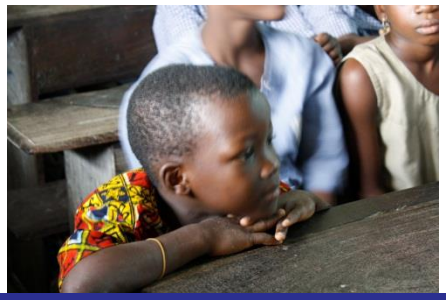
USAID
FROM THE AMERICAN PEOPLE

Health Finance & Governance
Expanding Access. Improving Health.



BAUCHI STATE 2012-2016 PUBLIC EXPENDITURE REVIEW

August 2018
This publication was produced for review by the United States Agency for International Development.
It was prepared by the Health Finance and Governance Project.

The Health Finance and Governance Project
USAID's Health Finance and Governance (HFG) project will help to improve health in developing countries by expanding people's access to health care. Led by Abt Associates, the project team will work with partner countries to increase their domestic resources for health, manage those precious resources more effectively, and make wise purchasing decisions. As a result, this five-year, $209 million global project will increase the use of both primary and priority health services, including HIV/AIDS, tuberculosis, malaria, and reproductive health services. Designed to fundamentally strengthen health systems, HFG will support countries as they navigate the economic transitions needed to achieve universal health care.

DATE 2013

Cooperative Agreement No: AID-OAA-A-12-00080

Submitted to: Scott Stewart, AOR
Office of Health Systems
Bureau for Global Health

Recommended Citation: The Health Finance and Governance Project. August 2018. *Bauchi State 2012-2016 Public Expenditures Review.* Bethesda, MD: Health Finance & Governance Project, Abt Associates Inc..

Abt Associates Inc. | 4550 Montgomery Avenue, Suite 800 North | Bethesda, Maryland 20814
T: 301.347.5000 | F: 301.652.3916 | www.abtassociates.com

Avenir Health | Broad Branch Associates | Development Alternatives Inc. (DAI) |
| Johns Hopkins Bloomberg School of Public Health (JHSPH) | Results for Development Institute (R4D)
| RTI International | Training Resources Group, Inc. (TRG)

BAUCHI STATE
PUBLIC EXPENDITURE REVIEW 2012-2016

DISCLAIMER

The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development (USAID) or the United States Government.

CONTENTS

Contents ..... **i**

Acronyms ..... **iii**

Executive Summary **5**

1. Introduction **9**

1.1 Background 9
1.2 Situation Analysis of Bauchi State 9

2. State Health budget and expenditure analysis **13**

2.1 Introduction 13
2.2 State Revenue 13
2.3 State budget and actual expenditure review 14
2.4 Public Health budget and actual expenditure review 15
2.5 Share of state budget and actual expenditure in other key sectors 19

3. Bauchi state health performance review **22**

3.1 Introduction 22
3.2 State Population Health Status Comparison Among HFG Selected States 22
3.3 Health Service Delivery/Provision 23
3.4 Health Financing Comparison with Other HFG selected States 24

4. Recommendations **27**

ANNEX **29**

List of Tables

Table 1: Bauchi State Health Performance Indicators 10
Table 2: Bauchi State Revenue Profile 2012 – 2015 13
Table 3: Budget Performance Rates 20
Table 4: Selected Health Indicators across HFG slected states in 2016 22
Table 5: Health service provison across HFG slected states IN 2016 23
Table 6: Selected Health Financing Indicators across HFG slected states during thr review period 24
Table 7: : Share of Health Expenditure in Bauchi and Plateau State 24
Table 8: Government General Health expenditure per capita in Bauchi and Plateau State 25

List of Figures

Figure 1: Funds Flow from Federation Account 11
Figure 2: Bauchi State Revenue Composition 2012-2016 14
Figure 3: Bauchi State Budget 14
Figure 4: Bauchi State Actual Expenditure 15
Figure 5: Share of Recurrent and capital conponments in State Budget and Actual Expenditure 15
Figure 6: Trend of Health Budget and Expenditure 16
Figure 7: Health share in state government budget and expenditure 16
Figure 8: TRend of Health Capital and Recurrent Budget 17
Figure 9: Trend of Health Capital and Recurrent actural Expenditure 18
Figure 10: Trends of Per capita public Health budget and expenditure 18
Figure 11: Budgetary Allocation to Key Sectors in Bauchi State 19
Figure 12: Key sectors' Actual Expenditure 20

ACRONYMS

AG	Accountant General
CSOs	Civil Society Organizations
FMoH	Federal Ministry of Health
GGE	Government general expenditure
HFG	Health Finance and Governance
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HMB	Hospital Management board
HMOs	Health Maintenance Organizations
IGR	Internally Generated revenue
OYSSACA	Bauchi State Agency for the control of AIDS
LGA	Local Government Area
MDAs	Ministries Departments and Agencies
MDG	Millenium development goals
MNCH	Maternal, Neo-natal and Child health
MoF	Ministry of Finance
MoLG	Ministry of Local Government
PER	Public Expenditure Review
PFM	Public Financial Management
PHC	Primary Health Center
SMoH	State Ministry of Health
SSHDP	State strategic health development plan
SSHIS	State Supported Health Insurance Scheme
UHC	Universal Health Coverage
USAID	United States Agency for International Development
VAT	Value Added Tax

EXECUTIVE SUMMARY

Globally, health systems are faced with increasing demands and responsibilities in the face of stagnated and dwindling financial resources from both internal and external sources. Increasing population size, high level of poverty, emerging and new disease areas and costly non-communicable diseases jointly contribute to the pressure being faced in the health system.

In a bid to reduce the pressure and improve the current health outcomes, Nigeria and many countries have subscribed to the principle of Universal Health Coverage (UHC) which is aimed at ensuring equitable access to needed health care without suffering financial hardship[1]. Bauchi State, like many other states, is in the process of embracing health financing policy reform thrust introduced at the national level in order to achieve more money for health and more health for the money. The state has therefore keyed in to health financing policy reform directives including decentralization of the national health insurance scheme that will usher in State Supported Health Insurance Scheme, PHC management integration policy called PHCUOR, Revitalization of PHC for UHC policy and other laudable policies.

However, it is increasingly recognized that public funding will play a crucial role towards achieving UHC. Efficiency of public spending on health is as important as the volume of the resources. In order words, more money for health and more health for the money are the key intermediate objectives on the path towards UHC. In order to understand the magnitude and flow of health resource which will enable Bauchi state to put available meager resources into better utilization, USAID/HFG embarked on Public expenditure Review (PER) in collaboration with the state stakeholders. A PER analyzes government expenditures over a period of years to assess their consistency with policy priorities, and what results were achieved.

The aim of this reivew is to collect, collate and compare health expenditures over a period of four years in order to help the state government and state ministry of health to determine the adequacy of public expenditures on health in total terms and in terms of the categories of expenditures, e.g. recurrent compared to capital expenditures, which allows decision makers to assess their capacity to meet health policy objectives. Expenditures can be compared across sectors, with other states, and with other appropriately selected countries. Equally, policy makers and planners can also use the result of the review to infer whether current public spending is sustainable, equitable and efficient.

Objectives

- The main objective of the review is to analyze and establish the trend in budgetary allocation and expenditure considered necessary for evidence based decision making in the health sector. Its specific objectives include:
- Analysis of the state capital and recurrent budget and expenditure for 2013 to 2016
- Analysis of budget and expenditure trends for the four key sectors (Health, Education, Agriculture

[1] (WHO 2017) Universal Health coverage

and works & transport) with a view to establishing the level of priority accorded the health sector

- Assessment of health financing system in the state, its efficiency and performance

Methodology

The PER team was constituted of members drawn from the State Ministry of Health, Ministry of Finance and economic development, Accountant General's office, Ministry of Budget and economic planning, Bureau for Local Governments affairs, BACATMA and HFG. The team was led by the State Ministry of Health with technical support from the HFG project. The team was led by the State Ministry of Health with technical support from the HFG project. During the review's start up a stakeholders' forum was convened to provide a platform for sharing the objectives and methodology for the exercise. The forum provided the medium for dialogue, to agree on data requirements and identification of data sources as well as outlining the roles and responsibilities of all stakeholders involved. It also provided the opportunity to understand the contextual peculiarities of the State and achieve a consensus on the relevant outputs required.

The method of data collection was designed and pretested to collect health expenditure data from all stakeholders. The PER team collected primary and secondary data from State Ministries, departments and Agencies as well as the interviews with relevant stakeholders. The main healthcare financing information provided by the state government were obtained from approved budgets and actual expenditure reported for years 2013 to 2016. Reviews of relevant document were carried out to elicit relevant information for quality of the assessment. Data management and analysis were done by HFG, in conjunction with State officials.

Limitations

- Data from the LGA was not sufficient for in-depth analysis of health financing at that level.
- Budgets were not linked to expected output and outcome/target, making it challenging to assess the effectiveness of health expenditure. The health indicator data provided was not sufficient to carry out adequate comparison with other states in order to establish its relative level of performance.
- Budget and financial statements were not disaggregated into program and intervention areas making it difficult to map out expenditure allocated based on this criteria; this problem is more profound under recurrent expenditure.
- Also, lack of adequate data on sector performance/health outcome made it difficult to measure the developmental impact of health spending. Accuracy and completeness of available data could not be confirmed.

Assumptions

1. Annual population growth rate of 3.46% from 2006 population result2
2. A rate of US$1.00 to N150, N170, N190 and N300 for 2013, 2014, 2015 and 2016 respectively

Main Findings

---

[2] Population by state and sex : population.gov.ng

Federal Government funding remains the dominant source of health sector financing during the period under review. During the years under review, statutory allocations from Federal Government remained the main source of the state's revenue contributing an average of 62% of the total revenue. Internally generated revenue (IGR) contributed an average of 6%; the rest came from excess crude transfers and miscellaneous receipts.

Public health sector financing ranged between 8 percent and 11 percent over the four-year period under review, and the share of the health budget in the total government budget remains below the 15 percent recommended under the Abuja Declaration. Although government is committed to sustaining increased funding for health as highlighted in the SHDP (2010 – 2015), health budget and expenditure is by far below the plan except in 2016 which had a one-off dramatic increase; health sector budget increased from N10.72 billion in 2013 to N12.74 billion in 2014, dropped significantly to N9.09 billion in 2015 and then reached a high of N18.16 billion in 2016; this translates to about 69% increase from the total allocation between 2013 and 2016. Though the health budget increased in 2016 relative to 2013 budget, the actual expenditure decreased from N6.61 billion in 2013 to N5.46 billion in 2016.

Small share of public health sector expenditure spent on capital investment. Within the context of generally low spending in the health sector, the share of capital investment as a proportion of general health spending is low as it represented only an average of 18.8 percent of government health spending in the period under review. The capital budget was constantly lower than the recurrent budget. The persistently low capital investment implies a failure to scale up infrastructure at a rate necessary to address gaps and a decline in the quality of existing infrastructure.

Per capita public health allocations kept decreasing between 2013 and 2016. In general, per capita health spending falls significantly short of the recommended target of USD86[3] to deliver a package of basic health service - average health expenditure per capita was $6.

H**ealth sector budget implementation was not satisfactory** throughout the review period; it remains vulnerable to persistent challenges in the implementation of the capital budget. The overall state health budget implementation rate for the period of 2013 – 2016 ranged between 30 percent and 80 percent staggering between the years; when broken down, the recurrent budget implementation rate stood at an average of 89 percent between 2013 and 2016 against that of capital which was on an average of 28 percent within the same period. This pattern of spending reveals the priority accorded recurrent expenditure at the detriment of capital expenditure and this calls for serious concern.

Recommendations

Both arms of government (state and LGA) and key stakeholders should be effectively engaged to advocate for increased allocation to the health sector. The budget and expenditure trend in the state show that health is not being accorded the priority suggested by the state's own SHDP. As a state with a high burden of disease, there is urgent need to invest far more than 8 percent of its resources on health. Despite the government's stated commitment to increase the share of health sector financing in the government budget to at least the 15 percent recommended in the Abuja Declaration,

[3] $86 (expressed in 2012 terms) being the estimate of per capita resource requirements for providing a minimum level of key health services in low-income countries. *Fiscal Space for Domestic Funding of Health and Other Social Services.* Di McIntyre and Filip Meheus. *March 2014*

this has yet to be achieved, the state stakeholders should build consensus and work collaboratively to have political attention addressed on health financing to public health.

Prioritize PHC care especially for maternal and child health. Government spending needs to be re-directed to care at the PHCs level which has been identified as the key to UHC. Bauchi State government should ensure funding and sustained implementation of Primary Health Care Under One Roof (PHCUOR) to support the integrated management and development of PHCs and increase the use of public funding for the Bauchi State Health Insurance Scheme to support the access to and increase coverage of maternal and child health services.

Improve the budget implementation capacity among major sectors including health sector. The budget implementation rate was extremely low in the reviewed sectors whatever the share of budget. Execution of the budget continues to be plagued by several impediments, such as the current practice of fragmented financing systems - an issue potentially addressed by PHCUOR which brings payment for human resources, supplies and infrastructure into one management agency unlike the current situation. The efforts should be addressed to those impediments to ensure the efficient implementation of the budget.

Consider developing a resource-tracking database to improve reporting systems and data availability for monitoring financial resource inflow and expenditures. As in many developing countries, Bauchi state government has very limited capacity to measure the impact of public expenditure and most agencies are pre-occupied with reporting how inputs have been used rather than highlighting outcomes achieved. In view of this, the HMIS/M&E team needs to be better engaged in order to identify the most feasible way to link performance to productivity. Increase the capacity of institutionalizing the PER (with better, more detailed data) and other resource tracking initiatives such as National Health Accounts (NHA) etc. is important for sustainable capacity build up.

Further public financial management (PFM) assessment is recommended to identify the cause of the current absorptive capacity for capital funds within the health sector and necessary technical support should be sought to remove identified bottlenecks. The low capital investment is unable to address the critical infrastructural gap identified during the recently conducted service availability and readiness assessment supported by USAID/HFG; and it is essential that the state understand why this rate is low and how it can be improved.

1. INTRODUCTION

1.1 Background

Bauchi State, like many other states in Nigeria, is in the process of embracing health financing policy reform directives introduced at the national level in order to achieve more money for health and more health for the money. Bauchi state has therefore keyed in to health financing policy reform thrusts including decentralization of health insurance scheme that will usher in State Supported Health Insurance Scheme, PHC management integration policy called PHCUOR and Revitalization of PHC for UHC policy.

Bauchi has made considerable progress towards introduction of state supported health insurance scheme as the legal framework has been passed into law by the State House of Assembly and accented by the executive Governor of the state.

In order to achieve context-appropriate and sustainable health financing reform USAID/HFG is supporting the state to conduct health financing diagnostic in a number of important areas including public expenditure review (PER), governance/political economy assessment and fiscal space analysis. A PER analyzes government expenditures over a period of years to assess their consistency with policy priorities, and what results were achieved.

Our expectation is that the PER will generate needed evidence to make necessary changes to the flow and magnitude of government health expenditure that is aimed at achieving the desired goal of more money for health and more health for the money.

1.2 Situation Analysis of Bauchi State

1.2.1 History

Bauchi State is one of the 36 States of the Federal republic of Nigeria; it is in the North east geo-Political zone of the country with Bauchi as its capital. The population of the State was put at 4,653,066 by the 2006 census with a growth rate of 3.46% per annum; the State was to have a projected population of 6,538,287 by the end of 2016. There are 20 LGAs in the state; 80 percent of the entire population in Bauchi state lives in the rural areas while only 20 percent reside in urban centers. The predominant occupation of the citizens is subsistence farming (e.g., animal husbandry and crop production).

1.2.2 Health status of the population

The demographics in Bauchi State shows that women of child bearing age and under five children, who are the most vulnerable, constitute 22% and 20% of the population respectively. The health situation in

the State, like the situation at the national level, is characterized by poor indicators amidst a growing population and dwindling health resources.

Table 1: Bauchi State Health Performance Indicators

INDICATOR	North-East	Bauchi	National
Infant Mortality rate (deaths/1000 live births)	62	81	70
Child mortality rate (deaths/1000 children surviving to age one)	56	87	54
Under-five mortality rate (deaths/1000 live births)	115	161	120
Estimated % of children 12 – 23 months with full immunization coverage by first birthday (measles by second birthday)	24	20	23
Use of FP modern method by married women 15-49 (%)	6	7.9	10.8
ANC provided by skilled Health workers (% of women with a live birth in the last two years)	67	59.8	65.8
No of deliveries in health facilities (% of women with a live birth in the last two years)	25.8	17.1	37.5
Skilled attendants at birth (% of women with a live birth in the last two years)	34	22.1	43

Source: Multiple Indicator Cluster Survey (MICS) 2016-2017

The bottleneck analysis conducted in the state at the PER stakeholder engagement meeting identified the following as the major challenges in the health sector:

- Political intervention in the implementation process limiting efficient resource allocation e.g. proliferation of health facilities
- Increased poverty level hindering access to effective health services
- Low level of awareness on the part of the citizenry in addressing their health care
- Inadequate human resource allocation for health/low staff motivation
- Inadequate resources for program implementation (modern equipment, funds and supplies)
- Poor monitoring and evaluation processes

However, the state government has within the last few years taken steps to improve the performance of the health sector. Some of the steps taken/proposed include:

- Assessment and renovation of some primary health facilities. (By now 20 PHCs have been upgraded to model PHCs by the state. HFG supported with evidence generation through development of Bill of quantities)
- Staff training/capacity building
- Subsidized or free at point of care MNCH services through state supported health insurance scheme (1% equity fund to cater for children U5 and pregnant women)
- Strengthened collaboration with partners
- Establishment of SSHIS and ensured legislative backing to support allocating 1% consolidated revenue

fund to cater for the vulnerable groups.

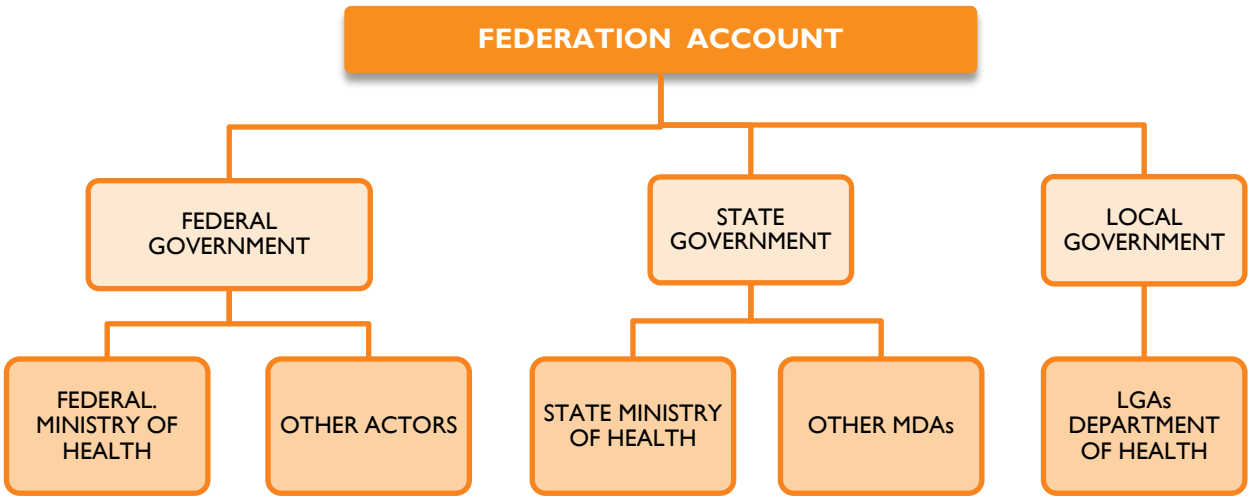
1.2.3 Overview of the State Health System

Nigeria is a Federal state with three tiers of government, namely the Federal, State and Local governments. Within the health public sector, primary-level health care falls under the responsibility of local government authorities (LGA), this means that primary health care (PHC) centres are owned, funded and managed by LGAs through their Departments of Health. Secondary level (and some Tertiary-level) health care falls under the responsibility of state Government through the Ministry of Health (SMoH), this level of care includes General Hospitals, the State-owned Teaching Hospitals and State specialist hospitals. The federal Government is responsible for teaching Hospitals of federal universities, FMCs and similar specialized tertiary level health care facilities and through the Federal Ministry of Health (FMoH).

It is worth noting that expenditure decisions of the three tiers of government are taken independently and the federal government has no constitutional power to compel other tiers of government to spend in accordance with its priorities and likewise, the State government cannot compel the LGAs to spend in line with its policy thrust.

The Nigerian government financial system operates a structure where funds flow to the three tiers of government from what is termed the Federation Account. the federation account serves as the central pocket through which government – federal, State and Local government – fund developmental projects as well as maintain their respective workforce. Figure 1 shows the flow of health fund from the federation account to the major actors in the health system.

Figure 1: Funds Flow from Federation Account



1.2.4 Bauchi State Strategic health development plan (2010 – 2015)

Bauchi State Strategic Health Development Plan (BSSHDP) (2010-2015) intends to reverse the trend of some of the health and development indices of the people of the state by reducing morbidity and

mortality due to communicable and non-communicable diseases to the barest minimum; meeting global targets and significantly increasing life expectancy and quality of life of the citizens of the state.

The plan was developed based on the generic framework provided by the national, as a guide to support evidence-based priority interventions that would contribute to achieving the desired targets.

The state set out its SSHDP by adopting the eight priority areas of the NSHDP. The priority areas are:

- Health service delivery
- Human Resources for health
- Leadership and governance for health
- Finance for health
- National health management information system
- Community participation and ownership
- Partnerships for health
- Research for health

The State planned to involve all partners (government, private health care providers, health development partner Agencies, CSOs, and NGOs) in the implementation of the plan while the State is expected to coordinate the activities of all the stakeholders to enhance efficiency.

2. STATE HEALTH BUDGET AND EXPENDITURE ANALYSIS

2.1 Introduction

This chapter presents an assessment of public health budget and expenditure trends between 2013 and 2016. The chapter also evaluates the sector budgetary absorptive capacity and resource allocation to key priority areas to support the SSHDP. The data used to carry out the analysis is appended at the end of this report which is archived from the state ministry of health, ministry of budget and economic planning, Accountant General's office, validated by HFG team and local officials.

2.2 State Revenue

The volume of revenue accruable to the state largely determines fiscal space available for government to spend on any sector including health. It is therefore, important to understand the volume, trend and composition of state government revenue (Table 2). The five-year government revenue review shows there are various sources of revenue available to the government which includes statutory allocation from the federation account (FAAC allocation and VAT), internally generated revenue, excess crude oil and other sources of revenue. Though fluctuating through the years under review, the revenue of the state increased from N77.6 billion in 2012 to N84.2 billion in 2016.

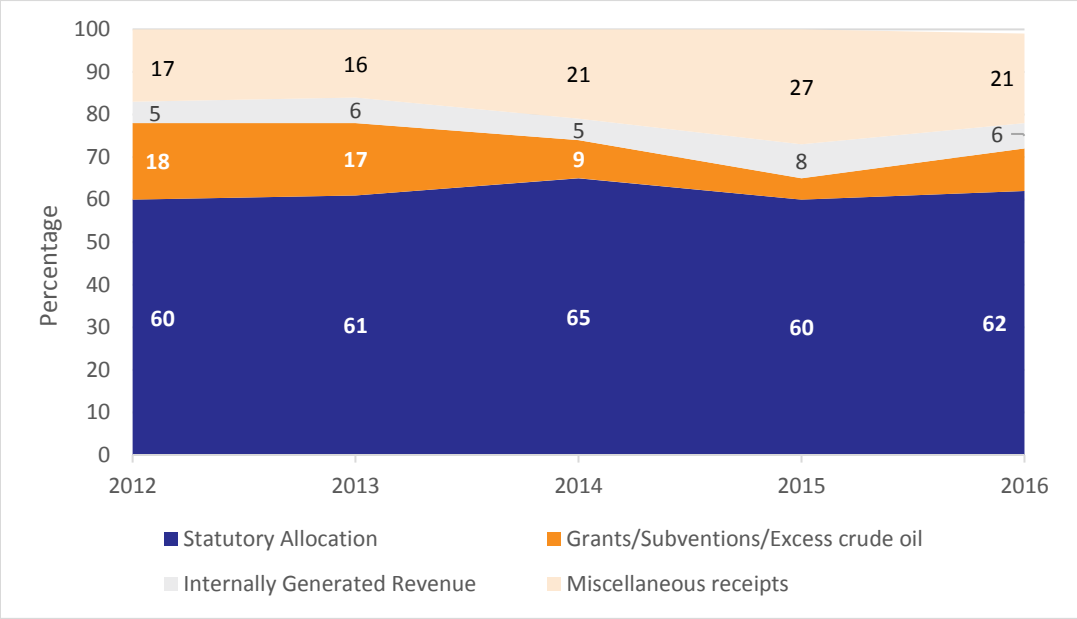
Figure 2 indicates that the Bauchi state revenue highly depended on statutory allocation from the federation account. During the years under review, statutory allocation remained the main source of the state's revenue contributing an average of 62 percent of the total revenue. Internally generated revenue (IGR) contributed an average of 6 percent while Excess crude and miscellaneous receipts contributed an average of 22 percent.

Table 2: Bauchi State Revenue Profile 2012 – 2015

SOURCE	2012 NGN	2013 NGN	2014 NGN	2015 NGN	2016 NGN
Statutory Allocation	46,453,672,367	51,967,077,759	57,418,441,067	45,150,702,383	52,456,272,433
Internally generated revenue	4,061,831,419	4,936,701,215	4,853,453,185	6,283,433,497	5,157,855,219
Grants/ Subventions/ Excess Crude	14,009,535,137	14,985,131,912	8,365,688,136	3,469,487,799	8,836,383,240
Miscellaneous Receipts	13,036,124,356	13,751,730,785	18,219,988,400	20,657,447,391	17,784,041,205
TOTAL	**77,561,163,278**	**85,640,641,671**	**88,857,570,788**	**75,561,071,070**	**84,234,552,097**

Source: Bauchi State Accountant General's report

Figure 2: Bauchi State Revenue Composition 2012-2016



2.3 State budget and actual expenditure review

The state total budget maintained a close range to the base year of 2013 except in 2015 when it declined significantly. In 2014, it declined slightly to N133.72 billion from N136.34 billion in 2013. The decline became more significant in 2015 at N102.86 billion and ended at N135.3 billion in 2016 (see figure 3). On the average, the state capital budget is above the recurrent budget. The actual expenditure reflects same trend and declined steadily between 2013 and 2016. Unlike the budget, the actual expenditure is spent more on recurrent part, ranging between 55% and 105% of the total health expenditure during the period under review; investment in social and economic infrastructure is required to grow the state and build its economy.

Figure 3: Bauchi State Budget

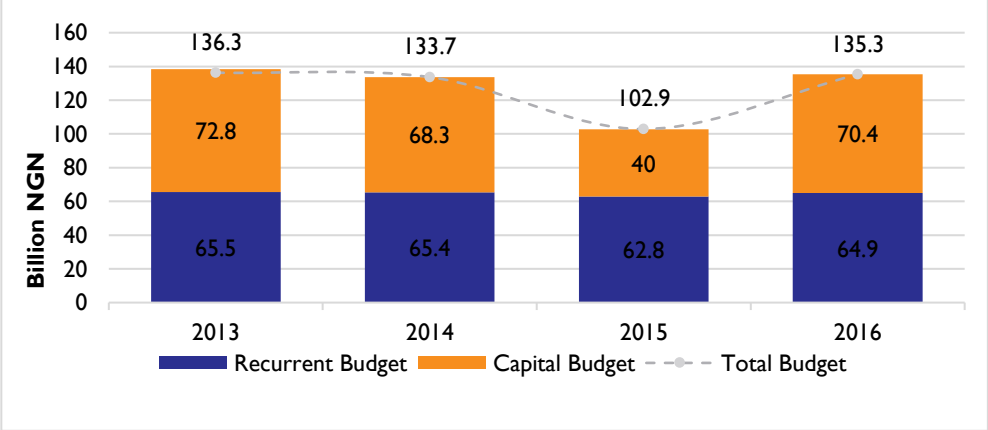


Figure 4: Bauchi State Actual Expenditure

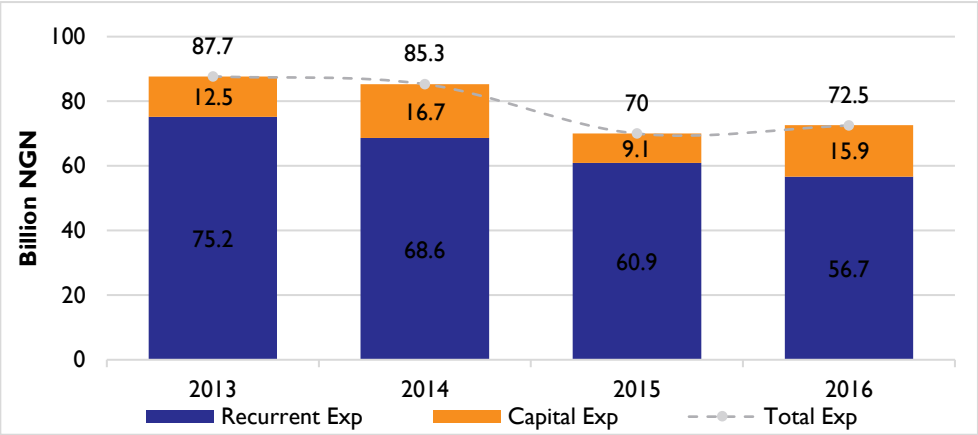
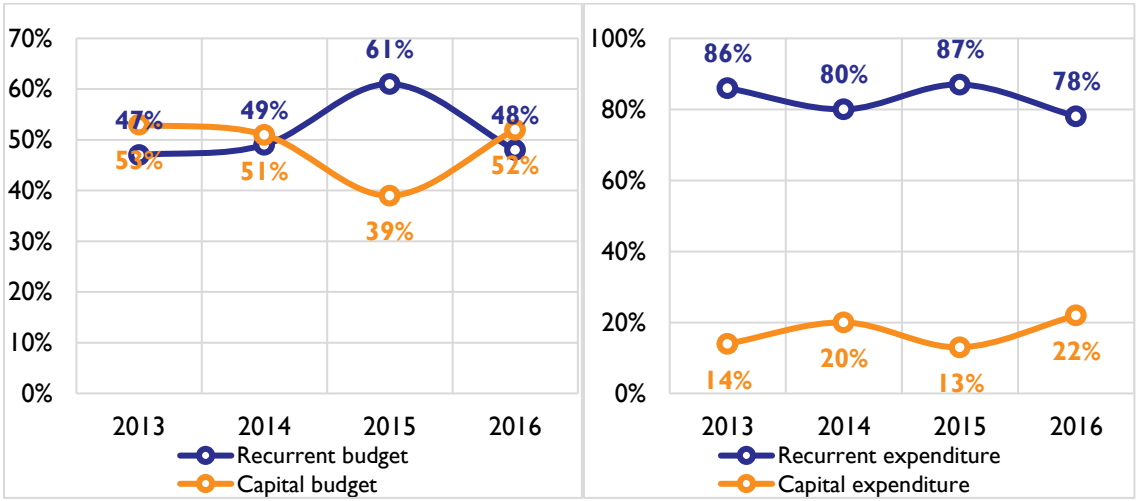


Figure 5: Share of Recurrent and capital conponments in State Budget and Actual Expenditure

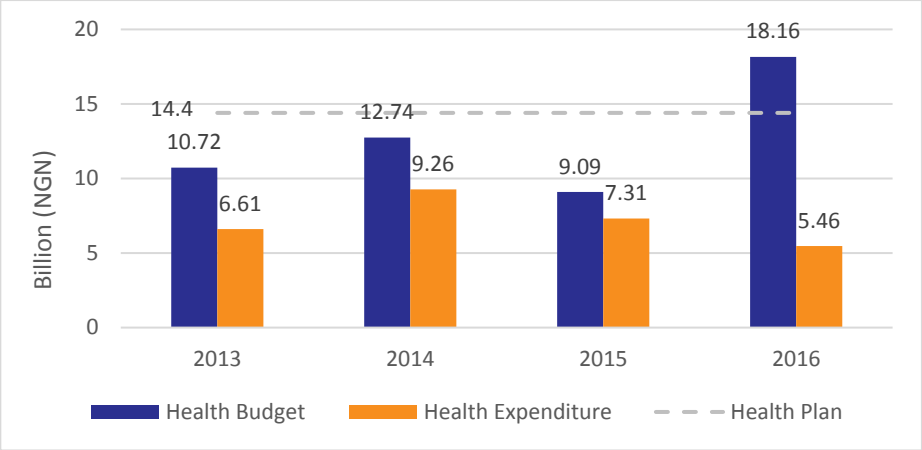


2.4 Public Health budget and actual expenditure review

2.4.1 Total Public Health Budget and Expenditure

Health budget and expenditure is lower than the funds planned for health as highlighted in the SHDP (2010 – 2015) except in 2016; total public health budget increased from N10.72 billion in 2013 to N12.74 billion in 2014, dropped significantly to N9.09 billion in 2015 and then reached an all-time high of N18.16 billion in 2016 as shown in figure 5. This translates to about 69% increase from the total allocation between 2013 and 2016. Though the health budget increased in 2016 relative to 2013 budget, the actual expenditure decreased from N6.61 billion in 2013 to N5.46 billion in 2016.

Figure 6: Trend of Health Budget and Expenditure

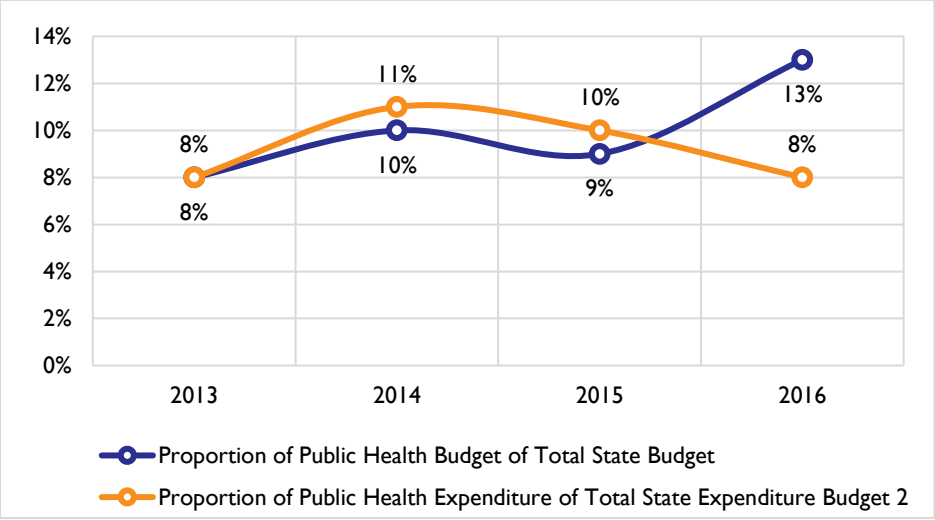


2.4.2 Health Share in State Government Budget and Expenditure

As a share of total state budget, health budget stood at 8 percent, 10 percent, 9 percent and 13 percent in 2013, 2014, 2015 and 2016 respectively - all below the recommended 15% allocation to health (and by extension, the expenditure is expected to follow same trend) as contained in the Abuja declaration of 2001. Although the state operates below target, an increase in health allocation was achieved between 2013 and 2016.

The proportion of health expenditure to the state expenditure stood at 8 percent, 11 percent, 10 percent and 8 percent in 2013, 2014, 2015 and 2016. A quick glance at the expenditure trend reveals a drastic fall in actual health expenditure from N6.6billion to N5.5 billion. The low investment in the health sector needs to be reversed to pave way for actualization of health objectives.

Figure 7: Health share in state government budget and expenditure



2.4.3 Trend of Health Recurrent and Capital Budget and Actual Expenditure

Health sector budget and expenditure was dominated by higher allocation and release to recurrent expenditure contrary to best practices of higher allocation and release to capital expenditure albeit 2016 when more funds were allocated to capital budget.

Figure 8: TRend of Health Capital and Recurrent Budget

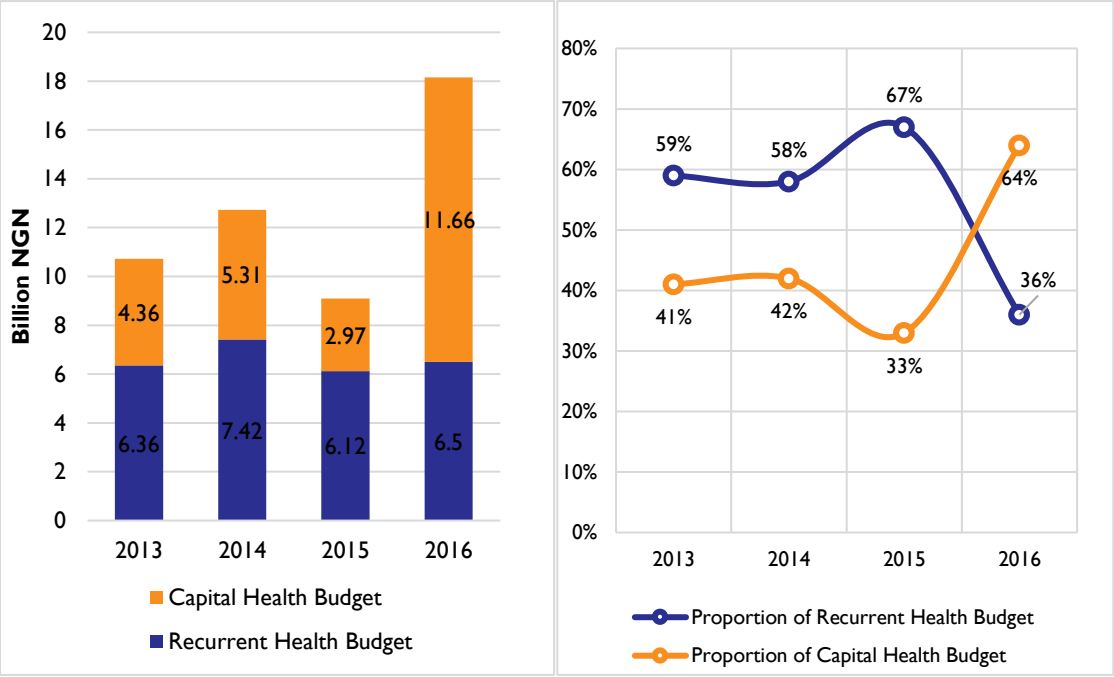
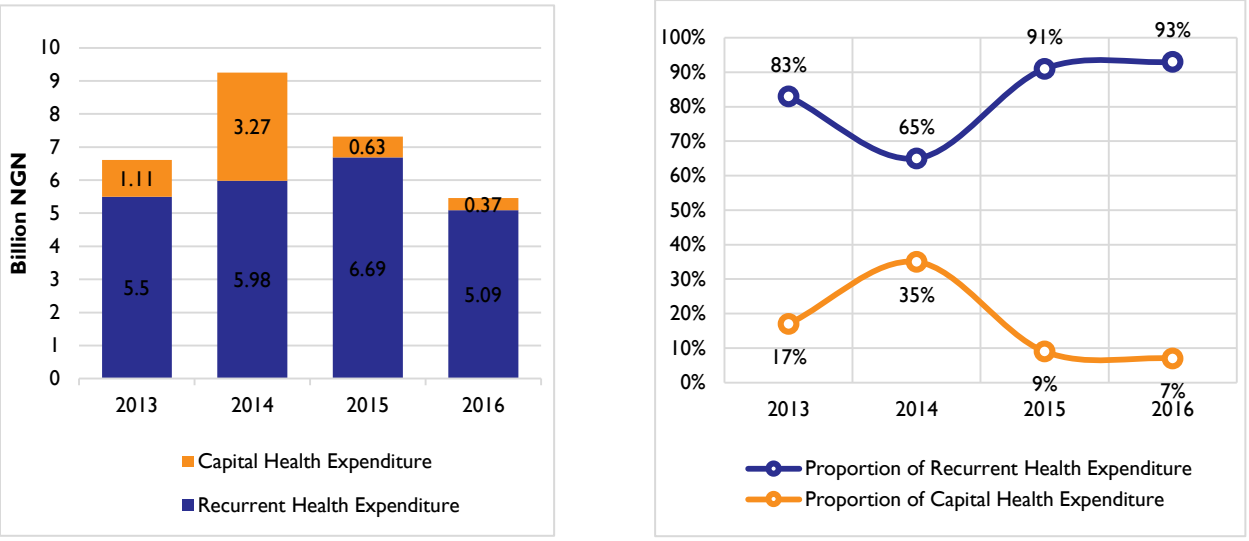


Figure 8 shows that recurrent expenditure witnessed more releases than capital in all the years. Especially in 2015 and 2016, the health sector was getting less than N1 billion release of capital expenditure. This trend is worrisome as best practice dictates that a higher proportion of expenditure should be on developmental activities to enhance a sustained health sector.

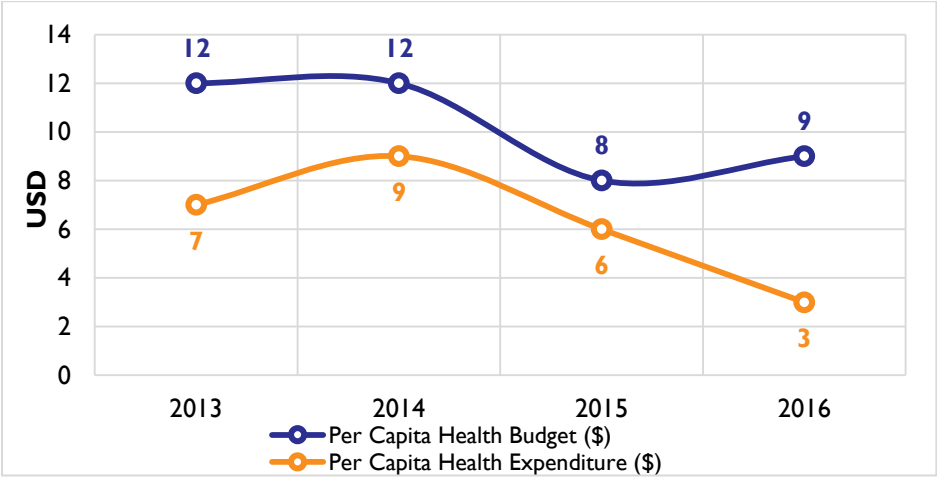
Figure 9: Trend of Health Capital and Recurrent actural Expenditure



2.4.4 Per Capita Public Health Budget and Expenditure

Figure 9 presents trends in per capita public health budget and actual expenditure. The health budget per capita was N1,815 ($12), N2,085 ($12), N1,438($8) and N2,777 ($9) respectively for each of the years under review. The GGHE on health per capita is N1,119 ($7), N1,515 ($9), N1,157 ($6) and N836 ($3) in 2013, 2014, 2015 and 2016 respectively. The per capita health general government expenditure on health in all the years fall far below the recommended benchmark of $86

Figure 10: Trends of Per capita public Health budget and expenditure



2.5 Share of state budget and actual expenditure in other key sectors

Allocation to health sector was on an average of 10 percent of state government budget in the years under review while an average of 17 percent went to education and an average of 6 percent and 5 percent went to agriculture and works & transport respectively. The proportion of state government budget allocated to health is a far cry from the internationally recommended Abuja Declaration benchmark of 15 percent[4]. The low level of prioritization accorded health sector is worrisome especially when compared with the state's education sector and some other states in the country; this could constitute obstacle to achieving health sector developmental objectives.

Figure 11: Budgetary Allocation to Key Sectors in Bauchi State

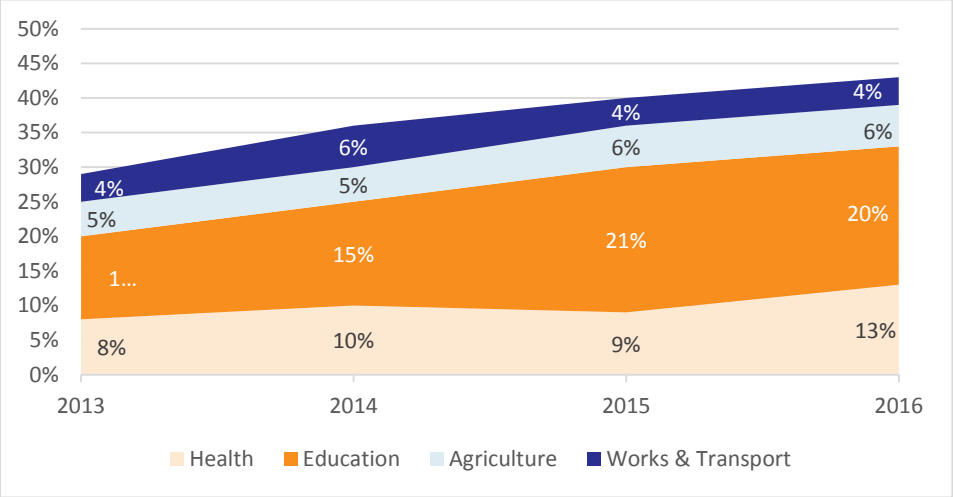
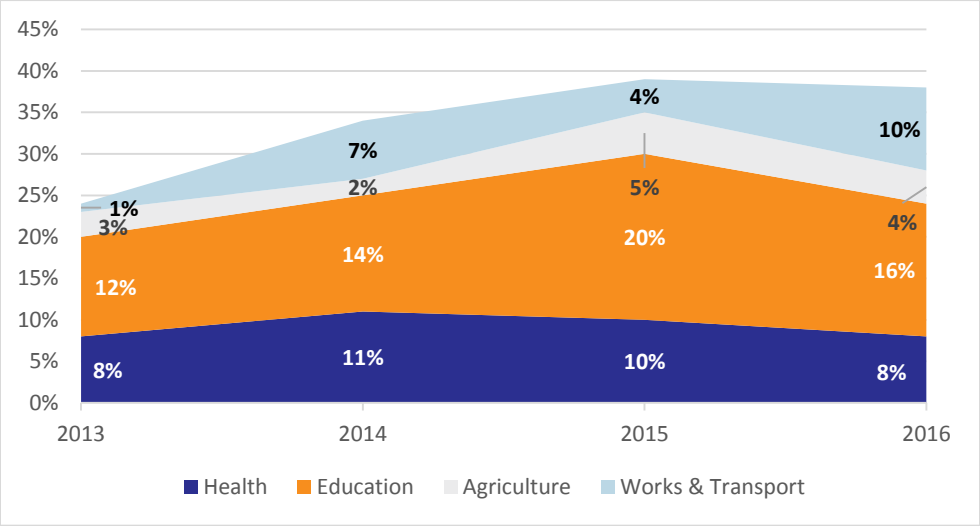


Figure 11 shows that actual state government expenditure has similar pattern to the allocation as an average of 9% of the state government expenditure was expended on health sector between 2013 and 2016 while education sector got the highest share of the expenditure at an average of 16% The share of state expenditure expended on Agriculture was the lowest of the four sectors at an average of 4%.

[4] WHO (2011) The Abuja declaration: Ten years on

Figure 12: Key sectors' Actual Expenditure



2.5.1 Budget Implementation Review

Table 3 presents the budget implementation rates across all the major sectors during the review period summarized according to budget classification (recurrent and development budget). The overall state budget implementation rate for the period ranged between 54 percent and 68 percent; when broken down, the recurrent budget performed better than the capital budget with an average of 86 percent against the average of 27 percent for capital budget. The consistently low and decreasing capital budget implementation rate suggests budget realism/accuracy issues. Budget performance across the key sectors calls for urgent intervention especially with the capital budget implementation rate; the recurrent expenditure performed far better than the capital expenditure.

The performance of the health sector budget has been lower than satisfactory throughout the review period, with an average annual execution rate of about 61 percent. The implementation rate of the recurrent budget has consistently exceeded 70 percent throughout the review period, and in 2015 the performance exceeded 100 percent and then fell to 78 percent in 2016. The capital budget performance has been generally lower than that of the recurrent budget.

Comparing the average implementation rate of health sector to that in other major sectors, it had higher implementation rate than that of sectors of education and agriculture and was next to works & transport at an average implementation rate of 61 percent. This suggests the need to improve on the budget performance rate in all the sectors. Efforts should be scaled up to address possible impediments to ensure smooth implementation of the budget, especially the execution of the capital budget.

Table 3: Budget Performance Rates

Implementation Rate (%)	**2013**	**2014**	**2015**	**2016**
Overall Implementation Rate (%)				
Health	**62**	**73**	**80**	**30**
Works and Transport	22	70	64	134
Agriculture	43	31	51	32

Education	65	59	65	42
State Overall	**64**	**64**	**68**	**54**
Recurrent Implementation Rate (%)				
Health	**86**	**81**	**109**	**78**
Works and Transport	84	78	107	96
Agriculture	92	66	104	75
Education	82	82	118	75
State Overall	**55**	**105**	**97**	**87**
Capital Implementation Rate (%)				
Health	**25**	**62**	**21**	**3**
Works and Transport	9	69	57	139
Agriculture	20	6	27	16
Education	33	21	8	4
State Overall	**14**	**24**	**23**	**23**

3. BAUCHI STATE HEALTH PERFORMANCE REVIEW

3.1 Introduction

The aim of this section is to analyze and evaluate the performance of Bauchi state health system, by comparing the selected indicators in terms of population health service provision and delivery and health financing capacity, in order to determine the position of Bauchi state health system performance in comparison with other HFG selected states in Nigeria. The indicators for the period under review have been analyzed below with a view to highlighting how the population health status has developed over time with the publicly funded health system and as well as identify areas requiring improvement.

3.2 State Population Health Status Comparison Among HFG Selected States

Comparing the health status in Bauchi state to that in other HFG supported states, generally population health in Bauchi state performed poorer than most other states. Table 4 shows that the maternal mortality rate, the infant mortality rate and child under five mortality rates was 705 per 100,000 live births, 81 per 1,000 live births and 161 per 1,000 live birth respectively; all of which were worse than what is obtainable in other HFG supported states. Bauchi States performance is better than the national average except for infant mortality and under five mortality rates.

Table 4: Selected Health Indicators across HFG slected states in 2016

State Name	Maternal Mortality Ratio Per 100,000 Live Births	Infant Mortality Rate Per 1,000 live births	Under 5 Mortality Rate Per 1,000 live births[5]	HIV Prevalence (%) [6]	Under 5 Malaria Prevalence (%)[7]
Bauchi	**705**	**81**	**161**	**0.6**	**19.6**
Oyo	108	59	73	5.6	19.2
Osun	165	78	101	1.6	33.4
Kebbi	490	111	174	0.8	63.6
Sokoto	1500	51	119	6.4	46.6
Ebonyi	576	47	62	0.9	30
Kogi	544	92	153	1.4	5.4
Akwa Ibom	450	42	73	6.5	22.8

[5] Multiple Indicator Cluster Survey (MICS) 2016-2017
[6] NARHS 2012 https://naca.gov.ng/nigeria-prevalence-rate/
[7] Percentage of children age 6-59 months tested using microscopy who are positive for malaria, MIS 2015

Benue	1318	70	82	5.6	44.5
National Average	**814**	**70**	**120**	**3.4**	**42**

3.3 Health Service Delivery/Provision

3.3.1 State Health Service Provision Comparison Among HFG Selected States

Table 5 shows that compared with the child and maternal service provision rates in other HFG selected states, the child and maternal service provision rates were low in Bauchi state; this trend was also noticed in the other two northern states of Kebbi and Sokoto states. There were 59.8 percent of women age 15-49 years with a live birth in the last two years that was attended to by antenatal care provider during the pregnancy for the last birth, 27.5 percent of them received HIV counseling during the antenatal care provision and 22.1 percent of them received assistance from skilled attendant during their delivery. This level of health coverage couldn't guarantee an improved maternal and children health.

Table 5: Health service provison across HFG slected states IN 2016

State Name	Antenatal Care Coverage [8]	Full immunization coverage[9]	Received HIV counselling During ANC [10]	Skilled Attendant Assisted at delivery [11]
Bauchi	**59.8**	**13.9**	**27.5**	**22.1**
Oyo	86.9	37.4	53.6	79.8
Osun	95.6	43.0	56.9	84.7
Kebbi	45.4	4.8	10.9	17.9
Sokoto	35.1	2.2	9.6	20.6
Ebonyi	75.0	35.0	45.7	72.6
Kogi	80.4	29.9	36.9	78.4
Akwa Ibom	80.5	44.2	63.5	40.0
Benue	67.5	37.0	57.6	62.8
National Average	**65.8**	**22.9**	**41.0**	**43.0**

[8] Percent distribution of women age 15-49 years with a live birth in the last two years by antenatal care provider during the pregnancy for the last birth, Nigeria, 2016
[9] Percentage of children age 12-23 months who received all vaccinations recommended in the national immunization schedule by their first birthday (measles by second birthday)
[10] Percentage of women age 15-49 with a live birth in the last two years who received antenatal care from a health professional during the last pregnancy and received HIV counselling
[11] Percent distribution of women age 15-49 years with a live birth in the last two years by person providing assistance at delivery

3.4 Health Financing Comparison with Other HFG selected States

3.4.1 General Comparison

Table 6 presents the share of health expenditure as a proportion of general state government expenditure and per capita public health expenditure among all the HFG selected states. Compared to other HFG selected states, on average, Bauchi state spent 9% of general government expenditure into health sectors which was moderate though lower than the benchmark. The average per capita public health expenditure was $6.3 over the review period; though this is unacceptably low, only few of the other HFG supported states performed better.

Table 6: Selected Health Financing Indicators across HFG slected states during thr review period

State Name	Gen. govt Expenditure on health as % of gen govt exp.	Govt Per Capita Expenditure on health at average $ exchange rate
Bauchi	9.3	6.3
Oyo	9.5	6.5
Osun	7.8	10.8
Kebbi	8.0	6.3
Sokoto	11.0	8.1
Ebonyi	8.5	8.0
Kogi	5.4	7.7
Akwa Ibom	4.3	13.0
Benue	8.5	6.3
National standard	15.0	97.0

3.4.2 Specific Comparison to Plateau State during the Review Period

This section provides specific comparison to Plateau state which took a closer examination of all the selected indicators in the time series from 2013 to 2016. The reason why the comparison to Plateau state needs further assessment is that Bauchi and Plateau State are similar in terms of geographical environment and epidemiological conditions. It is assumed that comparing the indicators with that of states with relatively similar circumstances will further reveal the level of efficiency or otherwise of the state health sector.

3.4.2.1 Health Expenditure as a percentage of State Total expenditure

On the average, Bauchi state performed far better than Plateau state as evidenced by the rate of health spending to total state expenditure (see table below); this indicator shows the level of priority accorded health sector in each of the states.

Table 7: : Share of Health Expenditure in Bauchi and Plateau State

	Year

State	2013 (%)	2014 (%)	2015 (%)	2016 (%)	Average (%)
Bauchi	8	11	10	8	9.25
Plateau	5	3	5	6	4.75

3.4.2.2 Government General Health expenditure per capita

Notwithstanding the higher priority accorded health by Bauchi state as indicated in the previous table, GGHE per capita in the two states are almost the same. Both states experienced decline in per capita spending on health between 2013 and 2016 with Bauchi moving from $7 in 2013 to $3 in 2016 while Plateau moved from $10 in 2013 to $6 in 2016. Both states have failed to meet up with the recommended benchmark of $78 per capita.

Table 8: Government General Health expenditure per capita in Bauchi and Plateau State

	Year				
State	2012 ($)	2013 ($)	2014 ($)	2015 ($)	Average ($)
Bauchi	7	9	6	3	6.25
Plateau	10	6	6	4	6.5

4. RECOMMENDATIONS

One of the objectives of this assessment is to help the State Government review their health public expenditure and identify areas for improvement; this will complement the findings from other assessments necessary to provide useful information that will facilitate health financing reforms aimed at making progress towards Universal Health Coverage. A summary of the main findings and recommendations are presented below.

Macro Fiscal Context

Overreliance on statutory allocation as a main source of revenue for the state is a danger to the growth of the financial strength of the state due to volatility of oil revenue accruable to the country. Loans also increase government's future spending commitments hence reduction in amount available for planned interventions. Improved IGR will go a long way to expand the fiscal space of the state as a whole and is expected to filter down to the health sector; the average monthly IGR of N0.42 billion by the state calls for a review of the state revenue generation mechanism.

Re-Prioritization of Health

Both budget and expenditure trends in the state show that health is not being accorded the priority it deserves. The low prioritization of the health sector funding by the government is a threat to achieving the health goals set by the state as captured in the state health policy document. As a state with considerably poor health indices, the state urgently needs to invest far more than 8% of its total expenditure on health. Both arms of government (state and LGA) should be effectively engaged to advocate for increased allocation to the health sector.

Capital Investment

Within the context of generally low investment in the health sector, capital investment as a proportion of general health budget and spending is unacceptably low. The low capital investment prevents the state's ability to address the critical infrastructural gaps in the health sector (these were identified in the HFG supported Service Availability and Readiness Assessment for the state). The capital budget execution rate is undesirable and needs to be improved upon. Further PFM assessment is recommended to identify the cause of the current low performance level of capital budget within the health sector and necessary technical support should be sought to remove identified bottlenecks.

Measurement of health systems efficiency

As stated earlier, expansion of fiscal space in the health sector requires efforts both at mobilising more resources and also ensuring efficient use of available resources. It is highly recommended to institute adequate measures for timely and periodic review of the health systems efficiency. The relevant authority needs to put concerted effort in place to improve on the current level of facility utilisation which will in turn improve the efficiency indices. Furthermore, personnel and overhead cost accounted for 65% to 93% of the state government health spending in the period under review, as this represents a very large proportion of government spending, this expenditure item needs to be reviewed vis-à-vis productivity of labor in the state and any source of inefficiency such as 'ghost' worker syndrome, moonlighting and absenteeism should be identified and addressed.

Budget Effectiveness

Bauchi has very limited capacity to measure the impact of public expenditure and most agencies are pre-occupied with reporting how inputs have been used rather than highlighting outcomes achieved. In view of this, the HMIS/M&E team needs to be better engaged and empowered in order to identify the most feasible way to link performance to productivity.

Health financing coordination

It would be beneficial if a multi-sectorial coordination platform is introduced (or reorganization of health stakeholders' forum currently present in the state) to coordinate all the players in the health sector. There is need to align the programs of donors with that of the state government to prevent duplication of effort; this will eliminate wastages of scarce resources.

Further Reviews

Some of the findings of this Public Expenditure Review suggest the need to conduct further studies that will produce additional evidence for decision making, for instance it will be necessary to conduct additional PFM to unravel the cause of low capital budget execution rate. LGAs, private sector and donor agencies should be further engaged for release of health expenditure data in order to expand the scope of this review.

Annex 1: Indicators – State Budget and Expenditure

BUDGET	2013		2014		2015		2016	
	Amount	**As a % of State Budget**	**Amount**	**As a % of State Budget**	**Amount**	**As a % of State Budget**	**Amount**	**As a % of State Budget**
Total Recurrent	63,508,536,797	47	65,382,009,613	49	62,813,519,682	61	64,895,109,167	48
Capital	72,833,571,530	53	68,338,820,437	51	40,042,340,558	39	70,407,990,843	52
Total State Budget	**136,342,108,327**	**100**	**133,720,830,050**	**100**	**102,855,860,240**	**100**	**135,303,100,010**	**100**
EXPENDITURE	**Amount**	**As a % of State Expenditure**	**Amount**	**As a % of State Expenditure**	**Amount**	**As a % of State Expenditure**	**Amount**	**As a % of State Expenditure**
Total Recurrent	75,272,320,975	86	68,579,858,365	80	60,947,930,160	87	56,671,699,200	78
Capital	12,456,362,483	14	16,678,313,379	20	9,083,093,601	13	15,854,087,858	22
Total Health Expenditure	**87,728,683,458**	**100**	**85,258,171,744**	**100**	**70,031,023,761**	**100**	**72,525,787,058**	**100**

Annex 2: Indicators - Health Budget and Expenditure

BUDGET	2013		2014		2015		2016	
	Amount	**As a % of Health Budget**	**Amount**	**As a % of Health Budget**	**Amount**	**As a % of Health Budget**	**Amount**	**As a % of Health Budget**
Total Recurrent	**6,356,354,742**	**59**	**7,422,888,901**	**58**	**6,123,402,429**	**67**	**6,496,692,094**	**36**
Capital	4,362,287,470	41	5,313,518,000	42	2,966,841,782	33	11,659,892,165	64
Total Health Budget	**10,718,642,212**	**100**	**12,736,406,901**	**100**	**9,090,244,211**	**100**	**18,156,584,259**	**100**
EXPENDITURE	**Amount**	**As a % of Health Expenditure**	**Amount**	**As a % of Health Expenditure**	**Amount**	**As a % of Health Expenditure**	**Amount**	**As a % of Health Expenditure**
Total Recurrent	**5,496,721,917**	**83**	**5,980,673,946**	**65**	**6,688,447,569**	**91**	**5,090,753,924**	**93**
Capital	1,109,762,595	17	3,274,491,528	35	625,801,113	9	374,242,931	7
Total Health Expenditure	**6,606,484,512**	**100**	**9,255,165,474**	**100**	**7,314,248,682**	**100**	**5,464,996,855**	**100**

Annex 3: Indicators - Key Sectors' Budget and Expenditure

BUDGET	2013		2014		2015		2016	
	Amount	**As a % of State Budget**	**Amount**	**As a % of State Budget**	**Amount**	**As a % of State Budget**	**Amount**	**As a % of State Budget**
Health	10,718,642,212	8	12,736,406,901	10	9,090,244,211	9	18,156,584,259	13
Education	16,632,541,087	12	20,022,233,762	15	21,485,768,793	21	27,211,579,183	20
Agriculture	6,188,919,205	5	6,389,006,200	5	6,363,263,479	6	8,448,914,786	6
Works and Transport	4,804,740,456	4	8,524,383,170	6	4,511,576,655	4	5,344,201,219	4
Others	97,997,265,367	72	86,048,800,017	64	61,405,007,102	60	76,141,820,563	56
Total State Budget	**136,342,108,327**	**100**	**133,720,830,050**	**100**	**102,855,860,240**	**100**	**135,303,100,010**	**100**
EXPENDITURE	**Amount**	**As a % of State Expenditure**	**Amount**	**As a % of State Expenditure**	**Amount**	**As a % of State Expenditure**	**Amount**	**As a % of State Expenditure**
Health	6,606,484,512	8	9,255,165,473	11	7,314,248,683	10	5,464,996,856	8
Education	10,865,115,599	12	11,759,968,606	14	14,037,353,348	20	11,446,828,484	16
Agriculture	2,686,878,505	3	1,994,723,257	2	3,274,309,159	5	2,727,095,897	4
Works and Transport	1,073,818,818	1	5,925,235,138	7	2,893,255,241	4	7,163,731,575	10
Others	66,496,386,024	76	56,323,079,270	66	42,511,857,331	61	45,723,134,246	63
Total State Expenditure	**87,728,683,458**	**100**	**85,258,171,744**	**100**	**70,031,023,761**	**100**	**72,525,787,058**	**100**

ANNEX 4: KEY PERFORMANCE INDICATORS – STATE

DETAILS	2013	2014	2015	2016
	N	N	N	N
Health Budget	10,718,642,212	12,736,406,901	9,090,244,211	18,156,584,259
Health Expenditure	6,606,484,512	9,255,165,473	7,313,268,682	5,464,996,855
Projected Population	5,880,077	6,079,999	6,286,719	6,500,468
Exchange Rate (NGN/$)	150	170	190	300
Health budget per capita (NGN)	1,823	2,095	1,446	2,793
Health Budget per capita ($)	12	12	8	9
Health Expenditure per capita (NGN)	1,124	1,522	1,163	841
Health Expenditure per capita ($)	7	9	6	3

ANNEX 5: RECURRENT AND CAPITAL EXPENDITURE IMPLEMENTATION REPORT

STATE

DETAIL	2013			2014			2015			2016		
	Budget	**Expenditure**	**% Implementation**	**Budget**	**Expenditure**	**% Implementation**	**Budget**	**Expenditure**	**% Implementation**	**Budget**	**Expenditure**	**% Implementation**
Total Recurrent	63,508,536,797	75,272,320,975	55	65,382,009,613	68,579,858,365	105	62,813,519,682	60,947,930,160	97	64,895,109,167	56,671,699,200	87
Capital Expenditure	72,833,571,530	12,456,362,483	14	68,338,820,437	16,678,313,379	24	40,042,340,558	9,083,093,601	23	70,407,990,843	15,854,087,858	23
Total	**136,342,108,327**	**87,728,683,458**	**64**	**133,720,830,050**	**85,258,171,744**	**64**	**102,855,860,240**	**70,031,023,761**	**68**	**135,303,100,010**	**72,525,787,058**	**54**

HEALTH

DETAIL	2013			2014			2015			2016		
	Budget	**Expenditure**	**% Implementation**	**Budget**	**Expenditure**	**% Implementation**	**Budget**	**Expenditure**	**% Implementation**	**Budget**	**Expenditure**	**% Implementation**
Total Recurrent	6,356,354,742	5,496,721,917	86	7,422,888,901	5,980,673,945	81	6,123,402,429	6,688,447,570	109	6,496,692,094	5,090,753,924	78
Capital Expenditure	4,362,287,470	1,109,762,595	25	5,313,518,000	3,274,491,528	62	2,966,841,782	625,801,113	21	11,659,892,165	374,242,931	3
Total	**10,718,642,212**	**6,606,484,512**	**62**	**12,736,406,901**	**9,255,165,473**	**73**	**9,090,244,211**	**7,314,248,683**	**80**	**18,156,584,259**	**5,464,996,855**	**30**

WORKS AND TRANSPORT

DETAIL	2013			2014			2015			2016		
	Budget	**Expenditure**	**% Implementation**	**Budget**	**Expenditure**	**% Implementation**	**Budget**	**Expenditure**	**% Implementation**	**Budget**	**Expenditure**	**% Implementation**
Total Recurrent	832,981,080	697,930,163	84	855,611,790	667,103,367	78	654,493,812	697,499,665	107	651,812,084	626,577,803	96
Capital Expenditure	3,971,759,376	375,888,655	9	7,668,771,380	5,258,131,771	69	3,857,082,844	2,195,755,576	57	4,692,389,135	6,537,153,772	139
Total	**4,804,740,456**	**1,073,818,818**	**22**	**8,524,383,170**	**5,925,235,138**	**70**	**4,511,576,656**	**2,893,255,241**	**64**	**5,344,201,219**	**7,163,731,575**	**134**

AGRICULTURE

DETAIL	2013			2014			2015			2016		
	Budget	**Expenditure**	**% Implementation**	**Budget**	**Expenditure**	**% Implementation**	**Budget**	**Expenditure**	**% Implementation**	**Budget**	**Expenditure**	**% Implementation**
Total Recurrent	1,979,524,769	1,825,996,224	92	2,689,142,700	1,763,820,516	66	2,006,631,468	2,093,283,109	104	2,294,999,698	1,717,910,640	75
Capital Expenditure	4,209,394,436	860,882,281	20	3,699,863,500	230,902,741	6	4,356,632,011	1,181,026,050	27	6,153,915,088	1,009,185,257	16
Total	**6,188,919,205**	**2,686,878,505**	**43**	**6,389,006,200**	**1,994,723,257**	**31**	**6,363,263,479**	**3,274,309,159**	**51**	**8,448,914,786**	**2,727,095,897**	**32**

EDUCATION

DETAIL	2013			2014			2015			2016		
	Budget	**Expenditure**	**% Implementation**	**Budget**	**Expenditure**	**% Implementation**	**Budget**	**Expenditure**	**% Implementation**	**Budget**	**Expenditure**	**% Implementation**
Total Recurrent	10,967,894,811	8,980,217,242	82	12,441,017,704	10,189,659,035	82	11,169,965,628	13,222,504,119	118	14,603,576,082	10,894,404,340	75
Capital Expenditure	5,664,646,276	1,884,898,357	33	7,581,216,058	1,570,309,571	21	10,315,803,165	814,849,229	8	12,608,003,101	552,424,144	4
Total	**16,632,541,087**	**10,865,115,599**	**65**	**20,022,233,762**	**11,759,968,606**	**59**	**21,485,768,793**	**14,037,353,348**	**65**	**27,211,579,183**	**11,446,828,484**	**42**

ANNEX 6: BUDGET BY HEALTH MDAS

2013

S/N	MDA	PERSONNEL	OVERHEAD	TOTAL RECURRENT	CAPITAL	TOTAL
1	MIN OF HEALTH	897,515,114	543,741,628	1,441,256,742	3,174,000,000	4,615,256,742
2	SPECIALIST HOSPITAL BOARD	317,984,260	92,700,000	410,684,260	0	410,684,260
3	COLLEGE OF NURSING BAUCHI	0	0	0	0	0
4	SCHOOL OF HEALTH TECH NINGI	0	0	0	0	0
5	BACATMA	94,435,712	121,530,000	215,965,712	682,650,000	898,615,712
6	HOSPITAL MANAGEMENT BOARD	2,984,461,090	343,513,000	3,327,974,090	0	3,327,974,090
7	PHCDA	608,147,442	293,450,000	901,597,442	305,637,470	1,207,234,912
8	DRUGS AND MEDICAL	58,876,496	0	58,876,496	200,000,000	258,876,496
	TOTAL	**4,961,420,114**	**1,394,934,628**	**6,356,354,742**	**4,362,287,470**	**10,718,642,212**

2014

S/N	MDA	PERSONNEL	OVERHEAD	TOTAL RECURRENT	CAPITAL	TOTAL
1	MIN OF HEALTH	939,754,370	588,650,000	1,528,404,370	3,273,700,000	4,802,104,370
2	SPECIALIST HOSPITAL BOARD	341,353,670	75,440,000	416,793,670	0	416,793,670
3	COLLEGE OF NURSING BAUCHI	38,274,520	77,854,520	116,129,040	75,000,000	191,129,040
4	SCHOOL OF HEALTH TECH NINGI	0	423,340,500	423,340,500	155,000,000	578,340,500
5	BACATMA	104,401,320	114,700,000	219,101,320	612,600,000	831,701,320
6	HOSPITAL MANAGEMENT BOARD	3,053,174,460	378,513,700	3,431,688,160	0	3,431,688,160

7	PHCDA	757,731,841	288,700,000	1,046,431,841	1,009,218,000	2,055,649,841
8	DRUGS AND MEDICAL	50,000,000	191,000,000	241,000,000	188,000,000	429,000,000
	TOTAL	**5,284,690,181**	**2,138,198,720**	**7,422,888,901**	**5,313,518,000**	**12,736,406,901**

2015

S/N	MDA	PERSONNEL	OVERHEAD	TOTAL RECURRENT	CAPITAL	TOTAL
1	MIN OF HEALTH	998,443,316	301,700,000	1,300,143,316	1,498,421,109	2,798,564,425
2	SPECIALIST HOSPITAL BOARD	322,626,021	57,600,000	380,226,021	0	380,226,021
3	COLLEGE OF NURSING BAUCHI	4,000,000	7,700,000	11,700,000	100,000,000	111,700,000
4	SCHOOL OF HEALTH TECH NINGI	0	16,450,000	16,450,000	0	16,450,000
5	BACATMA	98,525,219	35,350,000	133,875,219	1,091,145,672	1,225,020,891
6	HOSPITAL MANAGEMENT BOARD	3,072,356,923	233,911,496	3,306,268,419	0	3,306,268,419
7	PHCDA	737,594,808	115,750,000	853,344,808	165,275,000	1,018,619,808
8	DRUGS AND MEDICAL	15,694,647	105,700,000	121,394,647	112,000,000	233,394,647
	TOTAL	**5,249,240,933**	**874,161,496**	**6,123,402,429**	**2,966,841,782**	**9,090,244,211**

2016

S/N	MDA	PERSONNEL	OVERHEAD	TOTAL RECURRENT	CAPITAL	TOTAL
1	Ministry of Health	1,046,418,087	398,230,000	1,444,648,087	6,850,763,131	8,295,411,218
2	Specialist Hospital Board	310,053,533	90,140,000	400,193,533	-	400,193,533
3	College of Nursing	6,608,167	32,500,000	39,108,167	400,000,000	439,108,167
4	School of Health Tech. Ningi	88,795,174	135,906,000	224,701,174	860,687,210	1,085,388,384
5	BACATMA	78,875,126	27,330,000	106,205,126	1,063,160,850	1,169,365,976
6	Hospital Management Board	2,874,011,581	235,911,496	3,109,923,077	-	3,109,923,077
7	PHCDA	648,518,282	309,400,000	957,918,282	2,391,530,974	3,349,449,256
8	Drugs and Medical	15,694,648	198,300,000	213,994,648	93,750,000	307,744,648
	TOTAL	**5,068,974,598**	**1,427,717,496**	**6,496,692,094**	**11,659,892,165**	**18,156,584,259**

ANNEX 7: EXPENDITURE BY HEALTH MDAS

2013

S/N	MDA	PERSONNEL	OVERHEAD	TOTAL RECURRENT	CAPITAL	TOTAL
1	MIN OF HEALTH	896,144,399	475,301,178	1,371,445,577	650,054,175	2,021,499,752
2	SPECIALIST HOSPITAL BOARD	301,238,835	44,617,654	345,856,489	0	345,856,489
3	COLLEGE OF NURSING BAUCHI	0	0	0	0	0
4	SCHOOL OF HEALTH TECH NINGI	0	0	0	0	0
5	BACATMA	91,196,057	7,123,000	98,319,057	362,546,337	460,865,394
6	HOSPITAL MANAGEMENT BOARD	2,982,870,799	81,319,688	3,064,190,487	0	3,064,190,487
7	PHCDA	606,521,545	9,226,199	615,747,744	76,608,684	692,356,428
8	DRUGS AND MEDICAL	1,162,562	0	1,162,562	20,553,400	21,715,962
	TOTAL	**4,879,134,197**	**617,587,720**	**5,496,721,917**	**1,109,762,595**	**6,606,484,512**

2014

S/N	MDA	PERSONNEL	OVERHEAD	TOTAL RECURRENT	CAPITAL	TOTAL
1	MIN OF HEALTH	983,376,494	355,576,103	1,338,952,597	3,076,197,208	4,415,149,805
2	SPECIALIST HOSPITAL BOARD	332,561,825	59,650,527	392,212,352		392,212,352
3	COLLEGE OF NURSING BAUCHI	1,734,804	1,734,804	3,469,608	0	3,469,608
4	SCHOOL OF HEALTH TECH NINGI	0	0	0	0	0
5	BACATMA	85,225,451	13,918,550	99,144,001	4,972,000	104,116,001
6	HOSPITAL MANAGEMENT BOARD	3,034,092,463	337,832,895	3,371,925,358	0	3,371,925,358
7	PHCDA	707,782,523	58,327,500	766,110,023	192,322,320	958,432,343

8	DRUGS AND MEDICAL	6,400,007	2,460,000	8,860,007	1,000,000	9,860,007
	TOTAL	**5,151,173,567**	**829,500,379**	**5,980,673,945**	**3,274,491,528**	**9,255,165,473**

2015

S/N	MDA	PERSONNEL	OVERHEAD	TOTAL RECURRENT	CAPITAL	TOTAL
1	MIN OF HEALTH	1,325,247,188	198,644,864	1,523,892,051	618,801,113	2,142,693,164
2	SPECIALIST HOSPITAL BOARD	377,215,492	61,985,488	439,200,980	0	439,200,980
3	COLLEGE OF NURSING BAUCHI	1,601,275	1,480,000	3,081,275	0	3,081,275
4	SCHOOL OF HEALTH TECH	42,270,271	2,288,000	44,558,271	0	44,558,271
5	BACATMA	94,279,242	9,441,420	103,720,662	2,000,000	105,720,662
6	HOSPITAL MANAGEMENT BOARD	3,469,861,717	158,325,437	3,628,187,154	0	3,628,187,154
7	PHCDA	781,198,913	139,762,765	920,961,679	5,000,000	925,961,679
8	DRUGS AND MANAG.	13,135,498	11,710,000	24,845,498	0	24,845,498
	TOTAL	**6,104,809,595**	**583,637,974**	**6,688,447,570**	**625,801,113**	**7,314,248,682**

2016

S/N	MDA	PERSONNEL	OVERHEAD	TOTAL RECURRENT	CAPITAL	TOTAL
1	Ministry of Health	1,163,104,480	228,170,270	1,391,274,750	280,891,024	**1,672,165,775**
2	Specialist Hospital Board	262,339,550	47,138,520	309,478,070		**309,478,070**
3	College of Nursing	-	-	-	23,743,407	**23,743,407**
4	School of Health Tech. Ningi	127,057,836	10,621,627	137,679,463	49,608,500	**187,287,963**
5	BACATMA	35,065,090	9,455,000	44,520,090	10,000,000	**54,520,090**

6	Hospital Management Board	2,084,267,728	74,387,231	2,158,654,959		**2,158,654,959**
7	PHCDA	801,739,355	226,203,156	1,027,942,511	10,000,000	**1,037,942,511**
8	Drugs and Medical	9,380,201	11,823,879	21,204,081		**21,204,081**
	TOTAL	**4,482,954,241**	**607,799,683**	**5,090,753,924**	**374,242,931**	**5,464,996,856**

BOLD THINKERS DRIVING
REAL-WORLD IMPACT