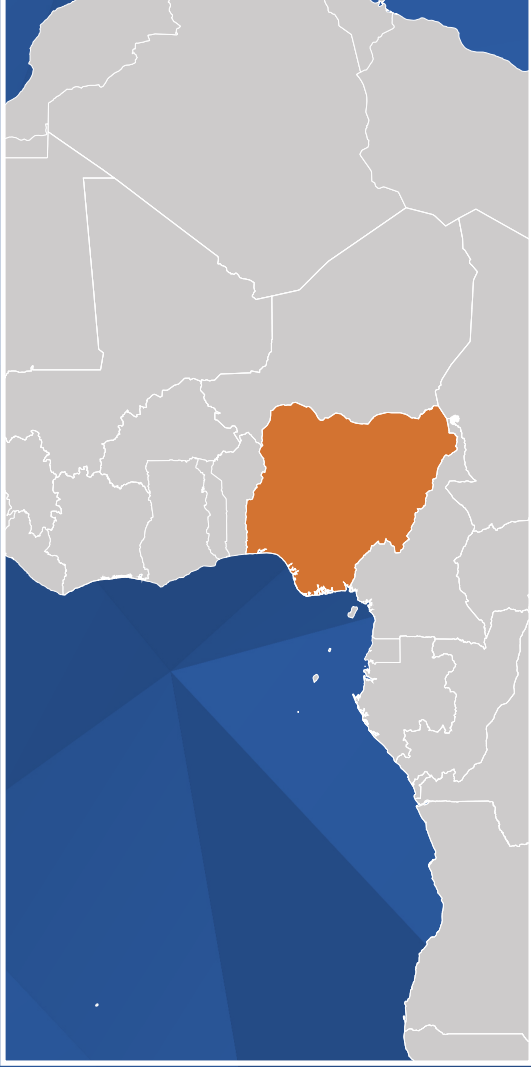


November 2019



FISCAL SPACE FOR HEALTH IN THE FEDERAL CAPITAL TERRITORY OF NIGERIA



November 2019

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Suggested citation: Carlson, A., O. Falade, F. Sadiq, and T. Fagan. 2019. *Fiscal Space for Health in the Federal Capital Territory of Nigeria*. Washington, DC: Palladium, Health Policy Plus.

ISBN: 978-1-59560-229-9

Health Policy Plus (HP+) is a five-year cooperative agreement funded by the U.S. Agency for International Development under Agreement No. AID-OAA-A-15-00051, beginning August 28, 2015. HP+ is implemented by Palladium, in collaboration with Avenir Health, Futures Group Global Outreach, Plan International USA, Population Reference Bureau, RTI International, ThinkWell, and the White Ribbon Alliance for Safe Motherhood.

This report was produced for review by the U.S. Agency for International Development. It was prepared by HP+. The information provided in this report is not official U.S. Government information and does not necessarily reflect the views or positions of the U.S. Agency for International Development or the U.S. Government.

Contents

| | |
|--|-----------|
| Abbreviations..... | 4 |
| 1. Introduction..... | 5 |
| 2. Fiscal Space for Health..... | 8 |
| 3. FCT Health Financing Landscape..... | 9 |
| 3.1. Current Health Financing Agents and Sources in FCT..... | 9 |
| 3.2. Prospective Health Financing Sources and Agents in FCT..... | 12 |
| 4. Methodology | 13 |
| 4.1. Framework and Analysis Design for FCT Fiscal Space for Health, 2018-22..... | 13 |
| 4.2. Macroeconomic Parameters | 14 |
| 4.3. Health Prioritization Parameters..... | 15 |
| 4.4. Health Earmark Parameters..... | 16 |
| 4.5. Nongovernmental Contribution Parameters | 17 |
| 4.6. Efficiency Parameters..... | 17 |
| 5. Results: Prospects for Expanding FCT Fiscal Space..... | 19 |
| 5.1. Summary of Fiscal Space Projections | 19 |
| 5.2. Macroeconomic Conditions..... | 20 |
| 5.3. Prioritization of Health | 22 |
| 5.4. Health Sector-Specific Resources..... | 22 |
| 5.5. Nongovernmental contributions..... | 23 |
| 5.6. Efficiency of Health Expenditures | 24 |
| 6. Discussion..... | 25 |
| 6.1. Considerations for Expanding Fiscal Space for Health in FCT | 25 |
| 6.2. Limitations..... | 26 |
| 7. Conclusion..... | 28 |
| References | 29 |
| Annex A. Formation of FSA Working Group | 30 |
| Annex B. FSA Data Collection | 31 |
| Annex C. Resource Mobilization Plan for the FCT Health Sector, 2018-2022..... | 33 |

Abbreviations

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|------------|--|
| BHCPF | Basic Health Care Provision Fund |
| CBN | Central Bank of Nigeria |
| CRF | consolidated revenue fund |
| FCT | Federal Capital Territory |
| FCT SHDPII | Federal Capital Territory Strategic Health Development Plan II |
| FSA | fiscal space analysis |
| GDP | gross domestic product |
| HHSS | Health and Human Services Secretariat |
| HIS | Health Insurance Scheme |
| HP+ | Health Policy Plus |
| HSSR | health sector-specific resource(s) |
| NGN | Nigerian naira |
| NHIS | National Health Insurance Scheme |
| NSHDPII | National Strategic Health Development Plan II |
| ODA | official development assistance |
| PHCB | Primary Health Care Board |
| SHDPII | Strategic Health Development Plan II |
| USAID | U.S. Agency for International Development |

1. Introduction

In 2017, the Health and Human Services Secretariat (HHSS) of the Federal Capital Territory (FCT) of Nigeria produced its Strategic Health Development Plan II (FCT SHDP II) to be implemented over 2018-2022. The goals of FCT SHDP II are to align all FCT health interventions and programs with the National SHDP II (NSHDP II) framework and significantly improve the health of all residents. The NSHDP II encourages all states, including FCT, to adopt the five strategic pillars and 15 corresponding priority areas provided in the national plan, yet provides for the states to develop their own strategic objectives, interventions, and activities (FMOH, 2018). The FCT SHDP II strategic framework adopts that of the NSHDP II, as portrayed in Figure 1. The FCT SHDP II has 47 strategic objectives spanning 208 interventions and 747 activities over the implementation period, distributed among the strategic pillars and priority areas.

The HHSS estimated the implementation costs of the FCT SHDP II using the One Health Tool.¹ Three implementation cost scenarios were developed: 1) baseline, which assumes no improvement in health coverage nor health system strengthening; 2) the essential service-moderate scenario, wherein improvements in coverage and health system strengthening would be in alignment with the primary health revitalization agenda while striving to achieve universal health coverage; and 3) the essential service-aggressive scenario, involving the implementation of additional interventions while attaining greater progress on universal health coverage.

For preparation of their SHDP II, FCT stakeholders resolved to implement the set of health interventions required to realize the essential service-moderate scenario; the estimated resource requirement is summarized in Table 1. The annual requirement for the essential service-moderate scenario grows from naira (NGN) 29 billion (US\$80 million) in 2018 to NGN 47 billion in 2022, a two-thirds increase over the period.² The major cost drivers under the essential service-moderate scenario are a) human resources; and b) medicines, commodities, and supplies—corresponding to 46 percent and 30 percent of the five-year cost requirement, respectively (FCT HHSS, 2017).

Table 1. Cost Requirement of SHDP II Essential Service-Moderate Scenario, in Billions Naira (NGN)

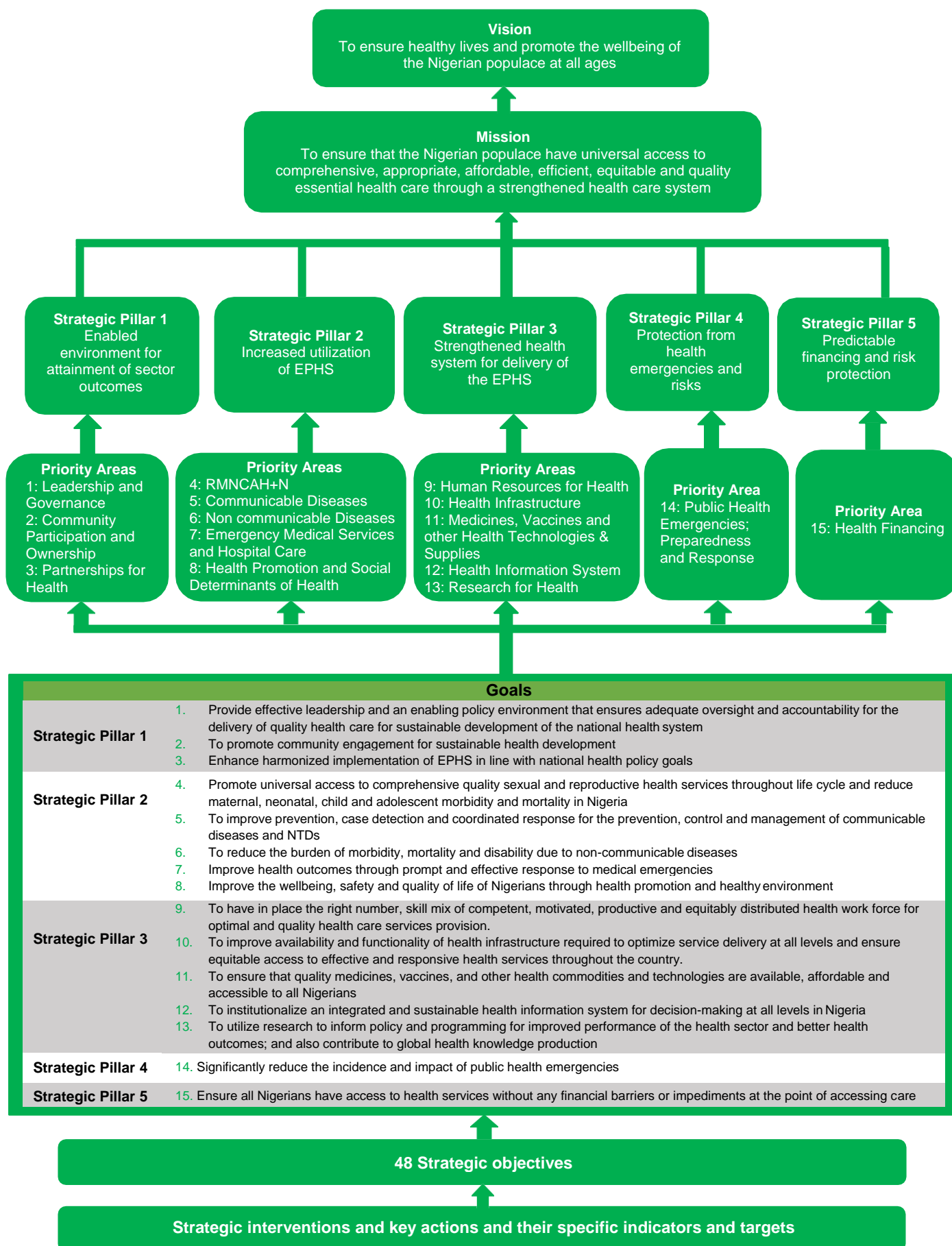
| 2018 | 2019 | 2020 | 2021 | 2022 | TOTAL |
|------|------|------|------|------|-------|
| 28 | 32 | 36 | 41 | 47* | 185 |

To meet the estimated resource requirement, FCT HHSS committed to developing a Resource Mobilization Plan. The Resource Mobilization Plan serves as HHSS' blueprint for strategic action to guide resource mobilization efforts in support of the five-year SHDP II. With funding from the U.S. Agency for International Development (USAID), the Health Policy Plus (HP+) project helped FCT HHSS to conduct a fiscal space analysis to identify the primary current and potential resources of financing for the health sector. The analysis was to serve as the main input in the development of the Secretariat's Resource Mobilization Plan.

¹ "The OneHealth Tool is a software tool designed to inform national strategic health planning in low- and middle-income countries." For further information, see: <https://www.who.int/choice/onehealthtool/en/>.

² Exchange rate is mid-year 2018 from Oanda currency converter: <https://www1.oanda.com/currency/converter/>.

Figure 1. National Strategic Health Development Plan II 2018-2022 Strategic Framework



Source: Reprinted from the National Strategic Health Development Plan II 2018-2022

This report summarizes the findings and recommendations of that fiscal space analysis and explores three main research questions:

1. What are the current and potential future sources of fiscal space for health in the FCT based on the current policy environment and policy proposals?
2. What are the baseline, moderate, and optimistic scenarios for each source based on current trends and policy targets and what is the potential value of resources that could be mobilized under each scenario?
3. How do these resource estimates compare to the resource requirements of the SHDPII?

To answer these research questions, this report is structured into five parts. First, it defines fiscal space for health and summarizes the common sources of fiscal space highlighted in previous literature. Second, the report examines and summarizes the current health financing landscape in FCT to understand current and potential future sources of health sector financing. Third, it outlines the methodology used for estimating fiscal space for health. It provides a framework, based on the health financing landscape in the FCT, for estimating where new fiscal space can be created. The report describes current and projected economic and policy conditions in FCT and develops scenarios and relevant parameters for each. Fourth, it presents estimates of the amount of fiscal space that can be created, by source, based on each set of defined scenarios. The report also compares these estimates to the resource needs of the SHDPII and discusses which combinations of scenarios meet--or fall short of--these resource needs. Fifth, it discusses key considerations for the FCT health sector's efforts to expand fiscal space for health through its Resource Mobilization Plan.

2. Fiscal Space for Health

Fiscal space can be viewed as the amount of funding available to finance a particular sector or activity from a variety of sources, particularly different government revenue streams. Heller (2006) more precisely defined fiscal space as “the capacity of government to provide additional budgetary resources for a desired purpose without any prejudice to the sustainability of its financial position.” Fiscal space analysis involves identifying these funding sources and estimating the amount of revenue that can be generated from each under a set, or competing sets, of preconditions, such as specific macroeconomic performance or the implementation of particular tax or budgetary policies.

The literature on fiscal space analysis, both in general and for the health sector specifically, identifies a range of potential sources of additional government fiscal space. Commonly, fiscal space for health is classified under five discrete “pillars:”

1. **Macroeconomic Conditions.** The overall resources available for health and other sectors are determined; these include both the total size of the local economy (measured by gross domestic product) and the share of the domestic economy collected as public revenues through taxes and other means.
2. **Prioritization of Health in Discretionary Government Health Expenditures.** This approach often is a major source of fiscal space. “Discretionary” refers to the autonomy of the government to adjust allocations during the budgeting process.
3. **Earmarked Resources for Health.** Unlike discretionary resources, earmarked resources come from restricted government revenues mandated through legislation.
4. **Nongovernmental Contributions:** These typically include funds from international donors and the private sector. Such contributions may either provide additional resources for government to allocate or defray government financing requirements by shifting costs to nongovernmental entities.
5. **Efficiency of Health Expenditures.** Improving efficiency involves reducing the amount of financial resources required to provide the same level of output or outcomes.

3. FCT Health Financing Landscape

This section describes current agents and sources of health financing in the FCT as well as the key recent trends in the FCT health financing landscape. It also briefly summarizes possible forthcoming policy and administrative changes that could greatly influence these trends. The estimate of fiscal space considers only financial resources spent by the FCT government on the SHDPII cost categories. As such, the estimate does not include private sector contributions to health purposes that fall outside priority areas in the SHDPII landscape assessment.

3.1. Current Health Financing Agents and Sources in FCT

3.1.1. FCT Government

There are four primary FCT governmental institutions charged with delivering public health services: HHSS, the Health Insurance Scheme (HIS), the Primary Health Care Board (PHCB), and the Hospitals Management Board. Collectively, these institutions are responsible for operating 254 public health facilities at primary, secondary, and tertiary levels of care. As is the case in Nigerian states, an aggregate health budget is passed annually that allocates funding to each of the health institutions' ministries, departments, and agencies. The roles and responsibilities of the four major health institutions are described below:

- **HHSS:** HHSS is responsible for policy formulation and planning, provision of medical services to the FCT population, and regulatory and oversight over all FCT healthcare providers.
- **FCT HIS:** The HIS began enrolling formal sector individuals in 2009 and informal sector individuals in 2012. In 2018, formal sector enrollment was estimated at 100,000 persons while informal sector enrollment was estimated to be very low. At the time of the analysis, all enrollees were obligated to pay an annual premium of NGN 11,200. However, because the HIS had not been established by law at that time, enrollee premiums had not been channeled to the HIS.
- **PHCB and Hospitals Management Board:** The PHCB and Hospitals Management Board are responsible for managing primary and secondary health facilities, respectively.

The FCT government finances health services from multiple revenue sources. Its two major public revenue sources are the consolidated revenue fund (CRF) and internally generated revenue. The CRF is managed at the federal level and receives its income from sources nationwide, while internally generated revenue refers to revenues collected within the FCT. Oil sector revenues constitute the majority of CRF inflows while internally generated revenue consists mostly of individual income tax revenues (CBN, 2018).

Recent trends show that 46 percent of CRF revenues are transferred to the federal government. The FCT government then receives 1 percent of the federal government's share of the CRF, in accordance with the Federal Allocation Act. Over 2012-16, CRF collections declined from NGN 10.6 trillion to NGN 5.7 trillion due to the national recession in 2015-16, corresponding to 6 percent of national gross domestic product (GDP) in 2016. The country is now in a state of post-recession recovery, and federal revenue collections are expected to stabilize or recover to pre-recession levels in the near term (CBN, 2018).

The FCT Internal Revenue Service is responsible for collecting internally generated revenue in the FCT. FCT internally generated revenue collections ranged from NGN 50 billion to NGN 75 billion, roughly 5 percent of FCT real GDP, over 2013–2016 (CBN, 2018). Stakeholders believe that FCT tax collections may improve, now that the FCT Internal Revenue Service has legal backing and a board.

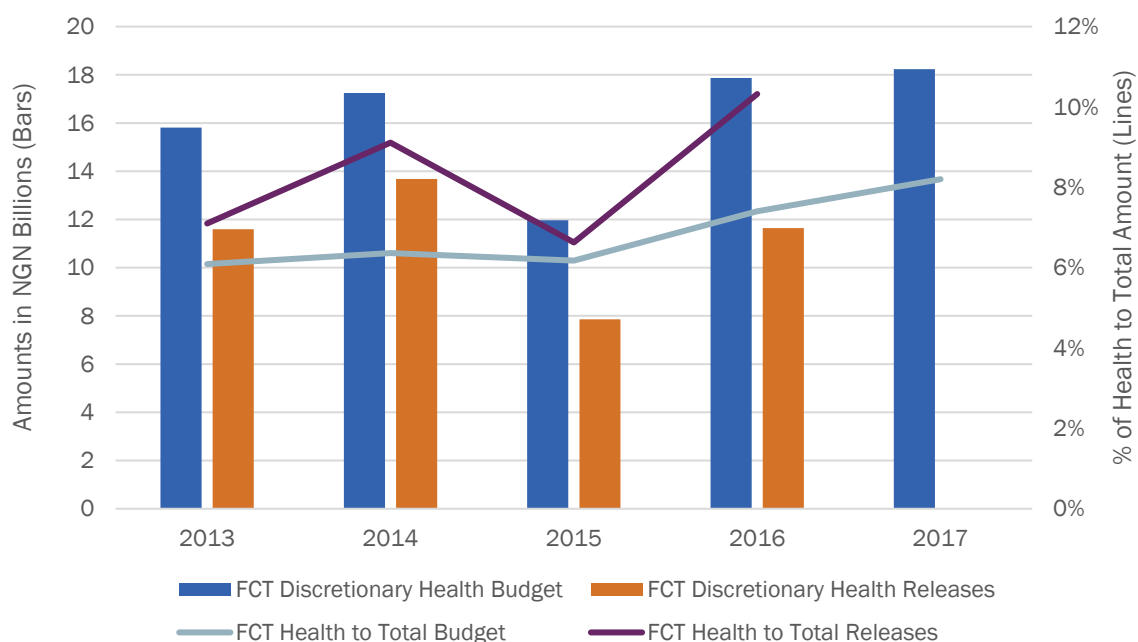
In addition to the publicly sourced revenues described above, contributions from donors serve as notable sources for health financing in FCT. Donor contributions are either channeled through the FCT budget and are thereby referred to as “on-budget” contributions, or are transferred directly, “off-budget,” to the target institutions or interventions. In our analysis, we observe only on-budget contributions, as the FCT government has more control over directing these inflows to priority areas in the SHDP; for this reason, the HHSS has expressed interest in moving off-budget contributions on-budget. Key informants have acknowledged that United Nations agencies, specifically UNICEF, have provided the most consistent on-budget support to health in FCT, in recent years, but there is a risk that this support will decrease. We estimate that on-budget donor contributions to health in FCT grew from NGN 0.4 billion in 2013 to NGN 0.9 billion in 2017.³ On-budget health official development assistance (ODA) is treated separately from discretionary health budgets as these inflows are restricted for spending on health purposes.

Over 2013-17, the annual FCT discretionary health budget ranged from NGN 12.0 billion to NGN 18.2 billion. Budget performance, or the proportion of budget allocations released to the FCT government health institutions, fell well below 100% over 2013-16. Annual budget releases for health amounted to NGN 7.9 to NGN 13.7 billion over 2013-16, corresponding to 65 percent–79 percent of annual health budget allocations. This is because the proportion of the capital budget that is released has been quite low. Consistent with trends before 2013, we noted a high degree of volatility in health releases, which rose by 18% over 2013-14, dropped by 43 percent over 2014, and then rose again by 48 percent over 2015-16. Historically, virtually all releases to FCT government health institutions are spent.⁴

Recently, the level of prioritization of health has grown in FCT budget allocations. The FCT discretionary health budget as a share of the total FCT budget remained flat at 6 percent over 2013-15 and has risen to 7 percent and 8 percent in 2016 and 2017, respectively. In contrast, prioritization of health in budget releases has been quite variable. Budget releases for health as a percentage of total budget releases varied annually by two to three percentage points over 2013-16. Still, budget performance in the health sector has been consistently higher than budget performance in all FCT sectors, as can be seen in the purple and gray lines of Figure 2.⁴

³ The analysis used estimates of on-budget donor contributions to health as follows. At the national level, donor contributions to health represent 0.2 percent of national GDP. Based on key informant interviews, donor contributions to health in FCT is lower than those in other Nigerian states. To account for this lower prioritization of FCT, the analysis assumes that FCT donor health contributions as a percentage of FCT GDP halves national donor health contributions as a percentage of national GDP, or 0.1 percent of FCT GDP. Finally, the analysis assumes that 25 percent of FCT donor health contributions are on-budget given the high proportion of health donors channelling funds to health interventions independent of the budget in FCT. Under these assumptions, donor contributions to health in FCT grew from NGN 0.4 billion in 2013 to NGN 0.9 billion in 2017 (FMOH NBS, 2018).

⁴ Federal Capital Territory of Nigeria, Department of Treasury, 2018. Informal correspondence with FCT Department of Treasury.

Figure 2. FCT Health Budget Performance and Health Prioritization, 2013-17

3.1.2. Area Council Governments

FCT is divided into six area council governments; one responsibility is to finance health services. Recent trends show that 23 percent of CRF revenues are transferred to local (sub-state) governments of which 2 percent have been transferred to the six FCT area councils. Exact estimates of area councils' own-source revenues are not known, though stakeholders suggest that the volume of these inflows is negligible (CBN, 2018).

Area council health releases are much lower than those at the FCT level. Over 2012-16, health budgets at this level are estimated at NGN 0.6 to NGN 0.7 billion, growing annually over the period.⁵ Prioritization of health at the area council level averaged 3 percent and peaked at 4 percent over the 2012-16 period (CBN, 2018).

3.1.3. Private Sector Organizations

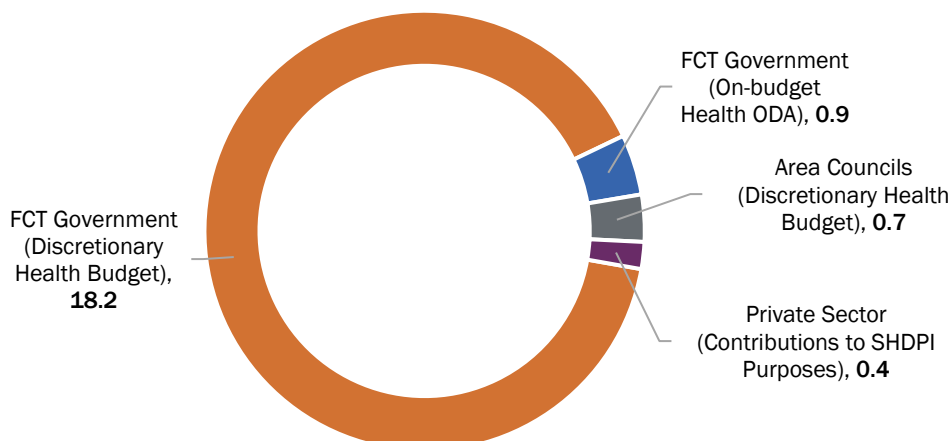
According to experts, private sector contributions have been lower than on-budget donor health contributions and are estimated to have grown from NGN 0.2 billion to NGN 0.4 billion over 2013–2017.⁶

Figure 3 illustrates FCT health financing from four of the five major spending agents in 2016. The fifth spending agent, not shown in the figure, is households; it is not currently clear that out-of-pocket expenditures on healthcare are made available for use by the FCT health sector and therefore are not used in this analysis.

⁵ These values were calculated by multiplying total government health expenditures from local government by the FCT population as a proportion of the national population (FMOH, NBS, CHECOD, 2018).

⁶ The analysis assumes that private sector contributions have represented 50 percent of on-budget health assistance from donors.

Figure 3. FCT Health Financing by Agent, 2017, NGN Billions



3.2. Prospective Health Financing Sources and Agents in FCT

There are currently two sets of public earmarks under consideration at the national and FCT level, which, when implemented, will generate funding restricted to the FCT HHIS and the FCT PHCB.

National-Level Earmarks: Basic Health Care Provision Fund. Enacted in 2014, the National Health Act provided for a Basic Health Care Provision Fund (BHCPF), which is financed by 1 percent of the federal government’s aforementioned 46 percent share of the CRF. As mandated in the act, the BHCPF transfers 50 percent and 45 percent of its income, through two of its “funding gateways” to eligible State HISs and PHCBs, respectively.⁷ To access the funds available through the BHCPF, the 36 states and FCT must have qualified PHCBs and HISs, which are authorized through official state- and FCT-level legislation. At the beginning of the 2018-2022 analysis period, FCT did not satisfy these requirements (FMOH, NHIS, NPHCDA, 2018).

FCT-Level Earmarks. At the time of the analysis, two bills—the FCT Primary Healthcare Board Bill and the FCT Health Insurance Agency Bill—had been drafted with additional earmarks for the FCT HIS and PHCB. Implementation of both earmarks is required for the implementation of both BHCPF funding gateways. Once the earmarks are implemented, the FCT HIS and PHCB will each receive 1 percent of FCT revenues annually. More specifically, the earmarks would be applied to the sum of (a) FCT internally generated revenue collections and (b) transfers from the CRF from the national level.

⁷ Technically, the Basic Health Care Provision Fund transfers amounts to the National Primary Healthcare Development Agency for subsequent transfer to the state-level PHCBs and to the NHIS for subsequent transfer to the state-level health insurance agencies.

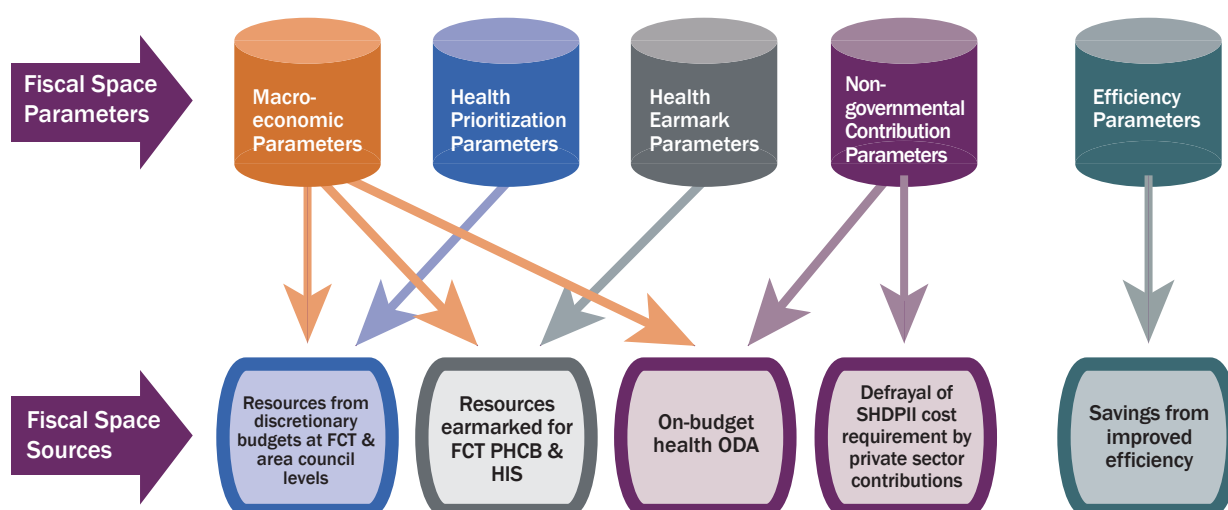
4. Methodology

4.1. Framework and Analysis Design for FCT Fiscal Space for Health, 2018-22

Our model for the estimation of fiscal space is structured around four primary sources of fiscal space for health in FCT: 1) resources from discretionary budgets at FCT and area council levels, 2) resources earmarked for the FCT PHCB and HIS, 3) on-budget health official development assistance and private sector contributions to health, and 4) savings from improved efficiency. We developed a multistage framework for estimating fiscal space for each of these sources, through which we created a set of model parameters covering each of the five typical pillars of fiscal space.

The parameters chosen at each stage of the analysis determine the value of resources available from each of these sources in any given year. At each stage, we develop three potential scenarios—a baseline, moderate, and optimistic scenario—which are intended to reflect the range of potential variation on the parameter. Figure 4 depicts the relationship between our model parameters and the four fiscal space sources in our framework. As can be seen in the figure, our model assumes that changes in macroeconomic parameters influence the first three fiscal space sources 1-3 enumerated earlier in this section. Macroeconomic conditions determine resources from discretionary budgets and earmarks, as both sources are derived from public revenues. As mentioned earlier, fiscal space from households is ignored in this analysis as it is not clear whether this source of fiscal space is made available for spending by the health sector. As explained later in the methodology section, the figure indicates that macroeconomic parameters influence nongovernmental sources because one of the model parameters expresses on-budget health official development assistance as a percentage of FCT GDP.

Figure 4. Fiscal Space Analysis Framework



The estimation framework, parameters, scenarios, and relevant assumptions were developed and agreed upon by the FSA Fiscal Space Analysis (FSA) Core Working Group. A list of FSA members and details of Core Working Group engagement are listed in Annex A. Data collection was carried out by HP+ through desk review of both primary and secondary

sources, and structured interviews and discussions with key informants. A list of the sources reviewed and key informants interviewed is provided in Annex B.

The following sections discuss in greater detail the methodology for estimating fiscal space from each source and parameters used to define baseline, moderate, and optimistic scenarios for each.

4.2. Macroeconomic Parameters

In our model, the total FCT budget is determined by three factors: GDP growth, CRF collections as a percentage of national GDP, and internally generated revenue collections as a percentage of FCT GDP. We assume that FCT annual GDP growth is the same as that at the national level and estimate FCT GDP based on FCT population estimates and on an assumed level of parity between the national average and FCT GDP per capita. (See Table 2.)

Parameter #1: National GDP Growth. Nigeria's real GDP grew by approximately 2 percent from NGN 111 trillion to NGN 113 trillion over 2017-18, suggesting that, following the national recession in 2015-16, the Nigerian economy was expanding at the beginning of the analysis period. The analysis considers three potential rates of GDP growth based historical trends and more optimistic projections. The baseline scenario assumes that annual GDP growth will remain at the 2018 rate of 2 percent over 2018–2022. It also projects GDP under moderate and optimistic scenarios, in which annual GDP growth rises to 4 percent and 6 percent, respectively, by 2022, consistent with projections made by BMI Audit Services and PricewaterhouseCoopers before 2019.

Parameter #2: CRF Collections. In our baseline, federal revenues as a percentage of national GDP remain constant at 6 percent based on 2016 collections. In contrast, the moderate scenario assumes linear annual growth from 6 percent in 2018 to the CEIC data-forecasted level of revenue collections in 2022, 8 percent. Given that the average annual proportion of federal revenue collections to national GDP was 10% in 2012-2016, this proportion is assumed to grow linearly from 6 percent to 10 percent over the period under the optimistic scenario (CEIC, 2018; CBN, 2018).

Parameter #3: Internally Generated Revenue Collections. We assume that internally generated revenue as a percentage of FCT GDP will remain at the 2013-16 rate of 5 percent in our baseline. Given the institutional improvements in the FCT Internal Revenue Service discussed earlier in this report, the moderate and optimistic scenarios assume tax collections will improve to Federal Inland Revenue Service rates. Our moderate internally generated revenue scenario forecasts linear annual growth from 5 percent in 2017 to the Federal Inland Revenue Service pre-recession (2015) proportion of 7 percent by 2022. The optimistic internally generated revenue scenario assumes linear growth to 9 percent by the end of the period.

Table 2. Macroeconomic Parameters, by Scenario

| Parameter | Scenario | Description |
|--|----------|-----------------------------|
| National Gross Domestic Product (GDP) Growth | Baseline | ~2% |
| | Moderate | Rise from 2% to 4% by 2022 |
| | High | Rise from 2% to 6% by 2022 |
| Consolidated Revenue Fund (CRF) Collections | Baseline | 6% |
| | Moderate | Rise from 6% to 8% by 2022 |
| | High | Rise from 6% to 10% by 2022 |
| Internally Generated Revenue (IGR) Collections | Baseline | 5% |
| | Moderate | Rise from 5% to 7% by 2022 |
| | High | Rise from 5% to 9% by 2022 |

4.3. Health Prioritization Parameters

To estimate the total amount of budgetary resources available for health, the analysis considers both the FCT discretionary budget and the budget of area councils. The FCT discretionary budget is assumed to be a constant share the share of all FCT revenues (including from both CRF and internally generated revenue). The total budget for area councils is considered to be the total amount transferred to them by the federal government. (See Table 3.)

Parameter #4: FCT Health Prioritization. For each of our health prioritization scenarios at the FCT level, the analysis assumes that the share for health within the FCT discretionary budget will be 8 percent. This report notes that health as a total of FCT discretionary releases fluctuated by two percentage points. The analysis therefore assumes that at baseline, health resources mobilized from FCT discretionary budgets will fluctuate between 8 percent and 10 percent annually. In the 2001 Abuja Declaration, Nigeria pledged to dedicate 15 percent of its budget to health; the optimistic health prioritization scenario assumes linear growth of this proportion from 10 percent in 2018 to the Abuja target by 2022.⁸ In the moderate prioritization scenario, the share of the FCT budget allocated to health would rise by half of that provided in the optimistic prioritization scenario over the five-year period, from 10 percent to 12.5 percent.

Parameter #5: Area Council Health Prioritization. Over 2012-2016, area councils allocated an average of 3 percent of their budgets to health—this value is assumed to remain constant at baseline through 2022. The moderate prioritization scenario assumes linear growth to the 2012-2016 peak of 4 percent by the end of the analysis period, assuming enhanced advocacy efforts at the area council level. The optimistic prioritization scenario assumes resource mobilization efforts increase considerably and the share of the budget allocated to health would increase linearly to 5 percent by 2022.

⁸ 2001 Abuja Declaration: http://www.un.org/ga/aids/pdf/abuja_declaration.pdf

Table 3. Health Prioritization Parameters, by Scenario

| Parameter | Scenario | Description |
|------------------------------------|----------|--------------------------------|
| FCT Health Prioritization | Baseline | 8% & 10% alternating annually |
| | Moderate | Rise from 10% to 12.5% by 2022 |
| | High | Rise from 10% to 15% by 2022 |
| Area Council Health Prioritization | Baseline | 3% |
| | Moderate | Rise from 3% to 4% by 2022 |
| | High | Rise from 3% to 5% by 2022 |

4.4. Health Earmark Parameters

The amount of funding for health available through health earmarks is determined by two factors: the year of implementation of the BHCPF and PHC/HIS earmarks, and HIS enrollment. (See Table 4.)

Parameter #6: BHCPF Earmark Implementation in FCT. At baseline, we assume the BHCPF earmark is not be implemented during the 2018-22 period. The moderate and optimistic scenarios assume earmark implementation in 2021 and 2020, respectively.

Parameter #7: FCT-level Implementation of PHC and HIS Earmarks. As with the BHCPF earmark, the primary healthcare and HIS baseline scenario assumes that neither earmark is implemented until after 2022. The moderate scenario assumes that one of the two FCT-level earmarks will be implemented starting in in 2020, while both earmarks would be implemented in 2020 under our optimistic scenario.

Parameter #8: HIS Enrollment. The baseline scenario assumes that enrollment levels will remain at current (2018) levels, at roughly 100,000 enrollees. More optimistic scenarios assume that the HIS is successful in its efforts to expand coverage to area council and private sector employees. By the end of the period, current enrollment of 100,000 enrollees would double or quintuple under the moderate and optimistic scenarios, respectively.

Table 4. Health Earmark Parameters, by Scenario

| Parameter | Scenario | Description |
|---|------------|----------------------------------|
| BHCPF Earmark Implementation in FCT | Baseline | Post-2022 implementation |
| | Moderate | 2021 implementation |
| | Optimistic | 2020 implementation |
| Implementation of FCT-Level PHC and HIS Earmarks in FCT | Baseline | Post-2022 implementation |
| | Moderate | 1/2 earmarks implemented in 2020 |
| | Optimistic | 2/2 earmarks implemented in 2020 |
| HIS Enrollees | Baseline | Flat at 100,000 |
| | Moderate | Linear growth to 200,000 by 2022 |
| | Optimistic | Linear growth to 500,000 by 2022 |

4.5. Nongovernmental Contribution Parameters

Estimates of fiscal space from development partners considered only on-budget contributions. The estimates in this analysis are based on a set of assumption as to total (on- and off-budget) health official development assistance in FCT as a percentage of FCT GDP, and the share of health official development assistance that is on-budget vs. off-budget. Again, the analysis includes only on-budget health official development assistance in the estimation model under the assumption that FCT has greater ability to channel these funds to cost items in the SHDPPII. We also assume that private sector contributions are equal to 50 percent of on-budget health official development assistance. (See Table 5.)

Parameter #9: Volume of Official Development Assistance to Health. In the baseline scenario health ODA as a percentage of the FCT's GDP declines from 0.1 percent to 0.04 percent over the five-year period, in line with increased efforts targeting domestic resource mobilization within the international development community. In the moderate scenario, ODA is assumed to remain relatively constant at approximately 0.1 percent of FCT GDP. The most optimistic scenario projects that ODA for health will increase linearly to 0.15 percent of the FCT's GDP by 2022.

Parameter #10: Proportion of On-budget vs. Off-budget Health Official Development Assistance. The second set of nongovernmental contribution scenarios were based on assumptions around the expected proportion of on-budget to total ODA for health in FCT. The baseline scenario assumes the gradual withdrawal of donors providing on-budget health support (largely United Nations agencies) and no success in moving health ODA on-budget: under this scenario, the proportion of on-budget ODA will decrease linearly from 25 percent to 20 percent of ODA by 2022. More optimistic scenarios project that the on-budget share of ODA will remain constant at around 25 percent or that efforts to move health ODA on-budget will increase this share to 33 percent by 2022.

Table 5. Nongovernmental Contribution Parameters, by Scenario

| Parameter | Scenario | Description |
|---|------------|---|
| Volume of Official Development Assistance to Health | Baseline | Linear decrease from 0.1% to 0.04% of FCT GDP over 2018-22 |
| | Moderate | Constant at 0.1% of FCT GDP over the period |
| | Optimistic | Linear increase from 0.1% to 0.15% of FCT GDP over 2018-22 |
| Proportion of On-budget vs. Off-budget Health Official Development Assistance | Baseline | Linear decrease from 25% to 20% provided on-budget over 2018-22 |
| | Moderate | Constant at 25% over the period |
| | Optimistic | Linear increase from 25% to 33% provided on-budget over 2018-22 |

4.6. Efficiency Parameters

Parameters #11-#12: Savings from Improved Distribution of Human Resources for Health and Savings from Bulk Procurement.

When developing the SHDPPII, the FCT Health and Human Services Secretariat (HHSS) identified the improved distribution of human resources for health and localization of commodity procurement as its two priority areas of potential SHDPPII cost savings. (See Table 6.)

In the FCT, there is an imbalance of government health worker density in rural and urban areas. In rural areas, the current worker density is insufficient to meet residents' health needs. In contrast, there are more than enough urban health workers to meet the demand of residents in these areas. By redistributing urban health workers to rural areas, the FCT stands to save greatly on personnel costs while achieving the same or increased worker output levels. (FCT HHSS, 2019).

The FCT Central Medical Store currently procures health commodities in small quantities from open market suppliers and stands to save on procurement costs through purchasing these goods in bulk rather than in multiple, smaller quantities over the course of a given fiscal year (FCT HHSS, 2019).

In the baseline scenario, the analysis assumes no efficiency gains for either potential source of increased efficiency (human resources for health and procurement) while the other scenarios provide for annual 2.5 or 5 percentage point savings until 2022.

Table 6. Efficiency Parameters, by Scenario

| Parameter | Scenario | Specification |
|--|------------|---|
| Savings from Improved Distribution of Human Resources for Health | Baseline | No efficiency gains |
| | Moderate | Annual 2.5 percentage point increase in savings on human resources for health spending until 2022 |
| | Optimistic | Annual 5 percentage point increase in savings on human resources for health spending until 2022 |
| Savings from Improved Procurement | Baseline | No efficiency gains |
| | Moderate | Annual 2.5 percentage point increase in savings on procurement costs until 2022 |
| | Optimistic | Annual 5 percentage point increase in savings on procurement costs until 2022 |

5. Results: Prospects for Expanding FCT Fiscal Space

The prior section described 14 parameters, each with three distinct scenarios, across the four fiscal space pillars included in this analysis. There are a multitude of combinations of these scenarios and parameters, each yielding different potential fiscal space outcomes for health in the FCT over 2018-2022 period. This section summarizes results of the parameter scenario combinations that best address three research questions:

1. What are the current and potential future sources of fiscal space for health in the FCT based on the current policy environment and policy proposals?
2. What are the baseline, moderate, and optimistic scenarios for each source based on current trends and policy targets and what is the potential value of resources that could be mobilized under each scenario?
3. How do these resource estimates compare to the resource requirements of the SHDPII?

Before presenting these results by fiscal space pillar, aggregate fiscal space projections are summarized in which all parameter scenarios are fixed to baseline, moderate, and optimistic scenarios.

5.1. Summary of Fiscal Space Projections

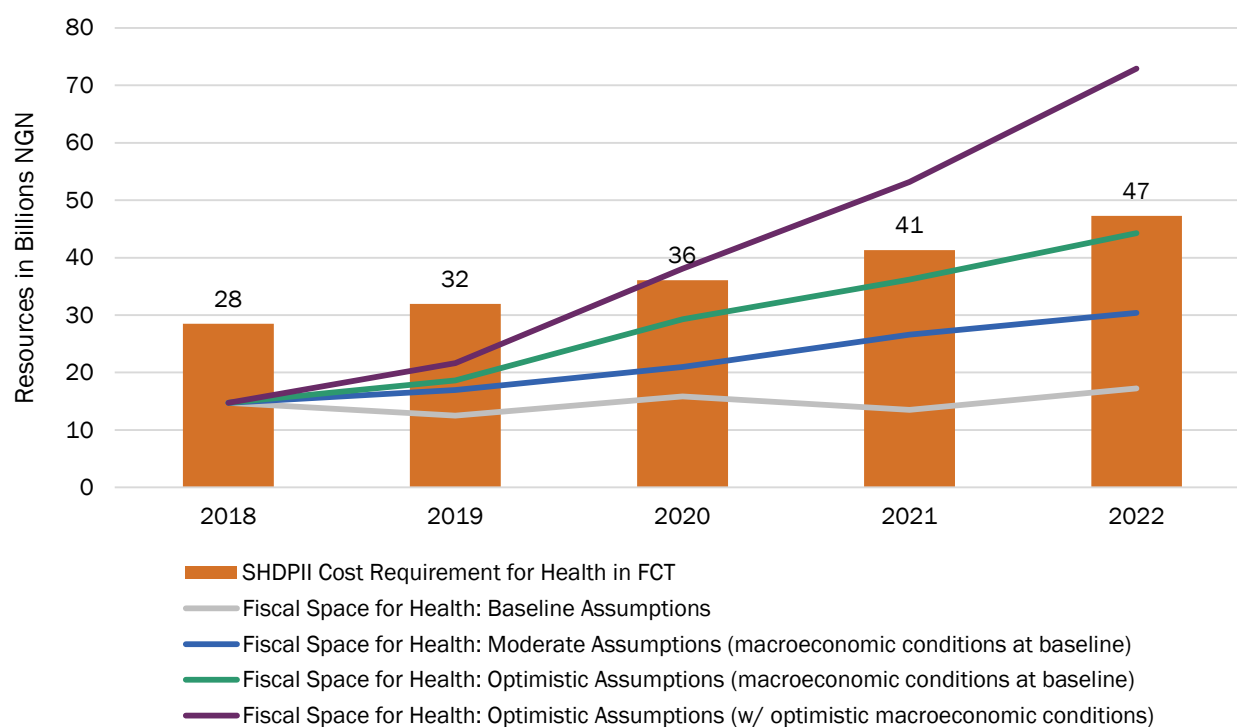
If current (baseline) trends remain unchanged, FCT fiscal space is expected to fall NGN 111 billion short of the five-year FCT SHDPII cost requirement of NGN 185 billion. Resources from the FCT health budget alone are projected to account for NGN 67 billion or 90 percent of fiscal space in the FCT. Area council health budgets, official development assistance, and private sector contributions would occupy a small portion of fiscal space (NGN 7 billion).

Even with moderate improvements in the health financing environment, i.e., with all parameter scenarios fixed at their “moderate” instead of their “baseline” scenarios, there would still be an SHDPII funding gap amounting to NGN 48 billion. The FCT health budget would still provide the largest share at NGN 105 billion or 77 percent of total fiscal space. Unlike the baseline case, health sector-specific resources and efficiency gains can now be seen. This is because health earmarks would be implemented before the end of the period and savings would be generated in human resources for health redistribution and improved procurement.

Under the most optimistic assumptions, there would be no SHDPII funding gap: instead, there would be a 15 percent funding surplus. Though the FCT health budget would still serve as the primary source of fiscal space under optimistic conditions, its distribution by source would be more even. The FCT health budget would account for 70 percent of fiscal space while health sector-specific resources, official development assistance and private sector resources, and savings would together provide 26 percent.

Overall, one can conclude from these three findings that resource mobilization efforts will need to dramatically escalate over the next few years to close the annual gap between the SHDPII cost requirement and fiscal space available for health under current baseline conditions.

Figure 5. FCT Fiscal Space for Health versus SHDP/II Resource Requirements, 2018-22, Billions NGN



5.2. Macroeconomic Conditions

At baseline macroeconomic conditions, FCT GDP would rise from NGN 2.0 trillion to NGN 2.5 trillion over 2018-2022, compared to the projection under optimistic assumptions, from NGN 2.0 to NGN 3.1 trillion. Each estimate assumes both GDP parameters are at baseline and optimistic scenarios, respectively.

Fiscal space for health in FCT is more responsive to fluctuations in internally generated revenue collections than fluctuations in CRF collections. At baseline, CRF collections would generate NGN 150 billion in revenues for FCT over the period; this number would grow to NGN 212 billion under optimistic assumptions. In contrast, internally generated revenue collections would amount to NGN 575 and NGN 801 billion under baseline and optimistic conditions, respectively. As depicted in Figure 6a, an optimistic improvement in internally generated revenue collections would create NGN 164 billion more in new revenues than an optimistic improvement in CRF inflows.

Because the FCT budget is financed by both internally generated revenues and a share of the CRF, the higher responsiveness of fiscal space to internally generated revenue fluctuations—relative to CRF fluctuations—can be seen in health budgets at the FCT level. Figure 6b shows that optimistic improvements in CRF and internally generated revenue collections would result in 9 percent and 31 percent increases in resources from the FCT health budget, respectively.

Figure 6a. FCT Total Revenues 2018-2022 under Varying CRF and Internally Generated Revenue (IGR) Specifications, NGN Billions

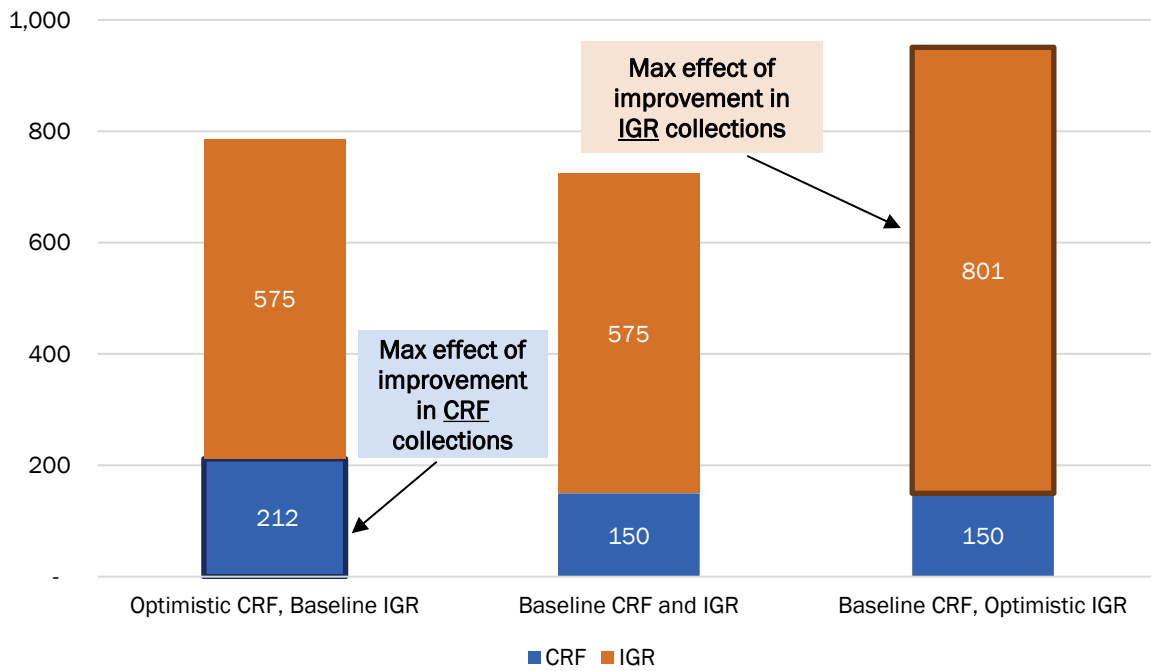
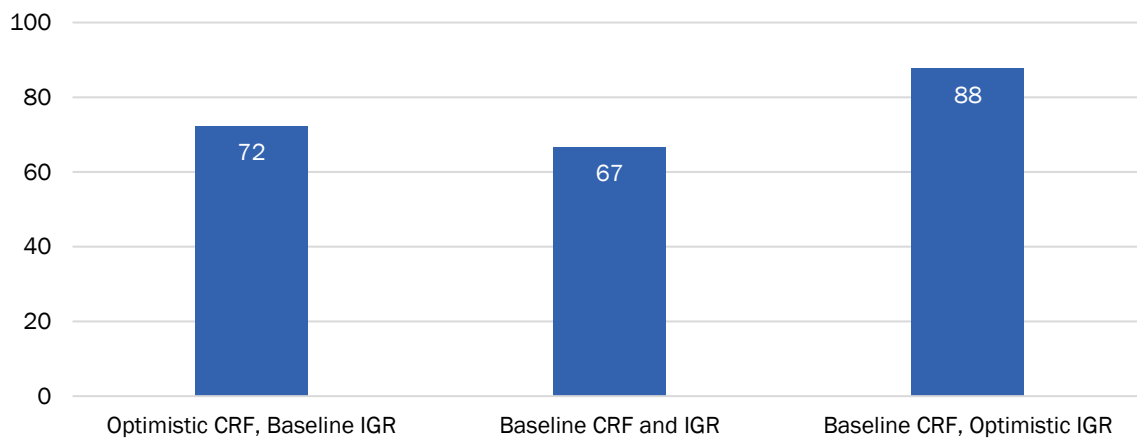


Figure 6b. FCT Health Budgets 2018-2022 under Varying CRF and Internally Generated Revenue (IGR) Assumptions, NGN Billions

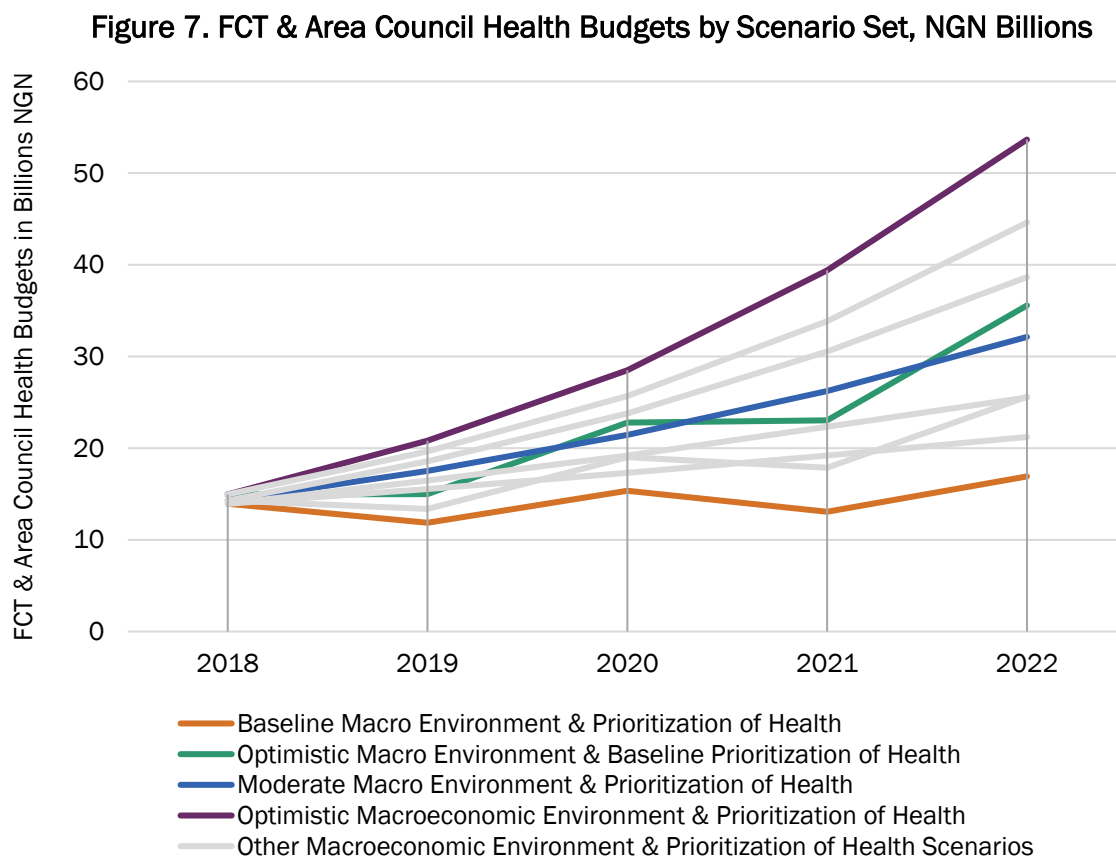


As was described in the methodology section of this report, the three internally generated revenue scenarios vary based on the degree to which recent institutional improvements in the Internal Revenue Service will strengthen internally generated revenue tax collections. From these findings, it is clear that the prospects for satisfying the SHDPII cost requirement would significantly improve if the FCT Internal Revenue Service could effectively translate these institutional advances into a higher rate of target tax revenues collected.

5.3. Prioritization of Health

Resources from discretionary health budgets are projected to account for most of the fiscal space over the period. An optimistic improvement in FCT’s health prioritization would create NGN 26 billion more in fiscal space, equal to a 30 percent reduction in the SHDPPII funding gap over 2018–2022. Notably, 98 percent of the SHDPPII funding gap would be closed if health prioritization and macroeconomic conditions simultaneously rose to optimistic levels.

Figure 7 illustrates projected annual trends in health budgets at FCT and area council levels over 2018–2022. Health budgets are projected to significantly vary year on year when health prioritization is fixed at baseline, rising by up to 29 percent or dropping by as much as 15 percent annually. This annual variance is driven by resources from health budgets behaving independently of annual health sector needs. Moderate and optimistic scenarios for the FCT health prioritization parameter assume linear growth in prioritization over the period, as shown by the green and yellow plots in the graphic.



Note: Gray trend lines show projected health budget amounts for additional scenario combination choices for the macroeconomic environment and prioritization of health parameters. For instance, one of the gray lines displays health budgets assuming moderate macroeconomic environment and optimistic prioritization of health.

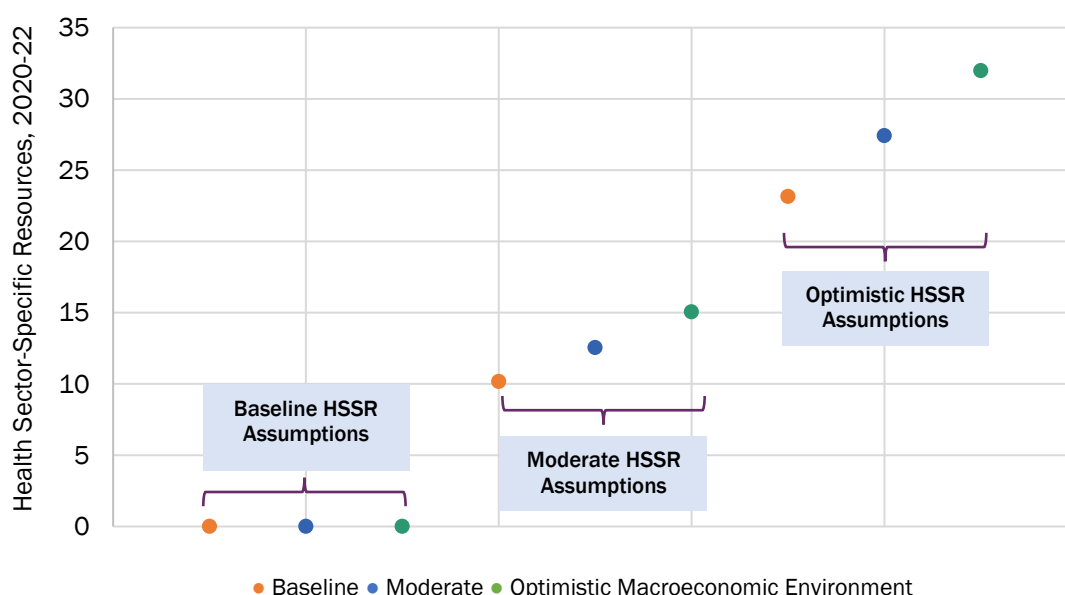
5.4. Health Sector-Specific Resources

Health sector-specific resources could account for as much as NGN 23 billion in fiscal space over 2018-2022, closing the SHDPPII five-year funding gap by up to roughly one-quarter (26 percent). Because the analysis assumes that no health sector-

specific resources are mobilized at baseline, any resources from health earmarks or premiums counts as new fiscal space. As much as NGN 26 billion in new fiscal space could be created through improvements in health prioritization, which is just above the NGN 23 billion that could be mobilized from health sector-specific resources. This finding suggests that similar gains in fiscal space can result from similar levels of resource mobilization effort targeting health prioritization and health sector-specific resources.

Figure 8 presents the range of possible health sector-specific envelopes under varying macroeconomic and health sector-specific resource assumptions. As can be seen in the graph, resources generated from an improvement in health sector-specific resource assumptions increase when macroeconomic conditions improve as well. This is because the BHCPF earmark and FCT-level earmarks each reserve government revenues for health, which are in turn influenced by GDP trends. The right-hand dot cluster illustrates that NGN 23 billion can be created if all health sector-specific resource assumptions are met, while a boost in macroeconomic conditions could expand the health sector-specific resource total to up to NGN 32 billion.

Figure 8. Health Sector-Specific Resources under Varying Macroeconomic and Health Sector-Specific Resource Assumptions, 2020-22, NGN Billions



Note: In each cluster of dots, all HSSR parameters are fixed to the same scenario and all Macroeconomic Environment parameters are fixed to the same scenario.

HSSR=health sector-specific resources

5.5. Nongovernmental contributions

Nongovernmental contributions would create little fiscal space for health in FCT, even under the most optimistic nongovernmental assumptions in the model. Additional contributions from these sources would amount to a maximum of NGN 6 billion over the five-year period, or a 5 percent reduction in the SHDPPII funding gap. To successfully mobilize this NGN 6 billion total, the FCT government would need to both increase its health official development assistance by 50 percent by the end of the period and increase the proportion of that official development assistance that is on-budget from 25

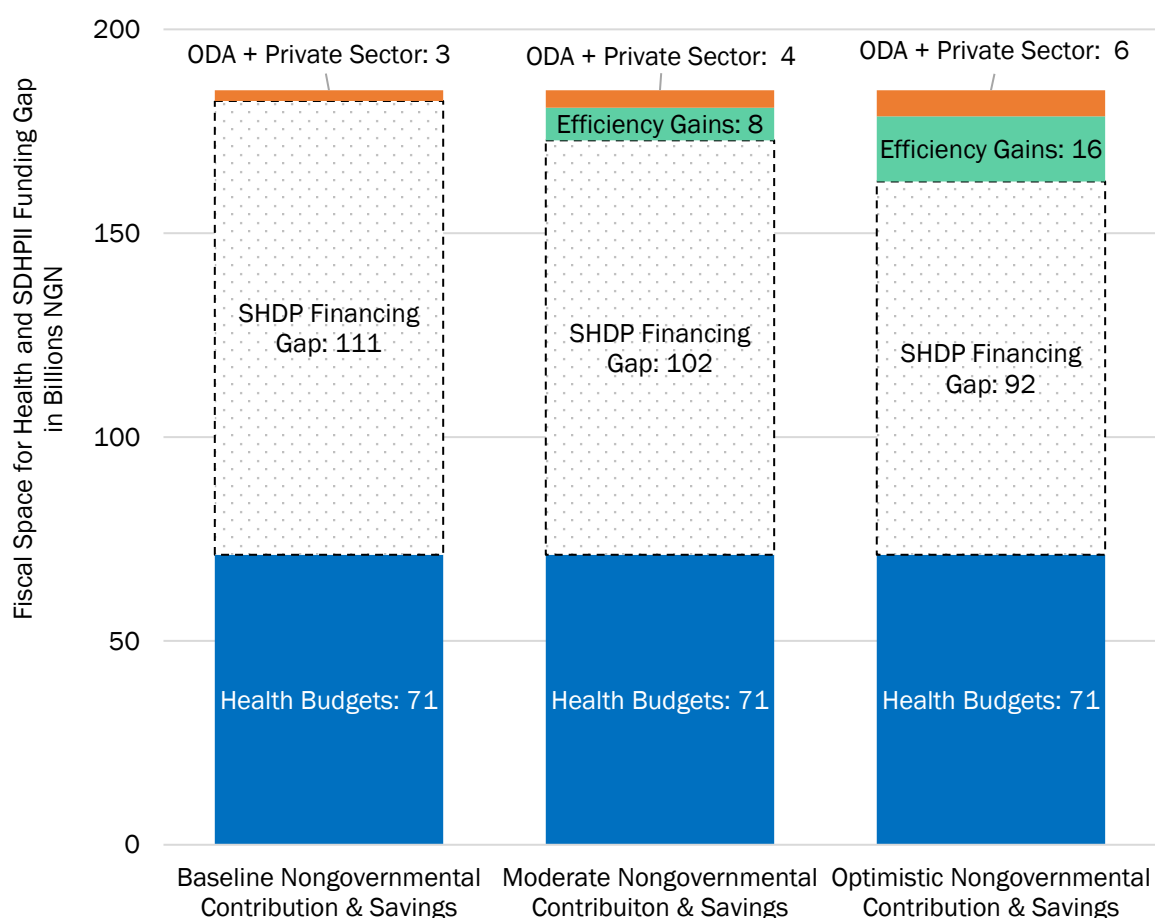
percent to 33 percent by 2022. Figure 9 illustrates the resources expected from nongovernmental contributions under three scenarios relative to resource from the other sources of fiscal space. In each bar plot, all parameters outside of nongovernmental contributions and efficiency gains are fixed at baseline.

5.6. Efficiency of Health Expenditures

Savings in human resource and procurement costs may account for a significant proportion of fiscal space in the FCT. If optimistic efficiency targets are reached, the SHDP cost requirement would drop by NGN 16 billion or 9 percent overall. Savings in human resource and procurement costs would make up 58 percent and 42 percent of total savings respectively when both parameters are fixed to the same scenario (moderate or optimistic). Figure 9 portrays the NGN 8 billion savings when both parameters are fixed at their moderate scenario, and the doubling of this figure to NGN 16 billion savings when optimistic efficiency conditions are assumed.

Encouragingly, it can be understood from this finding that minor efficiencies in the distribution of human resources and improved procurement could generate significant absolute savings in five-year SHDP implementation costs.

Figure 9. Impact of Official Development Assistance, Private Sector Contributions, and Efficiency Gains on Reducing SHDP Cost Requirements, NGN Billions



Parameter Assumptions (all other parameters fixed at baseline).

ODA=official development assistance

6. Discussion

6.1. Considerations for Expanding Fiscal Space for Health in FCT

The purpose of this analysis was to estimate the volume of resources that could be mobilized for health and how these resource estimates compare to FCT's SHDP II resource requirements. The critical subsequent step of determining *how* these resources would be mobilized was undertaken by the FCT Resource Mobilization Plan Task Force in developing 14 resource mobilization strategies, illustrated in Table 7.

Table 7. Resource Mobilization Plan Strategies 2018-2022, by Source of Fiscal Space

| Pillar | Strategies | Sub-strategies |
|--|---|--|
| Prioritization of Health (Target Envelope: NGN 117 billion) | Institutionalize Health Budget Expenditure Tracking & Reporting | N/A |
| | Align HHSS Budget Proposals with SHDP II & Prior Performance | N/A |
| | Advocate for Health Budget Allocation & Releases | N/A |
| Health Sector-Specific Resources (Target Envelope: NGN 22 billion) | Ensure Passage of HIS & PHCB Bills | N/A |
| | Facilitate Implementation of CRF Earmarks | N/A |
| | Meet Basic Health Care Provision Fund Gateway Requirements | <ul style="list-style-type: none"> • Support Set-Up of State Steering Committee and Treasury Single Account • Set Up/Operationalize Ward Development Committees • Conduct Facility Assessments of Ward Primary Healthcare Facilities |
| Official Development Assistance & Private Sector Contributions (Target Envelope: NGN 7 billion) | Implement International Public Sector Accounting Standards | N/A |
| | Establish a Donor Planning & Funding Coordination Platform | N/A |
| | Develop Investment Cases Targeting Private Sector | N/A |
| Efficiency of Health Expenditures (Target Savings: NGN 13 billion) | Rotational Posting of Healthcare Workers | <ul style="list-style-type: none"> • Rotational Posting of Hospitals Management Board Healthcare Workers • Leverage National Youth Service Corp and N-Power Programs to Resource Rural Primary Healthcare Facilities • Implement National Council on Health Resolution on Rotational Posting of Resident Doctors to Rural Areas |
| | Provide Conducive Accommodation for Healthcare Workers in Rural Facilities | N/A |
| | Initiate Bulk Procurement of Certain Commodities and Improve Maintenance of Commodities & Equipment | N/A |

In addition to implementing these resource mobilization strategies, the FCT health sector should ensure that the following conditions are met so that available fiscal space is sufficient to fully finance the SHDPPII by 2022.

1. **As fiscal space expands from one or more sources, this expansion should be prevented from displacing resources from another sources.** The FCT HIS and PHCB are eligible for funding from four separate earmarks at FCT and national levels. There is a risk that the FCT discretionary health budget for these two agencies will decrease significantly due to these new earmarked inflows, resulting in little net new fiscal space. In addition to ensuring that all four earmarks are implemented, the FCT health sector must ensure that, once implemented, resources from other sources are maintained at target levels.
2. **If the FCT health sector is to achieve the SHDPPII utilization and health outcome targets, expansions in fiscal space should be distributed optimally across each of the SHDPPII cost categories.** While the Resource Mobilization Plan articulated how the target resource envelopes by FSA pillar would be reached, the Plan did not articulate which health purposes these resources would serve. Annual funding gaps are projected over 2018-2021 even with full Resource Mobilization Plan implementation, which raises questions surrounding which SHDPPII cost categories would be favoured over others while resources are insufficient to finance all SHDPPII purposes. The FCT health sector will therefore need to distribute resource allocation across the eight SHDPPII categories in such a way that utilization and health outcomes are maximized with limited available fiscal space.
3. **Resource mobilization targets and strategies should regularly adapt to successes in resource mobilization efforts and shifts in the health financing landscape.** One of the fundamental assumptions guiding the FSA model scenarios and Resource Mobilization Plan strategies is that the model baseline for 2018 would remain fixed over 2019-2022. However, some key trends in fiscal space are bound to vary relative to the 2018 baseline. Where macroeconomic conditions become worse than was projected in the model, Resource Mobilization Plan implementers may consider redoubling efforts to mobilize resources from discretionary health budgets and health earmarks and/or set higher targets from alternative fiscal space pools, such as enrollee premium contributions, official development assistance and the private sector, and efficiencies. Improvements in fiscal space trends may require adjustment of resource targets as well.

6.2. Limitations

As is commonly the case in fiscal space analysis, efficiency gains in health expenditures proved difficult to quantify without a pre-existing study on spending efficiency in the FCT or a similar context. Because such a study could not be located, the analysis used generic 2.5 and 5 percentage point efficiency gains in human resources for health redistribution and in bulk procurement of health commodities and supplies, which were later validated through local expert opinion. Still, the analysis would benefit from savings estimates corroborated by analyses examining potential efficiency gains in human resource and procurement costs.

Because primary data on private sector contributions to SHDPPII activities could not be located, the analysis assumed that such contributions correspond to 50 percent of on-budget ODA. This estimate too was validated in a meeting with local experts. While the 50 percent estimate may noticeably overstate or understate private sector contributions, fiscal space

from ODA and private sector account for very little fiscal space: any error in the estimate would not have an important impact on total fiscal space in the FCT.

Finally, as existing estimates of FCT GDP were not available, the analysis used population estimates and an assumed level of parity with national GDP per capita. This level of parity was estimated based on the high rate of low-income migrants entering the Federal Capital Territory over the analysis period. Other factors could contribute to the level of GDP per capita parity, but the analysis team and the FSA core working group did not deem such factors sufficiently influential to include in the estimated FCT GDP calculation.

7. Conclusion

If there is no change in recent conditions, the model predicts that slightly more than half of the required resources will be available to finance the SHDPPII over 2018-2022. This massive funding gap would pose a major obstacle to the FCT health sector in its efforts to achieving coverage and HSS targets set out in the SHDPPII Essential Service Moderate Scenario.

Fortunately, a Resource Mobilization Plan has been developed which, if successful, will reduce annual SHDPPII gaps over the implementation period and meet full SHDPPII resource needs in 2021-2022. After the first two years of the 2018-2022 analysis period, the FCT health sector has made strides toward expanding fiscal space for health: the FCT HIS received its first instalment of NGN 106 million from the Basic Health Care Provision Fund HIS gateway in May 2019 and the FCT Department of Treasury released NGN 500 million in long-outstanding capitation and fee-for-service payments to providers in late 2018 (BHCPF, 2019; HP+, 2018).⁹ The FCT health sector can therefore regard fiscal space prospects through 2022 with a high degree of optimism.

⁹ The released funds from the FCT Department of Treasury are composed of enrollee premiums, one of the sources of fiscal space in the model.

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Annex A. Formation of FSA Working Group

A core FSA working group was established in April 2018 to advise the FSA analytic team from the conceptualization stage, through data and information collection, to analysis and interpretation. The following organizations were represented:

- Health and Human Services Secretariat:
 - Senior Statistics Officer, Health Planning, Department of Planning, Research, and Statistics
 - Desk Officer, Health Financing Unit, Department of Planning, Research, and Statistics
 - Deputy Director, Health Financing Unit, Department of Planning, Research, and Statistics
 - Deputy Director, Department of Plans and Programs
 - Deputy Director, Accounts Unit, Department of Planning, Research, and Statistics
 - Planning Officer, Department of Planning, Research, and Statistics
 - Statistical Officer, Department of Planning, Research, and Statistics
 - Head, Debt Management Unit
 - Desk Officer, Department of Human Resources for Health
- National Bureau of Statistics, Principal Statistician
- Federal Capital Territory Department of Economic Planning, Principal Planning Officer
- Economic Planning Unit, Department of Treasury

The analytic team produced an FSA model to guide data collection and analysis. HP+ technical staff and a consultant conducted an initial orientation session for core working group members to introduce the concept and elements of an FSA, to orient them to the situational purpose and scope for conducting an FSA for the FCT health sector, and to define the group's role. Core working group meetings were conducted at regular intervals:

- Conceptualization phase:
 - Review and advise on the FSA model and projection scenarios
 - Review data and information requirements
- Data collection phase:
 - Identify data and information sources and assist in obtaining access to official data
 - Identify key informants for targeted interviews to fill data and information gaps
- Analytic phase:
 - Review and advise on analytic methods for filling data gaps
 - Review and advise on projection scenarios
 - Review FSA model scenario outputs

Annex B. FSA Data Collection

The first phase of the FSA data collection process involved conducting a desk review of FCT and federal government documents and extracting relevant data and information required for the FSA model. The following key documents were reviewed:

- FCT health documents:
 - FCT government health budgets
 - FCT health statistical bulletins
 - FCT health budget performance reports and data
 - HHSS revenue and expenditure tracking reports
 - FCT SHDP II
- FCT non-health documents:
 - Total (all-sector) FCT government budgets
 - Total FCT government budget performance reports and data
 - FCT appropriation bills 2013–2017
- National and other documents:
 - FCT budget performance reports and data
 - Central Bank of Nigeria statistical bulletin
 - *Citizens' Guide to the Federal Budget*
 - National Bureau of Statistics reports
 - National Population Commission population projections
 - World Development Indicators database
 - FSA report from other applications in Nigeria
 - National Health Accounts 2010–2016
 - National Health Financing Policy
 - *Spending to Save: Challenges and Opportunities for Financing Nigeria's Saving One Million Lives Initiative*
 - *Saving One Million Lives Initiative*, Results for Development Institute, July 2014

Key informant interviews were conducted to fill gaps remaining after completion of the desk review. The following is a list of key informants' position and organizational affiliation:

- Honourable Secretary, FCT HHSS
- Head, FCT HHSS Debt Management Unit
- Executive Secretary, FCT Primary Health Care Board
- Deputy Director, FCT HHSS Department of Planning, Research, and Statistics
- Head, FCT HHSS Procurement Department
- Head, FCT HHSS Medical Services Department

- Head, FCT HHSS Pharmaceutical Department
- Project Officer, FCT Health Insurance Scheme
- Deputy Director, Federal Capital Authority Budget Administration
- Director, FCT Department of Treasury
- Director Economic Planning Unit, FCT Department of Treasury
- Director, FCT HHSS Department of Administration and Finance
- General Manager, Hospitals Management Board
- Assistant Director, Procurement, FCT HHSS
- Program Manager, FCT Health Insurance Scheme
- Director, Abuja Central Medical Stores
- Deputy Director, FCT HHSS Department of Plans and Programs
- Director, FCT Hospitals Management Board Clinical and Diagnostic Services
- Director, FCT Inland Revenue Board
- Director, Area Council Service Secretariat
- Director, National Primary Healthcare Development Agency

Tailored interview guides were developed for each key informant taking into consideration the informants' area of knowledge and expertise, as well as data and information gaps the FSA analytic team expected each to fill. Interviews were audiotaped and transcripts were analyzed to extract needed content to be incorporated into the FSA model.

Annex C. Resource Mobilization Plan for the FCT Health Sector, 2018-2022

With the fiscal space analysis complete, the FCT HHSS set up a Resource Mobilization Plan Task Force, charged with developing a set of strategies intended to tap the potential of these resource pools and savings as estimated by the FSA and close the SHDPII funding gap by 2022. Before developing the strategies, the Task Force first prioritized which resource pools and savings it was going to target to close the gap, by selecting the FSA parameter scenarios which it believed could be realized through enhanced resource mobilization efforts from the health sector, while remaining cognisant of the constraints outlined in each scenario's assumptions.¹⁰ The Task Force selected scenarios for each of the model's 14 parameters; the model was run to estimate potentially available resources for these combinations. These parameter selections by FSA pillar are shown in Table 8.

Table 8. FSA Parameter Scenarios Selected by Resource Mobilization Plan Task Force

| Pillar | Parameter | Scenario | Specification |
|---|--|------------|---|
| Pillar I: Macroeconomic Conditions | National Real Gross Domestic Product (GDP) Growth | Moderate | Rise from 2% to 4% by 2022 |
| | Level of Parity between FCT & National GDP/capita | Optimistic | 100% |
| | Federal Revenue Collections | Moderate | Rise from 6% to 8% by 2022 |
| | FCT Internally Generated Revenue (IGR) | Moderate | Rise from 5% to 7% by 2022 |
| Pillar II: Prioritization of Health (Target Envelope: NGN 117 billion) | Proportion of FCT Budget Allocated to Health | Moderate | Rise from 10% to 12.5% by 2022 |
| | Proportion of Area Council Budgets Allocated to Health | Moderate | Rise from 3% to 4% by 2022 |
| Pillar III: Health Sector-specific Resources (Target Envelope: NGN 22 billion) | Timeliness of Implementation of Basic Health Care Provision Fund Earmark for FCT | Optimistic | Implementation of earmark in 2020 |
| | Timeliness of Implementation of FCT Health Insurance Scheme (HIS) & Primary Health Care (PHC) Earmarks | Optimistic | Implementation of both earmarks in 2020 |
| | Amount of HIS Enrollees | Moderate | Rise from 100k to 200k by 2022 |
| | Timeliness of Availability of HIS Enrollee Premiums | Optimistic | Availability by 2020 |

¹⁰ The macroeconomic environment parameters are not influenceable by the health sector. Unlike the parameter scenarios under the other four pillars, the Task Force did not consider the degree to which enhanced resource mobilization efforts would affect the scenarios. Instead, the Task Force considered which scenarios are most likely to unfold given the conditions outlined in the scenario assumptions.

| Pillar | Parameter | Scenario | Specification |
|---|--|------------|--|
| Pillar IV: Official Development Assistance + Private Sector Contributions (Target Envelope: NGN 7 billion) | Amount of ODA Support | Optimistic | Rise from 0.1% to 0.15% of GDP by 2022 |
| | Proportion of On-budget vs. Off-budget ODA | Optimistic | Rise of co-managed funds from 25% to 33% by 2022 |
| Pillar V: Efficiency of Health Expenditures (Target Savings: NGN 13 billion) | Savings from Redistribution & Rotation of Healthcare Workers | Optimistic | Annual 5 percentage point rise |
| | Savings from Streamlining Procurement Practices | Moderate | Annual 2.5 percentage point rise |

Once the target resource envelopes for each pillar was defined, the Task Force developed 14 strategies intended to ensure that these funds are mobilized and to ensure efficiency gains in health spending are realized. Captured in Table 7 of the report are the strategies and sub-strategies by FSA pillar; the rationale and implementation approach for each are detailed in the FCT Resource Mobilization Plan report. Now endorsed by FCT health sector leadership, these 14 interventions constitute a strategic plan for resource mobilization in the FCT that is informed by the fiscal space projections generated by the FCT fiscal space analysis.

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