

# Public Budgeting and Expenditure Management in Three Nigerian States: Challenges for Health Governance

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## INTRODUCTION

Financial data and management are critical to effective health governance. Access to, and use of, timely and accurate health budgeting and expenditure data are key to public health officials' capacity to make future investment decisions, understand the effectiveness of current allocations for health, and act as effective stewards of the health system. Once decisions are made about how to allocate resources, the managerial processes for ensuring that resources arrive in the right place, are used for the correct purposes, and are reported on accurately and transparently, also form an integral element of health governance. Available and transparent financial data in turn enable the exercise of accountability. These data support accountability relationships within government – for example between health ministries and legislatures, and between federal and local levels of government – and relationships between government and citizens. Consistent internal financial control mechanisms, effective budget and expenditure reporting, and citizen monitoring all contribute to ensuring accountability.

Several tools exist that can help analysts and decision makers to review funding and spending flows and management, and to identify resource uses and leakages. These include assessment instruments such as Public Expenditure Tracking Surveys, which follow the flow of funds from the central government down to decentralized levels and to service providers, and Quantitative Service Delivery Surveys, which examine the efficiency of frontline service delivery. A Public Expenditure Management Review (PEMR) combines elements of both surveys and examines the overall governance environment of public expenditure management by studying both how health resources are used and the process by which those resources were allocated.

In 2010 and 2011, Health Systems 20/20 conducted a PEMR of the health sector in three Nigerian states (Cross River, Nasarawa, and Sokoto) based on the methodology developed and used by the World Bank (see El-Khoury et al. 2011a, 2011b, and 2012). The PEMR methodology was chosen because effective allocation and use of health sector resources have been a major concern for the Government of Nigeria, especially following a 2008 Health Systems Assessment in which data needed to track resource flows, budgets,

and expenditures were largely unavailable (Kombe et al. 2009). The assessment highlighted the need to perform an in-depth review of public health expenditure systems in Nigeria to provide a better understanding of the current links between public spending and service delivery outcomes.

Nigeria is a country with widely acknowledged and significant governance problems, which have been exacerbated by its high degree of natural resource dependence (Sala-i-Martin and Subramanian 2003). According to the Revenue Watch Institute<sup>1</sup>, the gas and oil sector accounts for 85 percent of government revenue and 52 percent of GDP. Nigeria ranked 41st out of 53 countries on the 2010 Mo Ibrahim African Governance Index<sup>2</sup>, with stagnant to worsening scores over the past five years. Nigeria's budget process remains largely impenetrable. The country fell among the poorer performers on the 2010 Open Budget Index<sup>3</sup>, scoring 18 out of 100 possible points, putting it at less than half the average country score of 42. As a result of increased federal transfers of oil funds, state and local government revenues have increased dramatically. Yet despite some efforts to improve budget planning, execution, and reporting at the federal level, such improvements have not extended consistently to subnational levels of government.

It was in this difficult governance environment that Health Systems 20/20 sought to carry out the PEMR. This brief discusses the assessment, and summarizes the governance challenges identified in the three state reports that relate to public financial management systems: unavailability of financial data, dysfunctional political influence over the budgeting process, weak budget execution, and weak civil society involvement in budget decisions and execution. Not surprisingly, these health governance problems closely mirror Nigeria's governance challenges more broadly. The brief draws upon findings from the reports on these three states, as well as information from the stakeholder engagement meetings that were held to discuss those findings.

## METHODOLOGY

Three surveys were implemented in December 2010 at various levels: a facility survey administered to a sample of health facility managers collected information on facility characteristics, human resources, governance structures, and financial information. An administrative survey and a strategic audit survey administered to public officials at local- and state-level ministries, departments, and agencies (MDAs) collected data on budgets, expenditures, and qualitative information on key issues related to budget preparation and execution processes. The questionnaires were developed through an interactive process of discussions among the various stakeholders. The design of the questionnaires followed a multipronged data collection strategy, which means similar and related information was collected from various sources as a way to cross-validate the information obtained separately. Following data collection and analysis, preliminary results were validated and discussed with state and local government authorities.

The PEMR survey is the first of its kind conducted in Cross River, Nasarawa, and Sokoto states. Acknowledging the sensitivity of the financial information collected through the surveys and the potential implications of the PEMR assessment, the survey team held initial consultative meetings and sensitization workshops with key federal, state, and local government stakeholders to encourage their engagement. Despite this effort, the data collection process proved significantly challenging, most notably due to the lack of accurate financial record keeping and reporting, and a general reluctance to share detailed financial information.

<sup>1</sup> [www.revenuewatch.org/countries/africa/nigeria/transparency-snapshot#\\_ftn9](http://www.revenuewatch.org/countries/africa/nigeria/transparency-snapshot#_ftn9)

<sup>2</sup> [www.moibrahimfoundation.org](http://www.moibrahimfoundation.org)

<sup>3</sup> [www.openbudgetindex.org](http://www.openbudgetindex.org)

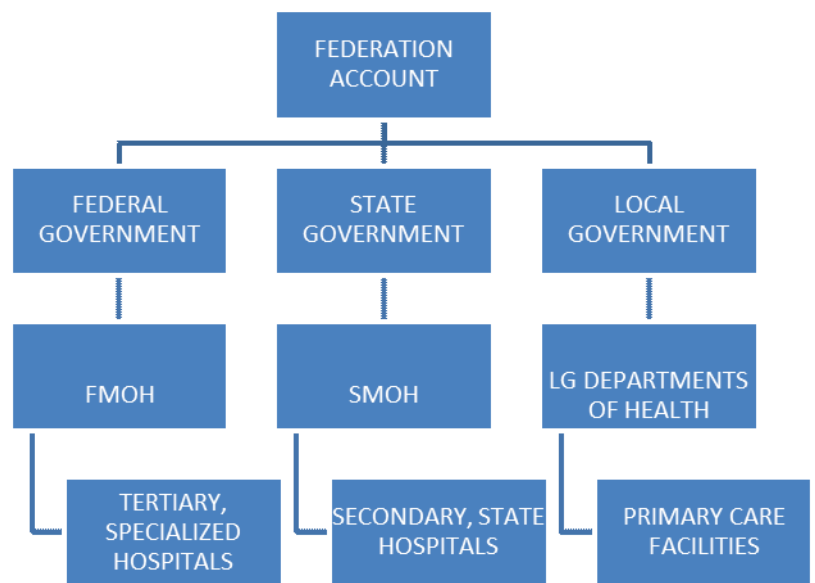
## OVERVIEW OF HEALTH EXPENDITURE SYSTEMS IN NIGERIA

Nigeria is a federal state with three tiers of government, namely, the federal government, 36 state governments, and 774 local governments. Within the public sector, delivery of primary health care (PHC) falls under the responsibility of local government authorities (LGAs). This means that PHC facilities are for the most part owned and funded by LGAs. Secondary-level (and some tertiary) health care, which includes general hospitals, the teaching hospitals of state universities, and state specialist hospitals, is the responsibility of state governments. Teaching hospitals of federal universities, federal medical centers, and specialized tertiary-level health care facilities, including the National Hospital in Abuja, are the responsibility of the federal government (Federal Ministry of Health [FMoH] 1988, 2004a, and 2004b).

The principal actors in the Nigerian public health sector are the FMoH, the 36 State Ministries of Health (SMoH), the 774 LGA Departments of Health, and the authorities of the Federal Capital Territory, as well as various government parastatals and training and research institutions that are concerned with health matters. The FMoH, the SMoH, and the LGA Departments of Health are responsible for planning and managing health spending in their respective jurisdictions. Under each of the ministries (federal and state), associated departments and agencies are referred to collectively as MDAs. Figure 1 illustrates the flow of health funds through these various agencies, down to the service provision level. The diagram is a simplified representation of how funds flow, since in each state funding channels vary slightly. For example, in some states, the federal government funds and operates selected model primary care facilities overseen by national PHC agencies.

Public expenditure streams for the three levels of government are largely uncoordinated. Federal, state, and local allocation and expenditure decisions are taken independently, and the federal government has no constitutional power to compel other tiers of government to spend in accordance with national priorities. Adding further complexity to the health spending picture, other ministries, including Defense, Education, and Internal Affairs, own and run extensive networks of health facilities, which provide treatment and care for armed forces personnel and their families, students, and prison inmates, respectively.

**FIGURE 1: FLOW OF PUBLIC EXPENDITURES IN THE HEALTH SECTOR**



Private health facilities – drug stores, pharmacies, clinics, and hospitals – cut across the three levels of care, primary to tertiary (FMoH 2004b). There are private for-profit as well as private not-for-profit health care facilities, including faith-based facilities and facilities owned and managed by nongovernmental organizations (NGOs), as well as community-based organizations. The PEMR looked only at public sector facilities. It did not include a review of the private sector or the other actors involved in the provision of health services noted above.

## KEY FINDINGS OF THE 2010–2011 PEMR ASSESSMENTS

Four key findings emerged from the PEMR conducted in Cross River, Nasarawa, and Sokoto. Their implications for health governance and financial management are discussed in this section.

### LACK OF ACCURATE AND CONSOLIDATED FINANCIAL DATA

The absence of accurate financial record keeping, especially at lower levels, is a significant finding of the PEMR. Health facilities either do not keep, or were reticent to reveal, expenditure records. More than half of surveyed facilities in Nasarawa and Sokoto and more than two-thirds of surveyed facilities in Cross River stated that they did not keep detailed spending records. On the other hand, according to LGAs in Cross River, PHC facilities actually do maintain spending records but are unwilling to share them. The study notes that further investigation is needed to understand what types of records PHC facilities keep and the reasons for their reluctance to share them. Inadequate supply of materials and a lack of capacity to update records were cited as the main reasons for the absence of record keeping in the facilities. It should be noted that lower-level health facilities rarely have cash budgets. Staff have their salaries paid by the LGA and may receive travel or meeting allowances; the facilities receive commodities (whether donated or purchased by higher levels). Thus these facilities have little independent control over public resources allocated to them. Any discretionary funds they have would be derived largely from user fees from patients.

The complexity of fiscal transfers and financial flows in Nigeria between federal, state, and local agencies makes it difficult for the government to reconcile and track resource flows across the different levels and agencies of the health system. The PEMR in Nasarawa found that spending figures reported at the local government level differed significantly from those reported at the state level, highlighting the inability of state governments to

fully track and understand health expenditures within LGAs. In Cross River, in addition to the SMOH, a number of other ministries and agencies appropriate funds to implement health-related activities. At present, the state does not have the means to coordinate or track all health-related spending across the various MDAs involved. In fact, the state was unable to provide the actual amount of spending for health. In Sokoto, while LGA budgets are broken down by sector (e.g., health and education), the study team was unable to obtain information on LGAs' health budgets.

In general, the absence of accurate and detailed records on budgets and expenditures indicates that governments at all levels do not have the means to ensure that health resources are distributed equitably, efficiently, and effectively. The system further creates disincentives for public officials to be transparent or to seek information for performance and/or accountability purposes. As a result, holding government officials and health facility managers accountable is difficult, leakage and improper use of funds is more likely to occur, and motivation to reform the system is limited. Partial and opaque information on budgets and spending maximize the discretion and impunity of those who have access to health resources. This situation undermines a foundational element of health governance: information availability for performance and accountability. A positive step that may eventually enhance access to information is the signing into law of the Freedom of Information Act in May 2011<sup>4</sup>.

### DYSFUNCTIONAL POLITICAL INFLUENCE

Politicians do, and should, have power over budgets and expenditures; that is why they are elected and given power. However, they should not have the power to subvert the procedures, rules, and regulations governing how their power is exercised. The PEMR revealed that political influence in the allocation of health resources at state and local government levels led to some dysfunctions in terms of: a) poor decisions that fail to support the best use of funds to achieve health outcomes, and b) apparent bending of rules to divert funds utilization away from their intended purposes. Health

<sup>4</sup> See <http://www.soros.org/initiatives/justice/news/nigeria-foi-20110531>.

funds allocation appears to be largely uninformed by empirical evidence. Overall disbursements to states occur at the federal level through the Revenue Mobilization and Allocation Commission using predetermined indicators that do not take into account state input. While the heads of various LGA departments develop and submit budgets on an annual basis, in some states, the LGA chairman has the final decision on all health expenditures in LGAs, with significant influence from other politicians at both the local and state levels. Consequently, per capita health budgets can vary significantly across LGAs in all states, and the resulting distribution of health funds across LGAs tends not to reflect demand or utilization data.

In Nasarawa, the 2010 PEMR found that political pressures drove the budget planning process at the state and LGA levels. In LGAs, budget planning and preparation did not rely on strategically informed plans. While the heads of various LGA departments developed and submitted budgets on an annual basis, planning and budgeting were primarily under the political influence of the LGA chairman. He had the final decision on all health expenditures in a large number of LGAs, with significant influence from other politicians at both the local and state levels. Similarly, according to state authorities in Sokoto, budgets also depended upon the motivation and willingness of LGA health department heads to advocate for health resources on behalf of the LGA's interests. In Sokoto, the state maintained a significant role in determining how LGA funding is allocated.

Similarly, while some LGAs release funds to PHC facilities based on the guidelines and priorities of strategic planning documents, in many Cross River and Sokoto LGAs individual LGA chairmen determined funds releases based on their own priorities and concerns. The study in fact determined that LGAs are the primary financial and operational decision makers for most PHC facilities. As noted above, most PHCs have extremely limited budgetary discretion, and a majority of facilities did not have knowledge of the budget allocated to their facilities. The result was large variances in budgetary execution that may be attributed to changes in leadership at the state and LGA levels, and corresponding shifts in political priorities and health budgets and expenditures.

The result of such strong political influence in making key decisions about health budgeting and expenditures is a governance pattern where short-term political priorities often overrule long-term strategic goals, and decision makers are not held accountable for deviations from plans. Transparency and accountability mechanisms requiring politicians to answer for their resource allocations decisions or to be held to a set of standards and goals for the health sector do not appear to function effectively.

## **WEAK BUDGETING AND BUDGET EXECUTION**

Another finding from the PEMR is important weaknesses in budget planning and execution. In budget planning cycles, decision-making authority at all government levels does not align with demand for, or usage patterns of, health services. Thus, from the outset, budgets are not well crafted to achieve health objectives. In addition, these budgets rarely match the capacity of government at various levels to finance them. Involving facility managers could help address these difficulties, but the PEMR found that budget allocation tends to be top-down, with facility managers having limited ability to participate. In Sokoto, for example, facility managers are reimbursed on an activity-by-activity basis, and thus active facilities are able to deliver services within the budget envelope allocated to them. This process, however, inhibits a more strategic approach to allocating resources to respond directly to the needs of service users.

Preparing and executing health budgets is important for ensuring that health priorities are met and that services are delivered. The PEMR discovered that, when reported, a large portion of the state and LGA health budgets did not appear to be spent. This spending gap is to some extent a function of the budgeting process. Budgets are largely "wish lists," prepared with the knowledge that there is little possibility that all items requested will in fact be funded. Actual allocations are much less than what is budgeted, and facilities were found to spend what they ultimately received. Thus the spending gap when compared to allocations may be smaller. However, the budgeting process limits the utility and credibility of budget planning as an effective tool for resource

stewardship; it is symptomatic of poor governance, and reflects the mismatch problem previously noted. In Nasarawa, state authorities and LGAs noted that funds are not usually released until the end of the year, leading to rushed spending during the final months of the year. This has clearly impacted the state's performance and ability to improve its health infrastructure and deliver quality health services, though subsequent anecdotal evidence suggests the situation has improved in the period following the PEMR. In sum, the budgeting issue is threefold, not simply a matter of poor execution. Budgets are poorly designed, do not reflect financial realities, and are poorly executed. Solving all of these problems will be necessary to improve health resources stewardship.

## LIMITED CIVIL SOCIETY AND CITIZEN INVOLVEMENT

Civil society and citizens can have a strong role in health resource allocation and budgeting through working group meetings, consultations, participation in legislative hearings, and other deliberative processes (Mitton et al. 2009). Citizen scorecards and monitoring initiatives can serve to inform assessments of service delivery. Engaging citizens through these and other mechanisms has been shown to increase provider responsiveness and accountability, reduce anti-poor bias in community services, and improve health outcomes (Diaz-Cayeros et al. 2011, Wallerstein 2006). The PEMR showed that civil society organizations' (CSOs') role in the budget planning and preparation process varied significantly across states; however, the studies converged in consistently documenting little evidence of CSO participation at the LGA level.

The Nasarawa and Sokoto SMOH's budget and planning teams did not include representatives from CSOs, the private sector, or the State Assembly. The PEMR found that the teams were composed for the most part solely of government technocrats. Civil society is also absent from the budget development process at the LGA

level in Nasarawa. In Cross River, however, civil society participated in developing the state's strategic plans, and the special advisor on budget at the state level invited CSOs to participate in budget preparations. Beyond serving as members of the strategic planning committee, civil society was also involved in organizing public consultations and meetings on budget development. Similarly, in Sokoto, CSOs participated in the presentation and defense of the annual budget before the State Assembly. However, such CSO engagement did not appear to have had much influence on health budget decisions.

The PEMR showed that some efforts were made at the facility level to include representatives from the community in decision-making. The majority of surveyed facilities in Cross River and Nasarawa reported having a health committee or a management board with district or community representatives. These committees meet regularly and discuss a variety of issues relevant to the management of the facility, such as service delivery, budgets, user fees, facility maintenance, and human resources. Facilities also attempted to remain accountable to their community through suggestion boxes, regular meetings with the community, presentation of an operations report to the community, and community participation in monitoring activities at the facility. Although facilities have made efforts to engage and remain accountable to the community, the PEMR found that decision-making at PHC facilities ultimately falls on the LGAs and the state. While many PHC facilities do try to engage CSOs, their efforts are discouraged by LGAs' strong grip on decision-making authority in health, leaving the PHC facilities with little discretion. Thus, the potential for these participatory tools and processes to contribute to better health governance through increased expression of citizens' concerns, stronger accountability, and better responsiveness appears to be limited in the three states studied.



## CONCLUSION

The three PEMR studies clearly confirm what Lewis and Pettersson (2009, 14) observe regarding the connections among public health funding flows, quality of governance, and service delivery:

Without funding public health care services grind to a halt....Weak governance structures, characterized by low capacity to plan, allocate and execute budgets; weak internal controls; poor management and supervision of funds; absence of external accountability (including audits); and distorted incentives that increase the opportunity for mismanagement and fraud, affect the funding received by health service providers, and therefore the delivery of health services.

The studies uncovered a host of health governance weaknesses and challenges in Nigeria, all of which reflect the problematic nature of the country's broader governance context. Basic processes of sound accounting and financial management were absent in a majority of facilities and a large number of MDAs, rendering any effort to track expenditures for accountability purposes extremely difficult and, in many cases, impossible. Further, the existing expenditure data were not comparable between the state and the LGA levels, impeding the ability of the state or citizens' groups to follow actual spending, and hold the LGAs accountable for health spending. Citizens' groups, while involved at some PHC facilities in monitoring services, did not have the mandate or the capacity to monitor budgetary allocations or track health expenditures. As a consequence, citizens are unable to hold health providers or government, at any level, accountable for delivering on either strategic plans or annual health budgets. As is the case in numerous countries, some governance mechanisms in Nigeria exist "on paper" that offer the opportunity, in theory, for citizens and CSOs to exercise voice and press for accountability. In practice, however, few to none of these mechanisms or procedures actually function.

Strong internal processes for tracking health budgeting and expenditures provide the foundation for ensuring the financial accountability of government health services. Without these processes and the information they provide, public health officials have little ability or incentive to influence or oversee resource allocation or spending decisions. Lack of information transparency similarly constrains the ability of civil society groups to play an effective role in voice and accountability for health spending and service delivery. The current weaknesses in the public financial management system enable politicians and special interests to become the final arbiters of health expenditures, regardless of the existence of annual budgets or longer-term health strategies and plans.

The PEMR studies offer a series of recommendations to assist reformers and their donor partners to improve the quality of financial management and governance in the health sector. These include: building financial management capacity, increasing internal transparency, improving management control and oversight, and expanding options for civil society input and engagement. These are all in line with appropriate practices for better public financial management (see Dorotinsky and Pradhan 2007). However, the political economy of the health system influences whether the results of technical analyses and the recommendations that flow from them have a chance of being acted upon. The PEMR experience in Nigeria demonstrates the limits of outside technical intervention when political will and incentives are not supportive.

These limits, however, are not cause to abandon such efforts. The PEMR exercise has shown that even when financial reports are absent or obscure, it can be possible to estimate, albeit roughly, the amount spent on health services in an LGA. It is then possible to examine the output of these services compared to need, and to identify what types of investments could improve coverage. This information can then be presented to those decision makers with a commitment to health, who could be convinced to use limited amounts of funds to drive real improvements, as long as it can be clearly outlined how to link funding to outcomes. The PEMR is a step in this direction.

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