient out-of-pocket payments or user fees, both the direct patient care costs and the indirect facility operating costs need to be covered by the Free MCH Programme.

A variety of provider payment systems are available for Kaduna State to choose from including line-item budgets, global budgets, capitated rate, case-based, per diem, and fee-for-service including fee schedules. As discussed above, when the objective of the programme necessitates targeting priority services and poor populations, usually only output-based payment systems matching payment to the priority services and poor populations should be used. Results-based financing (RBF) and pay-for-performance (P4P) are not completely different or separate systems but rather types of output-based provider payment systems and they can be implemented on top of or in concert with other payment systems to strengthen financial incentives.

Kaduna State has chosen a combination of these provider payment systems for the Free MCH Programme. Direct patient care is paid using an individual level fee schedule or payment for each service and/or commodity such as lab tests and drugs required by individual patients. Indirect facility operating costs are paid using a global budget or set facility level amount calculated based on pre-determined factors or criteria (called subventions). The combination of payments under these two systems is intended to help realize the goals of the Free MCH Programme by reimbursing facilities for the out-of-pocket or user fee payments previously received from patients.

The combination of the two provider payment systems shares the financial risk between health purchaser and health provider. For direct patient care, the risk is largely carried by the health purchaser as they are required to pay providers for all the services and commodities provided to patients as long as they are consistent with clinical practice and rational drug use guidelines. Financial incentives include increasing utilization which in the

short-term is consistent with state health policy and service delivery improvements. For indirect facility operating costs, the risk is largely carried by the health provider as they must operate the health facility within the constraints of the set facility level global budget payment based on pre-determined factors or criteria. Financial incentives include operating health facilities more efficiently which over time should contribute to increasing value for money and extending coverage and benefits. It's possible to conclude that this mixture of types of provider payment systems provides a good short-term balance as it enables the shift to active health purchasing better targeting budget funds to priority services and populations while it also contains a reasonable level of health purchaser and health provider risk-sharing.

Below are other questions on type of provider payment system raised in dialogue with Kaduna partners and DFID.

ii. Possibility of introducing other provider payment systems than fee-for-service?

As discussed above, the current Free MCH Programme provider payment system is a mixture of fee schedule and global budget and has potential to provide the financial incentives and risk-sharing desired in the short-term. Over time, Kaduna State could consider transitioning to payment systems such as capitated rate and case-based which bundle more services into the payment and strengthen financial incentives.

iii. Possibility of using different models for different types of health facilities (PHC centers and hospitals)

In active health purchasing, it is likely that different types of provider payment systems will be used to pay providers for health services received by the population at different types of health facilities (PHC centers and hospitals). However, use of different provider payment systems doesn't require different health financing functions, different institutional or health purchaser structure, different information systems structure or different roles of relevant stakeholders. The provider payment system parameters can be entered into information and financial systems to operate the payment systems for different types of health facilities (PHC centers and hospitals).

iv. Possibility of using one model for maternal service and another for child health services

Like the question of different models for different types of health facilities, the same health financing functions, institutional or health purchaser structure, information systems structure and roles of relevant stakeholders can be used for different types of health services including maternal and child health services. Unlike different types of health facilities, usually the same type of provider payment system is used for maternal and child health services. For example, a budget, capitated rate, or fee-for-service payment system can be used to pay for both maternal and child health services at PHC facilities. Or a budget, case-based, or fee-for-service payment system can be used to pay for both maternal and child health services at hospitals.

v. Implementation Phases for Expansion of Free MCH Programme

Very preliminary implementation phases for future expansion of the Free MCH Programme have been developed and are described below:

a) Implementation of Free MCH Programme health purchasing improvements and Clearinghouse as described in this paper.

b) Step-by-step transition from manual to automated Clearinghouse unified and shared information systems.
c) Providing support for PHC centers without a bank account to improve management and perform the procedures necessary to get a bank account for direct payment for services provided to Free MCH Programme beneficiaries. Also to leverage these management improvements into service delivery improvement.
d) Increasing the number of health facilities included in the Free MCH Programme
e) Refining the provider payment system to more output-based or bundled payment to enhance the financial incentives for health facilities to increase efficiency and provide high quality services to Free MCH Programme beneficiaries. In addition, begin to step-by-step incorporate active health purchasing or output-based payment into the general health budget or other health programmes.

vi. Relationship Other Revenue Sources or Programmes

The beauty of the Clearinghouse unified information system concept is that it can be used for all or almost all health revenue sources and programmes. Shared or jointly used information systems will reduce duplication, increase efficiency and contribute to reduced fragmentation in the health sector. Health revenue sources or programmes that can use the Clearinghouse include Free MCH Programme (and related DRF mark-up and deferral and exemption), general state budget, NHIS MDG programme, NHIS government worker insurance, community-based health insurance, private health insurance or donor budget support. Requirements to use the Clearinghouse information systems should not be burdensome and generally include agreement to use the standard information systems and forms, follow operating rules or guidelines in the MOU, and fund their own administrative costs.

vii. Communication and Advocacy

Communication and advocacy are extremely important elements of Free MCH Programme health purchasing and should take place at three levels – Government or policy-makers, providers and population. Population communication and advocacy should focus on the government commitment to Free MCH Programme, the benefits of the programme and population rights and responsibilities. Communication and advocacy at the health provider level should focus on the important role of the providers in improving the health of all women and children in Nigeria and that the financial incentives in their payment system have shifted from maintaining infrastructure or staffing a health facility to provision of priority services to poor populations.

Communication and advocacy at the Government or policy-maker level is critical to both implementing health purchasing improvements to the current Free MCH Programme and expanding it in the future. Content of communication and advocacy should include the benefits to the people of Nigeria and the main requirement to realize the programme which is to allocate and transfer funds to the SMOH in a timely manner based on payment to providers for services rather than by each budget line item or health expenditure. Nothing will undermine population trust and provider performance faster than untimely payment or not living up to government commitments.

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