Public financial management systems strengthening

Key messages: **Overcoming weak public financial management systems is both a technical and a governance issue. Solutions in both areas are needed to strengthen PFM systems.**

1. Strengthening PFM systems requires support across many components.
2. Ensuring transparency and accountability is vital.

The challenge: overcoming weak PFM systems

Finance is a major obstacle in the provision of better health services. Financial transparency and accountability are at the core of the global agenda to improve health funding, manage costs in the most effective manner and ensure value for money. For UKaid and many other development partners, value for money has become a priority.

Public financial management systems are essential for ensuring that:

- Government revenue projections are realistic
- Budgeting processes and systems are aligned with planning systems
- Financial resources are released according to approved plans
- Expenditure is linked with a monitoring and evaluation plan
- Expenditure is tracked, documented and associated with improved indicators
- Auditing processes confirm transparent and accountable processes

Since financial control is key to the struggle for political and economic power by politicians and other political stakeholders such as traditional institutions, bureaucrats and the private sector, the process of strengthening financial management in the health sector has a strong governance dimension. Strengthening PFM means taking actions that could potentially affect a range of powerful individuals and groups. Challenges include:

- Political interference, often leading to unrealistic fiscal projections, overbudgeting and ultimately central allocation of resources for political priorities
- Irregular and incomplete release of budgeted funds due to poor fiscal projections
- Limited capacity of administrators to defend their budgets
- Poor memo writing leading to limited release of budgeted resources
- Inadequate oversight by the legislative arm of government, especially at state and local government area (LGA) levels, leading to a failure to call the executive branch to account
- Distortion of budget processes and implementation due to the absence of transparency and accountability at all levels
- Weak capacity and commitment of budget planning teams grounded in their past experience where budgets and planning were seen as futile
- Poor resource mobilisation, coordination and harmonisation of funds at federal and state levels due to vested interests of development partners
- Limited capacity of the state assembly and non-governmental organisations (NGOs) to track budget allocations and budget releases

THIS DOCUMENT IS ONE OF A SERIES OF TECHNICAL BRIEFS THAT DRAW ON THE ACTIVITIES, RESULTS AND LESSONS LEARNED FROM THE PRRINN-MNCH PROGRAMME

The response: strengthening PFM teams

The approach focuses on increasing health sector access to financial resources and ensuring that health managers use financial resources in an accountable and transparent manner. This guarantees value for money and provides a safety net for the poor and those at greatest risk. Since 2009 PRRINN-MNCH has supported these five areas:

Budgeting:
This includes strengthening the annual budget process through budget planning, budget preparation, budget execution (accounting, auditing), budget monitoring and evaluation; expenditure tracking by line item and programme; tracking of health sector budget performance through design of programme and sub-programme budget structures; capacity building and advocacy.

Public health expenditure reviews:
This includes introducing and supporting the concept of regular budget activity reviews at 3-6 month intervals. Expenditure reviews look at budget release and expenditure as well as the relationship between release and service provision.

Financial management system strengthening:
The focus is on strengthening state and LGA financial management systems which covers the State Ministry of Health (SMoH) and its agencies, including PHC boards and the Gunduma system, state medical stores, LGA health departments and health facilities, with a special emphasis on drug supply systems.

Supporting PHC under one roof:
This includes establishing 'pooled funds' that require state and LGA joint financial contributions, building the capacity of the managers of pooled funds and the provision of financial and operational manuals and guidelines for pooled funds.

Mobilisation of federal government PHC resources by states and LGAs:
This includes designing, streamlining and strengthening financial mechanisms for leveraging funding from federal to state and LGA levels for immunisation and health care.

Success in leveraging extra resources for health

Basket fund in Zamfara

To strengthen PHC delivery in Zamfara a pooled fund (called the basket fund) was created. State, local government and development partners contributed and the funds were used for tasks such as supervision, vaccine distribution and outreach services. This has contributed to improved immunisation coverage, among other service improvements.

GAVI funds

Many states did not have the mechanisms in place to effectively retire GAVI funds for strengthening health systems. Before 2009 none of the states had accessed more than one tranche of funding. Following support provided to access and retire these funds, performance in the states has improved and GAVI funds are available on an ongoing basis.

Using the MDG funds in Jigawa

MDG funds were made available for states to access. The creation of an integrated health system in Jigawa (the Gunduma system) allowed for single integrated health plans to be developed. This has meant that multiple funding sources can be used to strengthen the healthcare delivery system. Using a Minimum Service Package approach, the Gunduma Board has directed MDG funds for maintenance and refurbishing of facilities in the state. In 2009 ₦377 million was spent in this way and ₦609 million in 2010.

The results: better use of increased financial resources

At federal level, PRRINN-MNCH support has assisted in:

Leveraging of financial resources including support to lobby for Global Alliance for Vaccines and Immunisation (GAVI), Millennium Development Goal (MDG) and other development partner funds to Nigeria and to the PRRINN-MNCH supported states

Designing and building the capacity of NPHCDA to manage GAVI funds via the development of guidelines and manuals as well as training of staff

Building government capacity to access Subsidy Re-investment and Empowerment Programme (SURE-P) health funds

At state level, PRRINN-MNCH support included:

Establishing budget and planning committees in the PRRINN-MNCH states and building their capacity to use PFM guidelines and manuals. The training has covered use of budget templates, unit costing, tracking tools and processes

Support to introduce appropriate budget codes in health budgets to improve budgeting and expenditure tracking

Strengthen capacity to access funds through memo writing (and documenting of previous impact) enabling the states to advocate more effectively for the release of budgeted funds

Establishing budget monitoring and tracking systems in all four states

Introducing a culture of regular budget reviews at state and sub-state levels ensuring that budget and expenditure figures are available and that financial data are reliable

Integrating budgets and plans at state, Gunduma and PHC board levels

Separating the budget by department and unit and add specific monitoring and evaluation (M&E) targets

Health expenditure (₦1bn) per annum by state

	2009	2010	2011	2012
Jigawa	5.2	7.7	10.3	11.8
Katsina	5.9	3.6	6.1	8.1
Yobe	2.8	2.4	3.5	1.8
Zamfara	3.0	3.8	4.2	3.8

Negotiating the joint account between states and LGAs as these are centrally controlled by the governor and impact on budget release particularly at LGA level

Supporting the establishment of pooled funds by developing financial management guidelines and training stakeholders in their use

Strengthening advocacy to policy makers and influential people to improve health funding

Aligning planning, budgeting and review processes:

- All four PRRINN-MNCH states and many LGAs have costed annual plans aligned to their respective strategic health plans, the available budget envelope and in line with the budget cycle
- All four states have monitoring and evaluation (M&E) frameworks to measure performance
- A system of performance reviews has been introduced in all four states
- Expenditure tracking tools are available and are being used to inform management decision making

In most states, health sector budgets are more realistic and better linked to annual health plans. Jigawa and Zamfara have developed medium term expenditure frameworks and access to financial data at state and LGA levels has improved significantly.

Data on the percentage of the total budget allocated to health (Fig 1) illustrate how far states have come in reaching the target of 15% of total budget stipulated by the 2001 Abuja Declaration. However, the picture is rather mixed. In Jigawa 12% of the entire state budget was allocated to health in 2012, while Zamfara achieved just over 6% (a decrease on the previous three years).

More importantly, analysis of total expenditure on health (table, below) shows that Jigawa has more than doubled its health expenditure in the last four years, Katsina has increased its expenditure by approximately 35% and Zamfara by 30% while Yobe was increasing but declined in 2012.

Analysis of per capita spend provides additional insights into changes in government health expenditure. The pattern shows an overall increase in three states, and a decrease in Yobe.

Data on per capita spend (in $, Fig 2) illustrate how close the states are to reaching the WHO minimal level of around $42 per capita per annum. In all cases, the states have a long way to go before they reach the WHO benchmark. However, the analysis in Fig 2 does not include LGA, Federal Ministry of Health (FMoH) or federal ministries, departments and agencies (MDA) expenditure. To obtain a full picture of per capita expenditure, reliable data relating to all three levels needs to be captured but is not yet available.

A further indicator is budget performance (Fig 3) which in the health sector is a measure of how accurate government fiscal projections and budgeting processes are, and also how good the budget releases are in relation to the budget. Health budget performance is good in Jigawa, improving in Katsina and deteriorating in Yobe. Zamfara presents a mixed picture, initially improving but deteriorating in 2012.

There are three major components to the budget (personnel, overhead and capital). Often there is overbudgeting and under-spending on the capital component, but excellent budget performance on the other two components. The Zamfara graph (Fig 4) illustrates that budget performance (for personnel and overhead) improved, reaching over 100% and total spend (for personnel and overhead) increased for the years 2009-2011. However there was a decline in 2012, contrasting with overall budget performance between 60-70% (with an equal decline in 2012).

Fig 1: Percentage of total budget allocated to health

Jigawa has nearly doubled its health budget, but Yobe's has declined.

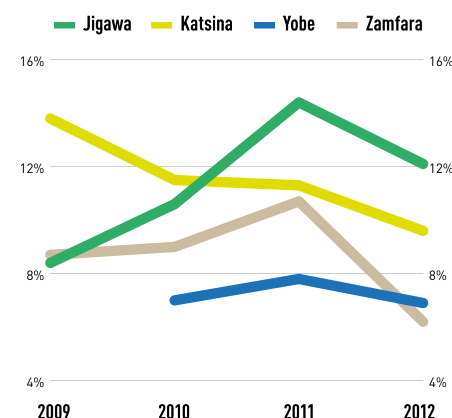


Fig 2: Per capita expenditure

Jigawa is closest to reaching the WHO minimal level of around $42 per capita per annum.

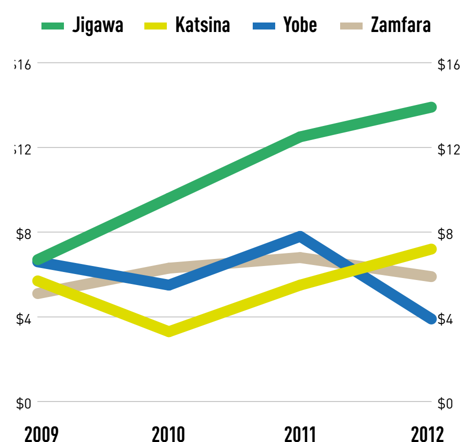


Fig 3: Budget performance

Jigawa performed well, Katsina improved but Yobe and Zamfara declined.

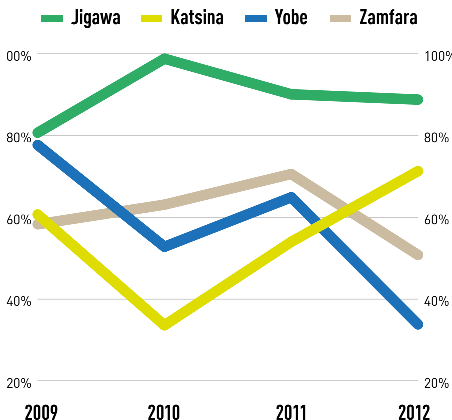
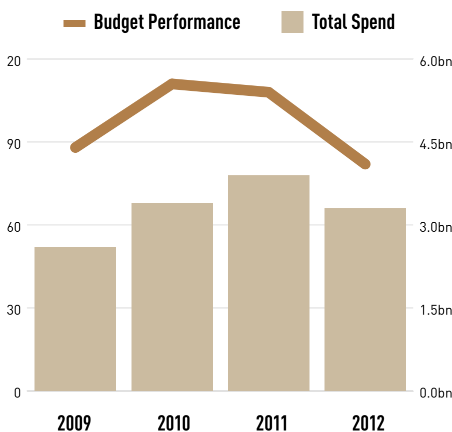


Fig 4: Zamfara – personnel and overhead budget performance

Budget performance for personnel and overhead improved and reached over 100%.



Policy implications

Probably the two most important components of a functional health system are finance and human resources. Neither of these is easy to deal with and both require technical and governance expertise. To strengthen PFM systems requires the capacity to work in several technical areas at the same time. These include strengthening financial management systems but also supporting revenue projections, aligning financial and budgeting skills with planning, monitoring and reviews. Allied to these technical aspects is the capacity to engage with political stakeholders and communities. If the governance aspect is ignored, then any changes are unlikely to take root and flourish.

Conclusion

Tackling weak PFM systems requires both technical and governance expertise. It also requires building trust over a long time. There are no quick fixes in strengthening PFM systems and many hiccups and challenges are to be expected along the way.

Partnership for Reviving Routine Immunisation in Northern Nigeria; Maternal Newborn and Child Health Initiative

The PRRINN-MNCH programme works with federal, state and local governments and local communities to improve the quality and availability of maternal, newborn and child health services.

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