RESOURCES TRACKING
A conceptual framework and its application

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WHAT IS RESOURCES TRACKING?

• Efforts to collect and analyze data on the flow of funds for developments, referred to now as resource tracking (RT).
  – The efforts on health resource tracking can be traced back to 1950’s
• The need for RT is increasing recently
  – Increasing resource constraints globally, which makes domestic resources more important for development.
  – Increasing attention on greater value for money and efficiency and effectiveness
  – Need for more transparency and accountability from all stakeholders
CONCEPTUAL FRAMEWORK

- Resource Mobilization
  - What determines the resource envelope for health at the Federal, Regional and local levels?

- Resource Allocation
  - Given the resource envelope for health, how are funds allocated to different health activities or functions? What factors determine the allocation for primary care?

- Resource Utilization
  - How much of the funds budgeted for primary care are utilized and reached to the healthcare facilities/providers? What factors drive successful execution? What are some existing bottlenecks?

- Resource Productivity
  - How effectively are primary care funds being translated into services? Are the right inputs available and are they being used effectively to maximize output and quality?

- Resource Targeting
  - Are public programs benefiting the intended beneficiaries? Is public spending reaching the poor?

Resource tracking is not a simple tracking tool for the financial number; it is a policy tool that help us develop a policy dialogue platform regarding the potential policy changes that are able to improve the resource availability and resource utilization for better service delivery.

EXISTING TOOLS/METHODS FOR THE RT

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GOVERNMENT REVENUE IN NIGERIA

Revenue as % of GDP

Source: IFM

HOW IS THE 2016 BUDGET DIVIDED IN NIGERIA?

The Top five

Infrastructure - N467bn
Defence - N429bn
Education - N406bn
Police - N300bn
Health - N257bn

Source: Budget Office
FLOW OF PUBLIC FUNDS FOR PHC IN NIGERIA

Sources of funding

- Federal accounts
- LGA revenue
- LG council
- LACA

Funding pool

- LMH
- NPHCDA
- NHIS
- NACA
- MDG
- SURE-P

Flow of funds

- Premium revenue
- State revenue
- LGA revenue
- Facility revenue

PUBLIC PHC EXPENDITURES AT EACH LEVEL: KADUNA

How does the public financing work? How much is spent at each level?

<table>
<thead>
<tr>
<th>Level</th>
<th>Total, USD millions</th>
<th>Per capita, USD</th>
</tr>
</thead>
<tbody>
<tr>
<td>National</td>
<td>1,828</td>
<td>11.1</td>
</tr>
<tr>
<td>State (Kaduna)</td>
<td>52</td>
<td>8.3</td>
</tr>
<tr>
<td>LGA (Kaduna)</td>
<td>59</td>
<td>8.3</td>
</tr>
<tr>
<td>Facility</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Key observations on public financing for PHC

- Majority (>90%) of PHC funding allocated for capital costs
- Multiple funding flow for PHC (MDG, Sure-P) which state/LGA do not control
- Majority of state health spending allocated for secondary/tertiary care
- ~30% PHC spending allocated for capital costs
- Comprises majority of public PHC funding
- LGA funds largely influenced/controlled by state level (governor, MoLG)
- Vast majority (~95%) of funding allocated for salaries
- >50% of facilities receive no cash; 85% receive less than $100 a month
- Rely on user fees for internally generated revenues to fund most of non-salary recurring costs

1 Projected 2012 population of 7.1M for Kaduna and 64.3M for Nigeria; 2 All health and PHC budget data for 2012 from PATHS 2 resource tracking report

SOURCE: SDI, PATHS 2

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PHC facilities require a minimum of $1,200 (180,000 naira) a year to fund operational expenses (excluding drugs)

- Primary Health Center visited in Kaduna reported needing a minimum of $1,200 (180,000 naira) a year in cash to fund operational expenses (excluding drugs) including:
  - Laundry detergent
  - Cleaning supplies
  - Gauze and other medical consumables
  - Utilities
  - Fuel for generator
- CHCs would require more cash than this minimum threshold
- Facilities fund operational expenses with user fees or cash loans from facility in-charge due to lack of public funding
- Most facilities received less than $1,200 a year

Cash received from government & NGO sources in last fiscal year

Percent of facilities surveyed

- 12
- 1
- 2
- 2
- 8
- 20
- 53

Minimum cash needed for operational expenses:
- $1,200 a year
- $100 a month

No cash $0-300/yr $300-600/yr $600-900/yr $900-1200/yr $1200-1500/yr $1500-1800/yr $1800+/yr

Receive less than minimum level of cash

Source: World Bank Service Delivery Indicators (SDI), 2013; Field visits

PUBLIC SECTOR PHC FACILITIES CASH FLOW

ALLOCATION OF PUBLIC PHC EXPENDITURES

PHC cost categories | Share of public funding for PHC | Funding Sources | Public Funding Reliability |
<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries</td>
<td></td>
<td>LGA Joint Account is primary funding source</td>
<td>Close to 100% budget execution for salaries</td>
</tr>
<tr>
<td></td>
<td></td>
<td>LGA controls salary payments for levels 7+</td>
<td>Strong political pressure from organized health worker associations</td>
</tr>
<tr>
<td>Drugs</td>
<td></td>
<td>Out-of-pocket payments primary funding source for drug supply</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>States, LGA’s and donors provide DPR seed funding</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Federal agencies and donors supply drugs for vertical programs</td>
<td></td>
</tr>
<tr>
<td>Operations</td>
<td></td>
<td>Out-of-pocket payments only funding source for operational expenses at the facility level</td>
<td>No funding for operations at the facility level</td>
</tr>
<tr>
<td></td>
<td></td>
<td>States allocate joint Account funds for capital expenditures</td>
<td>Only 30-60% of overall capital budgets are executed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>LGA Chairman funds capital projects</td>
<td>Capital projects often arbitrarily initiated by Governors and LGA Chairman</td>
</tr>
<tr>
<td>Capital</td>
<td></td>
<td>MDG and SURE-P fund specific PHC facilities</td>
<td>Little capital financing reaches facilities</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NACA funds HIV/AIDS initiatives</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>NHIS purchases PHC services from accredited facilities</td>
<td></td>
</tr>
<tr>
<td>Special initiatives &amp; programs</td>
<td></td>
<td>MDG and SURE-P without reliable future funding sources</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>NHIS/MDG program has limited current scope and dependent on MDG funding</td>
<td></td>
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Source: Field visits, expert interviews
On average, Nigeria’s PHC medical staff see 1.5 outpatient visits per day, which is very low compared with:

- 25-30 visits per day by PPMVs (Kabbi, Benue)
- 8.7 outpatients per day per PHC medical staff in Kenya
- 10 outpatients per day per PHC medical staff in Uganda
- 6.7 outpatients per day per PHC medical staff in Zambia

Very few public PHC facilities are productive: Less than 5% of health posts and health clinics, and less than 10% of PHCs see more than 5 outpatient visits per medical staff per day.

SOURCE: World Bank Service Delivery Indicators (SDI), 2013; ACEH PPMV study

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<table>
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<tr>
<th>Facility</th>
<th>Poorest Quintile</th>
<th>Quintile Q2</th>
<th>Quintile Q3</th>
<th>Quintile Q4</th>
<th>Richest Quintile</th>
<th>No. of HHs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public primary facilities</td>
<td>58.9%</td>
<td>49.4%</td>
<td>40.8%</td>
<td>34.6%</td>
<td>29.9%</td>
<td>16,991</td>
</tr>
<tr>
<td>Public secondary facilities</td>
<td>39.7%</td>
<td>38.8%</td>
<td>52.4%</td>
<td>53.4%</td>
<td>54.8%</td>
<td>17,018</td>
</tr>
<tr>
<td>Public tertiary facilities</td>
<td>8.3%</td>
<td>12.8%</td>
<td>19.8%</td>
<td>24.3%</td>
<td>34.8%</td>
<td>17,030</td>
</tr>
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Average Benefit Incidence Per Services (Naira)

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<th>Public secondary facilities</th>
<th>Public tertiary facilities</th>
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<tr>
<td></td>
<td>2,795</td>
<td>2,291</td>
<td>3,133</td>
</tr>
<tr>
<td></td>
<td>2,728</td>
<td>2,541</td>
<td>3,512</td>
</tr>
<tr>
<td></td>
<td>2,718</td>
<td>3,137</td>
<td>4,071</td>
</tr>
<tr>
<td></td>
<td>2,352</td>
<td>3,240</td>
<td>4,361</td>
</tr>
<tr>
<td></td>
<td>2,188</td>
<td>3,672</td>
<td>5,055</td>
</tr>
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HOW TO TRANSFER “CRISIS” TO “OPPORTUNITIES”? 

- In Chinese “Crisis” is “危机”, which includes to English words “Danger” and “Opportunity”
- The potential “Opportunities” are efficiency gains, in additional to better fiscal policies

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